Combating AIDS/HIV Spread In The Workplace: A Case Study Of The Durban Clothing Industry

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Declaration

This dissertation denotes original work by the author and has not been submitted in any other form to another university. Where use has been made of the work of other authors and sources it has been accordingly acknowledged and referenced in the body of the dissertation.

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Opinions expressed and conclusions attained are those of the author and are not necessarily to be attributed to the School of Development Studies.

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CHAPTER ONE

INTRODUCTION AND METHODOLOGY

The severity of the economic impact of the disease is directly related to the fact that most of the infected persons are in the peak productive and reproductive age groups. AIDS kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern nations and countries.

(Nelson Mandela, World Economic Forum, Davos, 1997 cited in Heywood, 2000: 1)

The "Millennium Bug" or "Y2K" is currently the focus of management throughout Southern Africa, and indeed the world. Millions of rands have been poured into preventative measures, to ensure that this bug does not disrupt the productive capacity of computer systems.

However, there is an incurable virus, currently escaping the attention of management, which is insidiously attacking and weakening the productive capacity of companies' human resources. The manner in which management addresses AIDS in the workplace will determine whether their companies survive the first decade of the 21st century.

(Deanne Moore, Actuary, Metropolitan Life, AIDS Analysis Africa, May 1999 cited in Heywood, 2000: 1).

1.1. INTRODUCTION

South Africa is only just beginning to grapple with the impact of HIV/AIDS in the workplace although it is now well into the second decade of its HIV epidemic. The long asymptomatic phase (7-10 years) post initial infection has resulted in the virus being inapparent and the opportunistic infections associated with the AIDS condition has further masked the emergence of the virus in the eyes of the public. However, this period of complacency in the light of the invisibility of the epidemic is rapidly changing (Evian, 1995).

Literature shows that there is a distinction between HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome), HIV being the virus that

causes AIDS (SHRM, 2001:1; Badri, 1997; Davies et al, 1997). This distinction is understood but the terms will often be used interchangeably. Wilkins (1995) undertook a study that looked at the responses of South African companies to AIDS in the workplace and found that 60.3% of companies did not have an official AIDS policy (p10). In a separate study, Mason (1995) adds to this by stating that the number of industries sampled suggests that few industries had formally adopted a policy on AIDS, and that these findings were consistent with other research assessing the response of industry to the AIDS pandemic (p11). Thus, as recently as 2000, research findings were following similar paths to Wilkins (1995) and Mason (1995). A leading Human Resource company named FSA-Contact conducted a survey on HIV/AIDS in companies and the research findings highlighted that there were relatively few South African companies that had taken active steps to address the problems and consequences of HIV/AIDS in the workplace. Statistics showed that of those that had an AIDS plan or policy in place, nearly one-third (30%) began drafting these policies in 1999, when 22.8% of South Africa's sexually and economically active population were already HIV-positive (www.fsacontact.co.za). Despite the scale of the epidemic, there are relatively limited data on its impact at the business level. One reason for this is undoubtedly the enormous stigma that is still attached to HIV infection (loveLife, 2001: 3). Therefore, actual development and implementation of prevention and coping strategies, especially at the workplace, have been slow in coming forth (Barese, 1995).

Research questions about how AIDS will distort the labour market and change labour patterns are being left untouched. A survey conducted in 1998 found that 84% of employers still had no idea what percentage of their staff might be HIV-positive. By 2000, with a few exceptions, most employers were still reporting no or only minimal impact of HIV on their operations. Research commissioned by the AIDS Legal Network (ALN) in 1998 found that only one-quarter of the employers surveyed had a policy on HIV testing in the workplace. Press reports repeatedly revealed that only a tiny minority of workplaces was offering employees access to information about HIV, counselling, care and condoms (Heywood, 2000). Part of the problem in organisations that have not

responded to HIV/AIDS is the lack of clear understanding on the part of senior management about the legal and financial ramifications of the HIV/AIDS epidemic in the workplace. Internationally, it has been proven that without top management's comprehension of the problem, workplace programs will either be ignored or doomed to fail (Barese, 1995).

HIV/AIDS impacts on all individuals and it knows no distinction between colour, race and age. Thus, HIV/AIDS is a 'democratic disease' with the potential to affect all members of society (Heinzen, 1995: 4). However, women are most likely to carry much of the burden of HIV due to a greater physiological risk of HIV infection, as well as being the primary caregivers for HIV infected men and children. Therefore industries that employ large numbers of women, such as the clothing and textile industries in Durban may be predicted to be severely affected (Heywood, 2000: 7). Thus the workplace is an ideal situation for the implementation of a thorough and ongoing AIDS prevention program (Mason, 1995). Davies, Schneider, Rapholo and Everatt (1997) reiterate this point by stating that the workplace provides an excellent environment to implement a comprehensive HIV/AIDS program and policy reform.

HIV/AIDS initially emerged as a workplace issue as a result of concerns relating to stigma and discrimination and this influenced much of the focus on AIDS in the workplace in the late 1980s. In the early 1990s much effort went into developing fair policies for the workplace and into advocacy targeted against unfair discrimination. This pattern is evident from the ground breaking 'AIDS agreement' between the National Union of Mineworkers and the Chamber of Mines (1990). Moreover, the inclusion of workplace issues in the AIDS Consortium Charter of rights on AIDS and HIV (1992) and the decision of the Centre for Applied Legal Studies (CALS) to host its first conference on legal rights and AIDS on the subject of employment (Heywood, 2000: 10) has encouraged the workplace to realise the threat of the epidemic.

In October 1998 the government signalled a revitalisation and heightened commitment to HIV prevention with the launch of the 'Partnership against AIDS' by the then deputy president, Thabo Mbeki. In 1999, after the general election on June 2nd, a new minister of health, Dr Manto Tshabalala-Msimang was appointed. Almost immediately a review of the National AIDS plan was initiated and in January 2000 Cabinet was presented with a revised plan covering the years 2000-2005 and HIV prevention in the workplace was taken cognisance of.

Given the threats posed by HIV/AIDS in the workplace the research underpinning this dissertation focused on issues of HIV/AIDS in the manufacturing sector and what firms were doing to protect themselves and their employees from the impacts of the virus. More specifically, the clothing sector was focused upon, as this is the sector with the greatest number of female employees. The focus of the research was on prevention programs that were being initiated and implemented by the firms surveyed. To obtain the answers to what firms were doing with respect to prevention programs, the following research questions were posed to key informants at the companies.

(1) What led to the development/implementation of such a program?
(2) What are the impacts of the HIV/AIDS epidemic on the firm, employee and management level?
(3) Is there long-term commitment to HIV/AIDS prevention?
(4) Are there any significant changes in employees' behaviours and attitudes after the implementation of the prevention programs?
(5) What is the degree of commitment to community HIV/AIDS outreach activities by firms?

The dissertation comprises of six chapters and is briefly summarised below.

Chapter One: Introduction and Methodology

This chapter commences by ephemerally discussing the research study, which looks at HIV/AIDS in the clothing sector and literature pertaining to the epidemic. A list of the

research questions that were asked to obtain answers is also presented. The primary method of attaining information was via semi-structured interviews and the key informants were individuals that were knowledgeable about HIV/AIDS information and prevention programs, as well as their workforces, and who were willing to share that information. The methodology utilised to analyse the raw qualitative data was Content Analysis. The reasons supporting this choice of method, as well as the use of secondary research is discussed in section 1.2. Lastly, the key findings for each dissertation chapter are summarised and offered below.

Chapter Two: Theoretical Framework

This chapter's theoretical argument is initiated by discussions on the epidemiology of the HIV/AIDS virus, which is followed by a description of the impacts of the epidemic, world-wide. The theoretical discussion then focuses specifically on the impacts of the epidemic in the context of South Africa and the country's response to the virus. The context of KwaZulu-Natal (KZN) is a complementary area of importance due to the prevalence of the disease in the province. Moreover, the discussion examines different theoretical frameworks that have been put forth in attempts to interpret and understand the virus.

Chapter Three: The Manufacturing and Clothing Sector

A literature review of the manufacturing and clothing sector in South Africa and more specifically, KwaZulu-Natal (KZN) is discussed. The central points of discussion are on the importance of the manufacturing sector to South Africa and the devastating implications that HIV/AIDS will have on this sector if firms continue to ignore the threat of the epidemic and if no prevention programs are instituted in the work environment to challenge and combat the virus. The greatest effects will be on the workforce, resulting in increased deaths, absenteeism and increased labour turnover, and regrettably these effects are already beginning to be evident in firms.

Chapter Four: HIV/AIDS and the World of Work

This chapter takes on a holistic approach in its discussions of HIV/AIDS and the effects of the epidemic on the world of work. Subsequently, possible prevention programs and policy strategies to overcome the threat of HIV/AIDS in the Durban clothing firms are highlighted. Thus, ongoing education on prevention is instrumental in fighting HIV/AIDS in the workplace.

Chapter Five: Survey Findings

Chapter Five explores the results of the fieldwork component of the study. It analyses the results of the data that were obtained from key informants in the eight firms on HIV/AIDS and prevention programs in the clothing industry. Informants' responses were very insightful and resulted in the emergence of five themes. The survey findings were that firms were not taking any serious and long-lasting initiatives to meet the threat of HIV and AIDS. Reasons for this apparent lack of seriousness stemmed from the virus having a long incubation period and the abundant supply of labour in the region. Due to high rates of unemployment, labour is constantly available and this has resulted in the bare minimum being undertaken for HIV/AIDS awareness in the work environment.

A common finding was that the virus was not, as yet, impacting on the firms' production levels or on their profits. A consequence of this is that management has shown disinterest and poor commitment to HIV/AIDS prevention programs. In addition to this, a further reason for disinterest stems from the employer-employee dichotomy that is still prevalent in firms, which has resulted in employers not being totally conscientious of the needs of their employees'. On further analysis of the key informants replies, it was found that there was a diverse range of responses regarding employees' attitudes, behaviours and their interpretation of HIV/AIDS. The analyses of the data on employees' views suggested that education on HIV/AIDS awareness is currently not effective and efficient in getting the messages across and that culture and traditional values continue to impact on the way the virus is perceived. For education to be successful one's tradition and culture must be taken cognisance of when firms' draw up prevention programs and

policies. The central findings were that the implementation of prevention programs and policy strategies are beneficial to firms and that it would equip firms to handle and meet the challenges of HIV/AIDS, now and in the future. Further, there needs to be greater effort and collaboration by all stakeholders from grass roots level, national levels to international support so that the fight against HIV/AIDS can become unified and more successful. Lastly, the findings demonstrated that firms were not committed to outreach programs in surrounding communities due to these firms showing minimal interest and support for prevention programs and education within their firm boundaries.

Chapter Six: Conclusion and Recommendation

This chapter provides a summation of the main discussion points in the dissertation pertaining to HIV/AIDS and the impacts of the epidemic on the Durban clothing industry. Recommendations from various literature services are presented, which put forth possible prevention programs, strategies and policies that can be utilised in the workplace. Firms need to utilise these programs as a basis and tailor educational awareness programs according to the needs of their employees' and internal work environment.

1.2. METHODOLOGY

Clothing firms in the formal sector in Durban were chosen as the study population. Firms of all sizes were randomly selected. Initially 21 firms were contacted telephonically and the researcher introduced the study and its aim. Follow up phone calls were then made to secure permission from management and arrange times for appointments with key informants.

Data was collected by means of a checklist that sought to ascertain whether key areas were being covered in the firm's HIV/AIDS prevention program. A semi-structured interview was then undertaken. The validity and reliability of the reported data was assessed by using key informants that were directly involved in the implementation of the prevention programs, who were responsible for disseminating information, who were

providing education on HIV/AIDS and who were representative of the employee population in the firm. Thus, the firm's nursing staff and union representatives (shop stewards) were the key informants in the study. The research interviews were conducted during the period of July to mid-September 2001. The duration of the interviews lasted from a minimum of 45 minutes to a maximum of one-and-a half hours. Prior to conducting the semi-structured interviews with the key informants, the researcher set up an interview with Dr F. Mansoor (2 July, 2001), the National Co-ordinator for the South African Clothing and Textile Workers union (SACTWU) HIV/AIDS Project for the KwaZulu Natal (KZN) region. This interview was very insightful as it provided invaluable background information as to the role of SACTWU and moreover, the expectations of the union regarding the role that clothing firms as employers need to adopt in dealing successfully with the impact of HIV/AIDS.

The research approach used was qualitative. Qualitative research is committed to understanding the unique experiences of the individual from his/her perspective of the social world by seeking to develop shared meaning (Pernice, 1996: 339). Furthermore, in qualitative research, the researcher has certain questions that he/she wants to have answered and by conducting a semi-structured interview, there is some freedom permitted in obtaining reliable answers. This technique also allows the researcher to delve deeper and explore the informant's insights or experiences. In addition, it allows the researcher to not only pick up on the non-verbal cues but the external cues projected from the informant (Qualitative Research Methods, 2001:www.polygot.Iss.wisc.edu/socwork/SW650/Lecture 10.ppt). This method of semi-structured interviews was deemed the most appropriate by the researcher because it led to a thorough investigation of the information key informants provided due to them having an extensive knowledge of the prevention programs and the issue of HIV/AIDS in their work environment. The advantage of having questions helped the researcher not to forget or misinterpret questions that were needed for the study and the usefulness of being able to delve into points that were important and required clarification.

The analyses of the raw data were undertaken using content analysis. Content analysis is based on developing a category of themes that can be applied to all data and the goal is to organise the data to describe it. Moreover, content analysis allows the researcher to look for key concepts, themes, propositions and cultural models (Qualitative Research Methods, 2001:www.polygot.Iss.wisc.edu/socwork/SW650/Lecture 10.ppt).

The sample utilised in this study were Durban-based clothing manufacturers, with the companies randomly chosen. The researcher had a list of the names of clothing firms, their addresses and telephone numbers, which was taken from the CODESA book and the researcher then proceeded to phone each company on the list. The clothing companies were chosen from the Durban area specifically due to the researcher wanting to find out in particular, the effects of HIV/AIDS in the Durban clothing industry.

Out of approximately twenty-one clothing companies whose names were on the list, the researcher interviewed eight companies. The reason that only eight companies were interviewed was due to the limitation in receiving permission from companies to conduct interviews with the individual that initiated the HIV/AIDS programs. A further limitation was that company managers were reluctant to allow interviews to take place due to time constraints. Managers were often not prepared to allow time off from work for key informants to talk to the researcher. Notwithstanding these research difficulties, the eight firm-level interviews that were undertaken uncovered a wealth of information with the key informants generally extremely happy to discuss their views and present an outline of their firm's HIV/AIDS policies and practices. The liberality of these key informants to share their views was on account of their confidentiality and anonymity being guaranteed and it has resulted in these eight firms being referred to as firms A-H in the dissertation.

Apart from the qualitative semi-structured interviews that were conducted, secondary research was also undertaken. Research material and information was gathered via access to the world wide web (Internet) and the consultation and reading of monographs, journals, newspapers and magazines on HIV and AIDS. Moreover, a visit to HEARD

(Health Economics and HIV/AIDS Research Division) at the University of Natal-Durban campus was also very useful to the researcher. The visit provided a backdrop to understanding the overarching socio-economic implications of HIV and AIDS on South Africa generally and on the world of work, specifically.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.1. EPIDEMIOLOGY

AIDS, which stands for Acquired Immunodeficiency Syndrome is caused by the human immunodeficiency virus (HIV), which destroys the immune system thus rendering the patient totally vulnerable to an array of infections and some forms of cancer (Badri, 1997 SHRM, 2001; Davies, et al, 1997). The belief that HIV is the only necessary and sufficient agent in the aetiology or causation of AIDS is the general consensus among scientists and practitioners and it is endorsed by national and international health organisations (Badri, 1997)[1].

The AIDS virus survives and multiplies by penetrating and taking over the cell bodies of another organism. For this reason, it was found to be extremely difficult to develop medicines like antibiotics, which disrupt or stop their life cycle, without seriously harming the cells of the host organisms. A further difficulty in treating viral infections is the rapidity with which the virus multiplies. When the symptoms of the disease appear, it is already too late for the anti viral drug to have any real effect (Badri, 1997; Davies, 1997).

The AIDS virus succeeds in getting into the human body through sexual contact, contaminated blood, or through transfer of bodily fluids, for example by sharing razor blades or needles for injections, or through contact with open wounds. Likewise, when a HIV-positive woman gives birth to or breast feeds her baby, the virus can be passed onto the baby (Nyathikazi, 2001: 16).

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[1] A different view of the cause of AIDS is held by President Thabo Mbeki, who disputed the fact that HIV caused AIDS (Crewe, 2000). This is a view that is held by a very small minority of scientists as well.

2.1.1. WHAT HAPPENS WHEN A PERSON IS INFECTED?

When a person is infected with the AIDS virus, it may take their weakened immune system from a few weeks to a few months to develop antibodies for the HIV, which is known medically as anti-HIV or antibodies (Badri, 1997; Davies, 1997; SHRM, 2001). Unfortunately, the late arrival of this antibody from the defective immune system wages a losing fight against the virus. This is not only due to the antibody being weak but also because the virus 'hides' inside the cells thus avoiding recognition. Accordingly, it has no effect in curbing the multiplying virus, and as the disease progresses, there may be also a decline in this ineffective antibody. So it may simply give the body the false impression of immunity. However, this antibody has a very useful role in revealing whether a person is infected with the virus or not. Anti-HIV found in the blood is taken as an evidence of the presence of the virus (Badri, 1997; Davies, 1997).

Though medical and scientific research into this newly discovered disease initially progressed with astonishing rapidity, it still remains the greatest threat to human health. AIDS as a syndrome was identified in 1981 and in 1983 research proved its viral connection. The virus was identified and AIDS tests were available by 1985. In spite of this, we still do not have any effective methods of treatment. According to a number of research studies conducted in England and the Netherlands and quoted by Root-Berstein (1993: 91 cited in Badri, 1997: 12), "HIV mutates much faster than that of colds and influenza and that in reality, every HIV-positive person is infected by dozens of different kinds of HIV". This is one of the reasons for the pessimism of an early vaccine or cure for AIDS (Badri, 1997).

Table 1: Summary of the different stages of HIV and its transformation into AIDS.

STAGE	DIFFERENT STAGES
Stage 1: HIV Infection	Initial infection with HIV
Stage 2: Window Period	HIV infection with no signs or symptoms of disease and no detectable antibodies. An HIV antibody test will be negative although

	the virus is present. This stage usually lasts 2-12 weeks but may last several months or occasionally even longer.
Stage 3: Seroconversion	The development of antibodies. It may be accompanied by a few days of flu-like illness. Some people experience no illness at this stage.
Stage 4: Asymptomatic HIV Infection	Antibody tests are positive but there are no apparent signs or symptoms of illness. This period may last from a few months to many years.
Stage 5: HIV/AIDS related illnesses	Signs and symptoms of diseases increase because HIV is damaging the immune system (example diarrhoea, swollen glands and night sweats) but symptoms are not life threatening. This period may continue for months or years. Infections gradually become more persistent and serious.
Stage 6: AIDS	Life threatening infections and cancers occur because the immune system is severely weakened. The patient could die when an untreatable life-threatening condition develops. Life expectancy depends on the conditions that develop and the treatments available

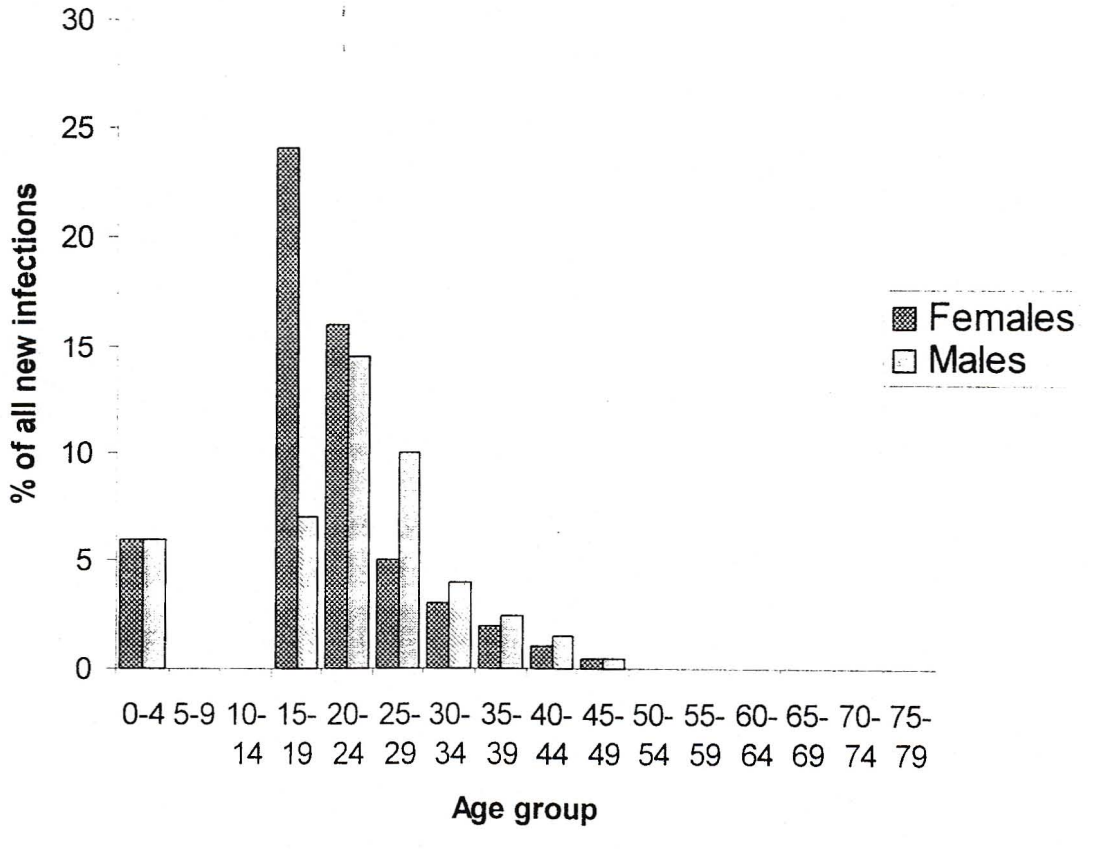
Source: Davies, et al (1997)

The importance of Table 1 lies in its last two stages. Stage 5 and Stage 6 impacts on the world of work and it is at these stages that one may find it is too late to try and fight the virus. The consequence of the latency stages are that employees begin to fall ill and inevitably, companies lose valuable employees through HIV and AIDS-related deaths.

2.2. HIV/AIDS: the global picture

According to recent estimates from the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), 34.7 million adults and 1.4 million children were living with HIV worldwide at the end of 2000 (loveLife, 2001: 4). 32.4 million out of 33.6 million persons living with HIV are in their most productive years, that is, between the ages 15-49 and 1.2 million are children aged 15 years and younger. In 1999 alone, 5.6 million people (570 000 children) became infected with HIV and 2.6 million died from AIDS (ILO, 2000: 4). Around half of all people with HIV become infected between the ages of 15 and 24 and die approximately 10 years later (ILO, 2000; Halweil and Brown, 1999; loveLife, 2001). In addition, females are more susceptible to infections and the rates are significantly higher for females than males (loveLife, 2001: 25). It is estimated that over 60% of all new infections currently occur in those between 15 and 25 years of age with women generally being infected earlier than men (See Figure 1) (loveLife, 2001: 24-25).

Figure 1: Incidence of HIV by gender and age group. (Source: loveLife, 2001: 25).



2.3. Regional features

The pandemic has taken on different forms in the various parts of the world. In some areas, HIV has spread rapidly to the general population. In some others, certain sub-populations have been particularly affected, including sex workers, men who have sex with men and injecting drug users. Over 23 million people in sub-Sahara Africa (S-S-A) are reported to have HIV infection or AIDS. This figure amounts to 70% of the global total of persons living with HIV/AIDS and yet this is a region inhabited by around 10% of the world's population (ILO, 2000: 6). In nine African countries, the rate of adults living with HIV/AIDS is 10% or more. Two other countries have rates of 20%; this means that approximately every fifth person between 15 and 49 years of age is HIV-positive and will, in all likelihood die in the course of the next 10 years (ILO, 2000).

2.4. Behavioural change framework

The epidemiology of the epidemic is greatly influenced by the size of the pool of HIV infected individuals. If preventative interventions do not bring about prevention of infection in the medium to long-term, any delay in infection contributes to a reduction in the rate of growth of the epidemic. Regarding the requirements of behaviour change, the Population Information Program of the John Hopkins University detail a simplified framework for personal behaviour change in relation to health education (Parker, 1994):

THE RATIONAL ELEMENT: based on knowledge. People need to understand what the disease is, how it is transmitted, how they are at risk of infection and how these risks can be avoided (Parker, 1994; Department of Health, 2000).

THE EMOTIONAL ELEMENT: based on the intensity of attitudes or feelings. People need to feel intense and personal vulnerability to the disease and have an emotional commitment to the behaviours needed to avoid it. This element also includes a compassion for those already affected and concern to prevent others from contracting it. Emotions may be negative, based on fear and/or anger, or positive, based on love or hope for reward (Parker, 1994).

THE PRACTICAL ELEMENT: based on personal skill in the new behaviour. People need to be competent and confident in practising the new behaviour, whether it is use of condoms, avoidance of multiple sexual partners or changes in sexual behaviour (Parker, 1994; Nyathikazi, 2001).

THE INTERPERSONAL ELEMENT: or social networks. People need to associate with and be supported by others, in the family, peer groups, communities' etc, whose knowledge, emotions and skills reinforce healthful changes (Parker, 1994; Department of Health, 2000).

THE STRUCTURAL ELEMENT: or social, economic, legal and technological context in which behaviour takes place. People need to have access to the necessary suppliers and services (such as condoms and blood) and to live in an environment where safer behaviour is made easy, accepted and even routine, while risky behaviour is made difficult (Parker, 1994: 1-2; Nyathikazi, 2001).

The crucial issue in AIDS prevention is the bringing about of sustained behaviour change. Given that it is difficult to demonstrate that this can be sustained over the long term, some health professionals view the concept with deep cynicism. In addition to this, it is becoming increasingly clear worldwide that changes in behaviour, even in the short term, occur within a broader context that is supportive or otherwise, of that behaviour change. Strategies that seek to bring about behaviour change therefore needs to recognise the multidimensional nature of these contexts. In a review of HIV/AIDS prevention methodologies, Jonathan Mann in Parker (1994: 2) emphasised the need for a broad-based approach:

The failure of information to lead reliably, regularly or predictably to behaviour change has been documented repeatedly in varying cultures and contexts and underscores the need for a comprehensive approach to prevention.

A contrasting view offered by Evian (1995) states that at first it seemed that focusing on human behaviour (that is, sexual behaviour) was a logical approach to controlling the epidemic. One assumed that if people learned about AIDS and did the 'right thing' that the epidemic would look after itself. Unfortunately, this type of thinking is naïve. AIDS is essentially a virus governed by and intertwined in the relationships between people, which in turn are influenced by many social and economic factors. Maintaining stable, lasting and trusting relationships is at the heart of the control of the epidemic. In addition to this, past, present and future forces, influences and stresses on community and family life in South Africa have and will continue to determine the ultimate size and impact of the epidemic.

2.5. THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA

As with other parts of Africa, the South African AIDS epidemic is over 15 years old. However, during the 1990s, the curve of new infections (the incidence of HIV) began to increase dramatically. One result is that within the last two years South Africa has crossed the threshold into a visible AIDS epidemic, people who were infected seven or eight years previously are now becoming ill and dying in larger and larger numbers. It is estimated that around four million South Africans are currently infected with the HI-virus (loveLife, 2001: 6).

It is further estimated that approximately 200 000 South Africans' are currently living with AIDS. This figure will rise rapidly over the next decade to almost a million people living with AIDS by the year 2010 (loveLife, 2001: 6-7). AIDS is not 'notifiable' in South Africa and statistics on AIDS and AIDS-related deaths are not systematically collected or analysed. However, epidemiologists have estimated that by 1998 over 120, 000 people were dying per annum of AIDS. According to UNAIDS 300,000 South Africans died in 1998 and 1999 and 210, 000 will die in the year 2000. ING Barings Bank projects that deaths from AIDS will peak at around 600,000 per annum in 2011 (The Sunday Independent, 23 April 2000 cited in Heywood, 2000: 5).

On April 19th 2000 the Minister of Health released the results of the tenth HIV sero-prevalence survey of women attending public antenatal clinics in South Africa. The results indicate that by late 1999 up to 4.2 million people in South Africa had been infected with HIV. This will have a profound and lasting impact on human, social and economic development in South Africa. Broken down by gender, these figures suggest HIV infection in

- 2.2.million women
- 1.9 million men
- Approximately 100,000 infants (Heywood, 2000)

Table 2: Statistics of HIV/AIDS infection indicated by different age groups

AGE GROUP	PREVALENCE1999
<20	16.5%
20-24	25.6%
25-29	26.4%
30-34	21.7%
35-39	16.2%
40-44	12%
45-50	7.5%

(Source, Heywood, 2000: 2-3)

The statistics in Table 2 highlight that the highest prevalence rates are in the age groups 20-24 and 25-29. These age groups are the most economically and sexually active in the population (Heywood, 2000). The statistics found in Table 2 fits in with the statistics highlighted by other research studies (see Figure 1).

For the purpose of analysis of the impact of HIV/AIDS on the world of work, several shortcomings of the annual 1999 sero-prevalence survey should be noted at the outset. Firstly, although the results are used to make estimates about the infection rates amongst

men and women, the survey is entirely of women. Secondly, because the survey is entirely based upon pregnant women, HIV prevalence amongst people over 50 is not measured. Finally, the survey provides no information on the socio-economic status of the participants (including such basic information as to whether they are employed or unemployed) (Heywood, 2000: 3).

Nonetheless, two findings of the 1999 sero-prevalence survey are particularly salient to the workplace. The first is the confirmation provided by statistics of the greater vulnerability of women to HIV infection (Heywood, 2000). AIDS prevention in the workplace has, up to now, ignored this fact. Prevention programs have been largely gender neutral, or by default, biased against women's particular needs. Similarly, the direct and indirect implications of the impact of AIDS on women have not been factored into thinking about or planning for the consequences of the AIDS pandemic on the world of work (Heywood, 2000: 3). This is especially significant for an industrial sector such as clothing, where the majority of employees are women.

HIV/AIDS is a threat to gender equality. Women are highly vulnerable to HIV/AIDS for both biological and cultural reasons. Women are particularly affected by HIV/AIDS when a male head of the household falls ill. Burden of caring for children orphaned as a result of the pandemic is borne mainly by the women. Loss of income by the male compels the women to seek other sources of income, putting them at risk of sexual exploitation. HIV/AIDS also increases child labour in impoverished households. It is difficult to attend school due to pressures from the home to work. The result is that these children do not receive proper care and guidance, and easily fall victim to all kinds of exploitation (ILO, 2000; Evian, 1995). An imbalance of power within relationships often results in young women not being able to ask their partner to wear a condom. Such a request may lead to a violent response and can be interpreted as a sign of unfaithfulness on behalf of the female partner, or an accusation that the male has not been faithful himself or that he has a Sexually Transmitted Disease (STD) (Dallimore, 2000).

Current information indicates that women tend to become infected far younger than men do (loveLife, 2001; ILO, 2000; Evian, 1995). Recent studies of several African populations, girls aged 15-19 years are five times more likely to be HIV-positive than boys of that age. This is due to gender-related risk factors that increase women's exposure to HIV and sexually transmitted infections, and impair their ability to protect themselves from infection. These include:

(1) Behavioural factors: inability to negotiate use of condoms, refuse sexual intercourse or demand divorces because of adverse economic, social or legal consequences.

(2) Gender-related cultural factors: different expectations regarding sexual roles, fidelity and marriage or harmful traditional practices.

(3) Socio-economic factors: inadequate access to health care, unequal educational and economic opportunities, which may promote dependency on a male partner or even lead to commercial sex (loveLife, 2001; ILO, 2000; Smith, 2000; Evian, 1995).

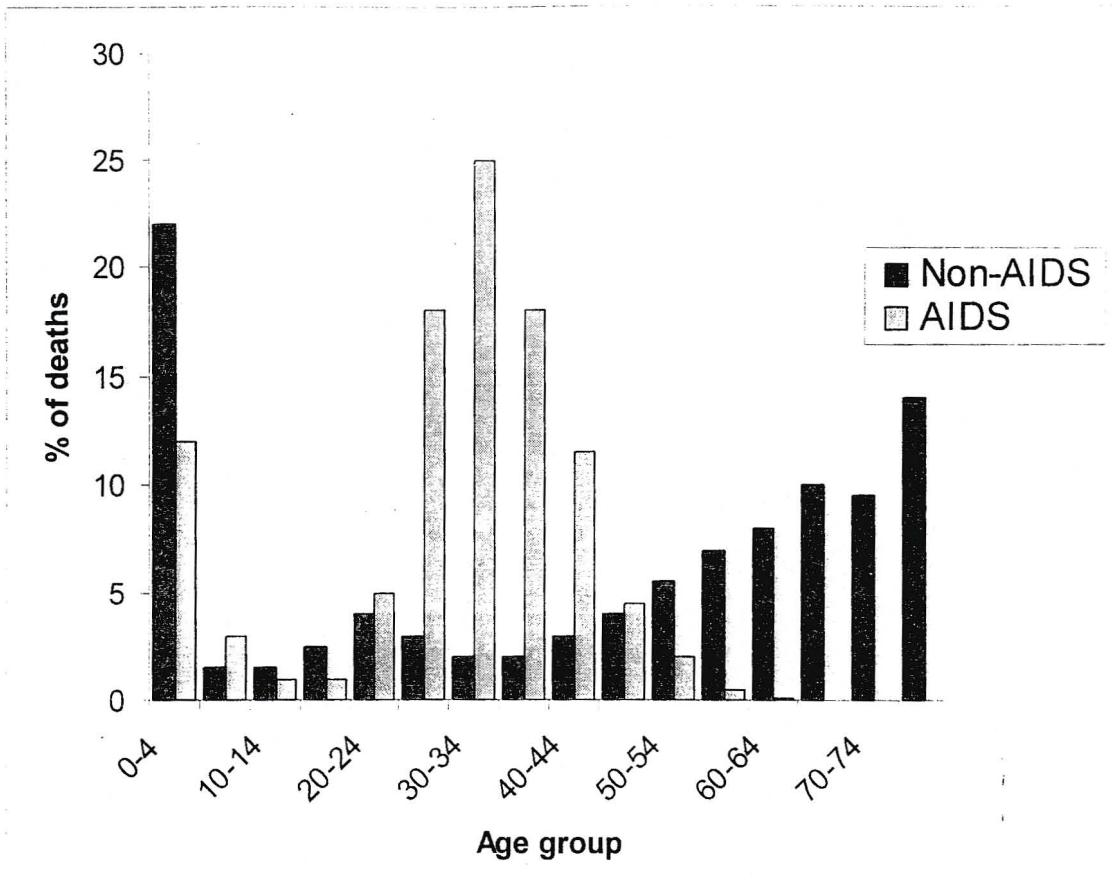
The second finding from the 1999 sero-prevalence survey that is relevant to the workplace, is that it confirms that the vast majority of HIV infections occur in adults who are (or would be if it were not for unemployment) at the prime of their economically active life, that is between 20 and 30 years old. In the words of the South African Minister of Health (Dr Manto Tsabalala-Msimang)

> *People in their twenties constitute more than 50% of the infected population in South Africa. This has tremendous impacts on the social fabric of the country and on the economy, as this age category represents the youngest portion of our productive class.*
>
> (Minister's speech, 10 April 2000 cited in Heywood, 2000: 4)

Figure 2 shows the projected age distribution of AIDS deaths compared to non-AIDS deaths in 2010. Young children excepted, virtually all AIDS deaths will be in age groups that have been relatively recently trained (loveLife, 2001: 32).

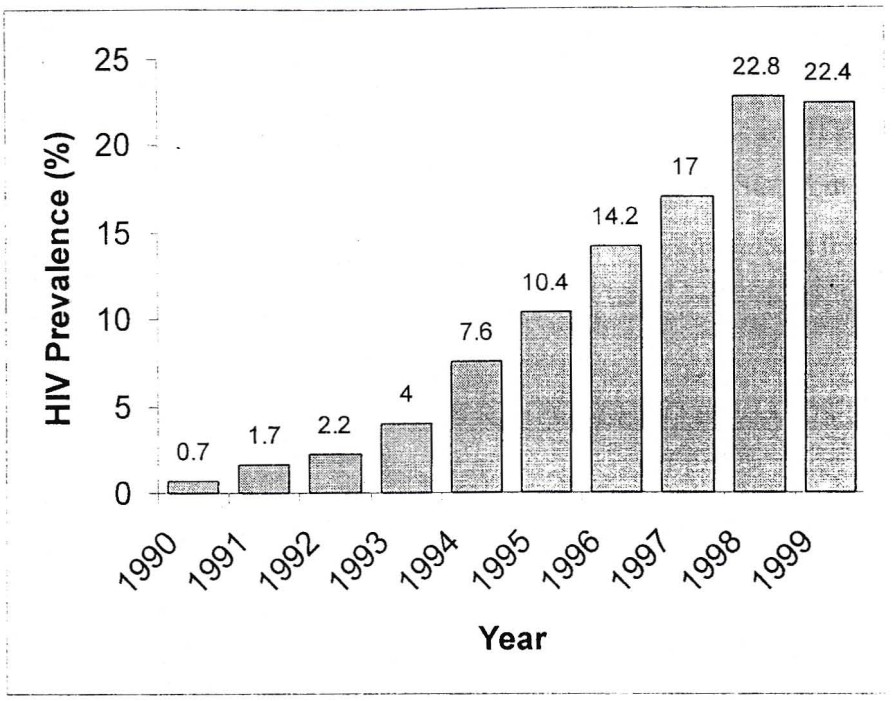
Figure 2: Age distribution of AIDS and non-AIDS deaths in 2010

(Source: loveLife, 2001: 32)



Data from the Department of Health (2000) highlights the annual National Seroprevalence Surveys of women attending Antenatal clinics for the past nine years and it provides a good estimate of HIV prevalence and trends over time in South Africa (see Figure 3).

Figure 3: National HIV survey of women attending antenatal clinics of the public health services in South Africa, 1990-1999



Source: Department of Health (2000: 7).

Table 3: 1999 survey of HIV prevalence as indicated per Province (Source: Heywood, 2000: 4).

PROVINCE	1998 HIV PREVALENCE (%)	1999 HIV PREVALENCE (%)	% INCREASE FROM 1998
EASTERN CAPE	15.9	18.0	13.3
FREE STATE	22.8	27.9	22.4
GAUTENG	22.5	23.9	05.8
KWAZULU-NATAL	32.5	32.5	0
MPUMALANGA	30.0	27.3	-9
N.CAPE	9.8	10.1	3.1
N.PROVINCE	11.5	11.4	-0.87

N.WEST	21.3	23.0	08.0
W.CAPE	5.2	7.5	36.5
TOTAL	22.8	22.5	

The statistics from Table 3 show that there has been a drastic increase in HIV prevalence rates between 1998 and 1999 in the Western Cape followed by Free State but KZN has the highest HIV infection rate. The factors that contribute to this high infection rate are discussed in sub-section 2.5.2.

2.5.1. THE HISTORY OF SOUTH AFRICA'S RESPONSE TO HIV/AIDS IN THE WORKPLACE

2.5.1.1. *1987-1994: PANIC AND DISCRIMINATION*

Almost since the advent of HIV/AIDS in South Africa, the impact of the epidemic on the workplace has been a cause of concern and also frequently, of conflict between employers and trade unions. As early as 1987, for example, the Chamber of Mines sparked a dispute with its decision to introduce mandatory screening of migrant workers and to cease employing mineworkers from Malawi, on the grounds of their high risk of HIV infection (Heywood, 2000: 10). Within the South African mining sector, as many as 1 in 5 workers are currently estimated to be infected with HIV (UNAIDS, 1998).

2.5.1.2. *1994-1999: BROADENING THE RESPONSE*

After 1994, the concern with unfair discrimination continued and was translated into concrete legal protections for people with HIV who were job seekers or employed (Heywood, 2000). However, perhaps as a reflection of the growing magnitude of the epidemic, the response broadened and advocacy began to centre on a more holistic set of recommendations that aimed to:

(a) Build partnerships between employers and employees to implement effective HIV prevention programs in the workplace

(b) Prevent unfair discrimination and stigma both by employers and fellow employees

(Heywood, 2000).

Regrettably, during this period, the response and engagement of the vast majority of private and public sector employers, as well as of organised labour, remained half-hearted and faltering (Heywood, 2000; UNAIDS, 1998). The reasons for this are complex but can largely be attributed to: ongoing denial about the impact of HIV and the actual threat it posed both to the individual and the workplace; business concern with restructuring and implementing changes required by a more regulated legal environment; labour movement concern with transformation and the loss of a layer of experienced leaders to positions in government; an apparent belief in business that HIV will impact on unemployed, unskilled and semi-skilled employees who can be easily replaced at little cost; a lack of leadership from government in dealing with HIV prevention generally (Heywood, 2000: 11).

The Employment Equity Act applies to all employers except the South African National Defence Force, National Intelligence Agency and Secret Service. "HIV status" is included in the list of grounds where "No person may unfairly discriminate, directly or indirectly, against an employee in any employment policy or practice..." This means that employee benefits that discriminate on the grounds of HIV status will have to show that such discrimination is fair. The Act specifically prohibits HIV testing that is conducted for unfair purposes (such as pre-employment testing) and requires that authorisation for HIV testing is sought from the Labour Court (Heywood, 2000: 12).

The Labour Relations Act (LRA) protects employees from being dismissed simply because they are HIV-positive and from being discriminated against with regard to employment benefits, staff training and other work-related opportunities. The Occupational Health and Safety Act requires employers, as far as it is reasonably practicable, to create a safe working environment. In an HIV/AIDS context, this can be interpreted to mean that employers must ensure that universal precautions are used when responding to an occupational accident (Davies, 1997).

2.5.1.3. *DURING 1995-1998*

During this period a great deal of the debate took place around the content and implementation of a Code of Good Practice on AIDS and Employment. In 1996 the HIV/AIDS Directorate in the Department of Health began to develop a more concise strategy to encourage HIV prevention and awareness programs in the workplace. Two separate but linked initiatives were launched:

(1) A 'Workplace Forum' was set up under the auspices of the Department to provide a forum for information and advice on AIDS in the workplace

(2) An inter-departmental committee on HIV/AIDS was established. Each government Ministry was asked to identify HIV/AIDS focal persons who then received training and were given responsibility for initiating prevention and awareness programs in their departments (Heywood, 2000: 12).

2.5.2. HIV/AIDS IN KWAZULU-NATAL (KZN)

Of all the regions in South Africa, KZN has the highest HIV infection rate[2]. Prevention efforts are hampered by the remoteness of certain areas where modern communication methods or transport do not reach the population (du Toit, 1996). A contrasting view is that since 1990 KZN has had a prevalence rate twice that of the national level, 1.6% versus 0.76% and since then has maintained approximately 10% higher prevalence compared to South Africa nationally. The reasons for this higher-than-average HIV prevalence in the KZN province are probably complex, but contributing to the phenomenon are the following:

(1) The province has two major seaports, Durban and Richards Bay. These are linked to roads which form major trucking routes to East and Central Africa. Throughout Africa, the influence of truck routes on the spread of HIV has been documented and may well be related to the early introduction of the epidemic in the province (Smith, 2000: 7; Heywood, 2000: 6; loveLife, 2001: 5).

[2] Refer to Table 3

(2) KZN has a population of 8.4 million, which represents 20.7% of the total population of South Africa but only 7.6% of the total land area. This high density is accompanied by population demographics that show a very high proportion of young people, 64.6% of the population is younger than 25 years of age (Smith, 2000; loveLife, 2001: 5).

(3) Family structure: although the 1996 census figures show a female to male ratio of 1:1, this is not a true picture when one examines the population in more detail, for between the ages of 20 to 59 years (the economically active ages) the ratio is 1:2 (Smith, 2000; loveLife, 2001: 5).

(4) Employment structure: despite the high population density, KZN industry has never developed commensurate with the numbers of its residents. Many workingmen join the ranks of migrant labour and work most of the year in Gauteng province. These men are away from home for long periods of time, have their sexual needs met on a commercial basis, with the eventual transmission of HIV to their partners at home (Smith, 2000; loveLife, 2001: 5).

(5) The absence of the male parent for long periods from home adds to the risk of a dysfunctional family (Smith, 2000; loveLife, 2001: 5).

(6) The influence of migrant labour practices and the spread of HIV may be illustrated in the surveillance data, which show little difference between urban and rural prevalence, both in terms of overall prevalence and in-age prevalence (Smith, 2000; loveLife, 2001: 5).

(7) Extreme poverty, prevalent in much of KZN is another factor contributing to the high HIV prevalence in the province (Smith, 2000; loveLife, 2001: 5).

CHAPTER THREE

THE MANUFACTURING AND CLOTHING SECTOR

As the second largest city in South Africa, and the site of the biggest port in terms of volumes of cargo, Durban has a major role to play in the economic development of South Africa. Durban provides 33.8% of KZN's total employment and 59.3% of the province's GGP, while contributing 8.4% of national GDP. Durban is more dependent on manufacturing than other major South African cities (Morris, Barnes & Dunnè, 1998). Manufacturing is the most diverse sector of most economies, and is defined as the physical or chemical transformation of materials or compounds into new products (Whiteside and Barnett, 1996). Durban's position as one of the largest cities in South Africa has made it the premier location for industry within KZN. This is reflected in the strong basis for consumer goods sectors in Durban-clothing and footwear, furniture, paper and printed products (Morris, Barnes & Dunne, 1998). Within manufacturing, Textiles and Clothing constitutes the sixth largest industry constituting about 10% of enterprise, 15% of (formal) employment and seven percent of net output but only about two percent of total exports (OETH, 1997: 83 cited in Baden and Velia, 2001).

Ancillary policies also played a role in the establishment and location of sectors. A lower minimum wage payable at the coast was key to the location of labour-intensive clothing firms in Durban. Currently, the six most important industries in Durban in terms of employment and output are chemicals, clothing, food, textiles, metals, paper and textiles. Four industries fall into both groups, which are food, chemicals, textiles and clothing. In addition, paper makes a noticeable contribution to output and the metal industry to employment (Morris, Barnes & Dunne, 1998).

Table 4: Contribution of Manufacturing Sectors to total Manufacturing Output and Employment

OUTPUT		**EMPLOYMENT**	
Food	13.5%	Clothing	18.6%

Chemicals	13.3%	Food	10.5%
Paper	7.7%	Textiles	10.1%
Textiles	7.3%	Chemicals	6.5%
Clothing	6.8%	Metals	6.4%

(Source: 1993 CSS Census of Manufacturing statistics cited in Morris, Barnes & Dunne, 1998: 3).

Of the six most important industries, clothing, textiles and metals can be considered labour-intensive industries, with a salary to net output ratio[3] of greater than 50%.

Table 5: Most labour intensive sectors: salary/net output >50%

SECTOR	**SALARY/OUTPUT**
Clothing	0.63
Other transport	0.63
Footwear	0.62
Machines and Appliances	0.61
Other	0.60
TV Radio, etc	0.60
Textiles	0.57
Electrical	0.55
Metals	0.55
Wood	0.53
Rubber	0.52
Furniture	0.51
Leather	0.50

(Source: 1993 CSS Census of Manufacturing statistics cited in Morris, Barnes & Dunne, 1998: 4).

[3] This ratio will be given an indication of the relative labour-intensity of sectors. A salaries to net output of 50% implies that 50% of value-added is accounted for by salaries and wages

Manufacturing is also seen as the major source of employment growth. As most manufacturing operations are urban based, this has led to Rural-Urban-Migration, as rural people move to the town in search of employment (and what may be perceived as a higher standard of living). Movement of people is associated with increased risk of disease transmission including HIV/AIDS with many new urban dwellers finding themselves living in shantytowns with few services. HIV/AIDS is affecting and will continue to affect the economy and society at all levels, from the household through to the macro-economy. Between these two extremes are the effects on communities, enterprises and social and economic sectors. The epidemic will affect production in two ways: (1) There will be increased morbidity (illness) and mortality (death) among the workers and (2) There will be changes in earning capacity and the pattern of expenditure (Whiteside and Barnett, 1996). UNAIDS (1998) states that some of the costs of AIDS to business are increased health-care expenses; increased retirement, pension and death benefits claims; decreased productivity as worker absenteeism rises owing to personal illness or absence from work to care for sick relatives and increased recruitment, increased labour turnover and training costs from the loss of experienced workers.

The impact of HIV/AIDS will vary with the type of operation, its size, location and employment package. These will themselves vary depending on the level of staff employed, the scarcity or otherwise of the skills, and whether they are locally or internationally recruited. Manufacturing is generally the most dynamic part of the industrial sector and the economy, and anything that threatens manufacturing is likely to have a disproportionate effect on the overall economy. HIV/AIDS may be such a threat. The ability of less developed countries to increase their global share of the manufacture, already severely hampered by structural economic problems, will be threatened even more by the potential impact of HIV/AIDS on the economically active population (Whiteside and Barnett, 1996).

3.1. PRODUCTIVITY

Productivity will be affected by

- Morbidity: employees taking time off during illness, including the maximum allowable sick leave (in some countries labour legislation may make provisions for long periods of sick leave and require a medical board before a person is dismissed) and annual leave before they are dismissed or resign on medical grounds. There will be instances of unauthorised absenteeism (Whiteside and Barnett, 1996; UNAIDS, 1998).
- Mortality: once a person dies (or has been released from employment) they must be replaced, and productivity will be reduced while the replacement is trained (Whiteside and Barnett, 1996; UNAIDS, 1998).
- Other absenteeism: this will include compassionate leave to care for sick family members. In some countries time spent on funerals of families, friends or colleagues is considerable (Whiteside and Barnett, 1996; UNAIDS, 1998).
- Replacement and training of labour: the ease with which labour can be replaced will vary depending on the labour intensiveness of a specific operation, the level of skills employed and the general availability of labour. If suitably skilled labour is unavailable it may take some time to replace the person (Whiteside and Barnett, 1996; UNAIDS, 1998).
- Staff morale: the loss of colleagues, increased workloads, potential discrimination, and general uncertainty about HIV/AIDS and the fear of infection may undermine staff morale. There have been instances of workplace disruption were workers refuse to work with a colleague known or believed to be HIV-positive (Whiteside and Barnett, 1996; UNAIDS, 1998).

3.2. THE CLOTHING SECTOR IN DURBAN

The Durban Metropolitan Area contains the largest clothing cluster within KZN. Of a total of approximately 525 clothing firms in KZN, 416 are based in Durban, Pinetown, Inanda and Chatsworth areas. There are moreover 32,409 employees within the Durban clothing industry and about 229 working proprietors. The reasons underpinning the

development of an important clothing industry in Durban are numerous. The existence of a relatively skilled labour pool in Durban, cheaper wage rates than Gauteng, and the concomitant development of a large textiles industry in the area were all important factors. Importantly, however, all these factors were grounded in the previous government's ISI (Import Substituting Industrialisation) policies. The growing and highly protected domestic clothing market generated a demand for clothing manufacture, thus creating a strong impetus for the development of a local clothing industry. The overall size of the clothing market in 1995 was US $4.1 billion, of which half was in women's wear, 30% in men's with the latter rising faster (Morris, Barnes & Dunne, 1998).

There is a major process of restructuring and regional consolidation of the clothing value chain underway in Southern Africa, as a consequence of changes in the trade regime at international and regional levels, as well as in domestic and global retail markets (Baden and Velia, 2001; Kaplinsky and Morris, 1999). Government has recently identified Textiles and Clothing as a priority sector, in view of potential export opportunities and its employment generating potential, and the Department of Trade and Industry (DTI) is actively pursuing a regional strategy in this respect (Baden and Velia, 2001)

The dynamic development path of Durban's clothing industry is now, however, one of its major weaknesses. Unlike the clothing industry in the Western Cape, which is closely tied to the major retail chains (such as Pepcor, Ackermanns, Wooltru, Foschini and Shoprite) the industry in Durban is largely wholesale based and thus focused on a lower value-added segment of the clothing market, which has become the most severely contested market segment in South Africa (Morris, Barnes & Dunne, 1998 and Kaplinsky & Morris, 1999: 719; Baden and Velia, 2001). The weaknesses of the Durban clothing industry relate in part to its failure to reorganise production relationships to best capture the advantages inherent in the new competitive environment (Morris, Barnes & Dunne, 1998).

In general, clothing firms in South Africa have faced major competitive pressures in the last decade, due to a combination of factors centred around the collapse of their domestic market. This relates to a massive increase in both legal and illegal imports (mainly from East Asia) related in part to tariff reduction but also to poor enforcement of existing regulation, especially in the early 1990s. Also, there is stagnation in domestic demand, which is linked to poor overall economic performance and the stagnation in spending on clothing. Besides this, there is restructuring in the retail sector featuring movement of discount operators offshore, and a factor mentioned by employers is the increase in labour costs related to increased regulation in the post-1994 period (Baden and Velia, 2001).

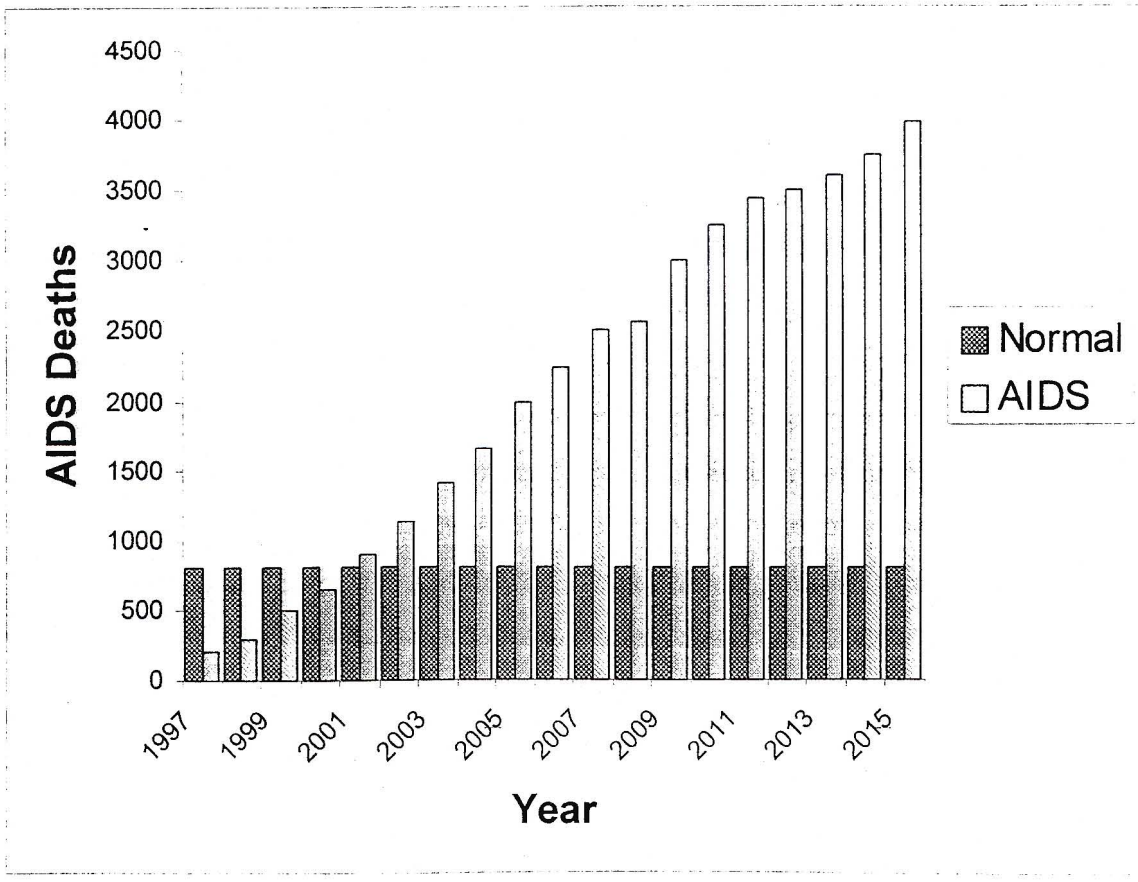
CHAPTER FOUR

HIV/AIDS AND THE WORLD OF WORK

4.1. INTRODUCTION

In the early years of the pandemic, HIV /AIDS was largely seen as a medical crisis rather than one with potentially serious socio-economic ramifications (Heinzen, 1995; ILO, 2000). This perception changed when it became evident that HIV/AIDS is a major development problem, which is threatening to reverse a generation of achievements in human development (ILO 2000). The epidemic primarily affects working age adults and far exceeds any other threat to the health and well being of South African employees (see Figure 4 below) (loveLife, 2001: 12).

Figure 4: Projected AIDS deaths among employees in a South African workforce (Source: loveLife, 2001: 12)



There are several mechanisms by which HIV/AIDS affects macroeconomic performance.

- Firstly, AIDS deaths lead directly to a reduction in the number of workers available and particularly workers in their most productive years. As younger, less experienced persons replace experienced workers, productivity is reduced (ILO, 2000).
- Secondly, a shortage of skilled workers leads to higher production costs and a loss of international competitiveness (ILO, 2000).
- Thirdly, lower government revenues and reduced private savings (because of greater health care costs and a loss of income for workers) can lead to slower employment creation in the formal sector, which is particularly capital intensive (ILO, 2000). As a result some workers will be pushed into lower paying jobs in the informal sector.
- Fourthly, there will be expenditure increases on the monitoring of high-risk groups, the establishment of prevention strategies, the provision of health care and welfare (ILO, 2000).
- Fifth and lastly, there are pressure increases on the social security system, including life insurance and pension funds, which are important sources of capital for both the government and the private sector (ILO, 2000).

4.2. THE IMPACT ON THE WORKFORCE

It is to be expected that the age and sex distribution of the labour force will change, due to the rising number of widows and orphans seeking a livelihood and the large proportion of people with AIDS in the age group 20-49 years, resulting in early entry of children into the active labour force, the early withdrawal of people with AIDS and the retention of older persons in the labour force due to economic need (ILO, 2000). Labour force projections also provide some indication of the lowering of the average age of the labour force due to the impact of HIV/AIDS. HIV/AIDS is therefore likely to have profound effects, not only on the size, but also on the composition and quality of the labour force in high prevalence countries (ILO, 2000).

4.3. THE IMPACT ON EMPLOYERS AND THEIR ORGANISATION

At the level of individual businesses, HIV/AIDS among managers, employees and their families will impose significant direct and indirect costs (loveLife, 2001: 13). AIDS-related illnesses and deaths of workers affect employers both by increasing their costs and reducing revenue. They have to spend more in areas such as health care, burial, training and recruitment of replacement employees (ILO, 2000; loveLife, 200; Roberts, 1995; Barese, 1995). Revenues may be decreased because of absenteeism due to illness or attendance at funerals as well as time spent on training. Increased labour turnover can lead to a less experienced and therefore less productive work force. Compounding the HIV/AIDS issue is the lack of employees' having a formal education, which makes the dissemination of facts on HIV/AIDS more difficult to achieve. It is generally held that thirty percent of the South African labour force has no formal education, thirty-six percent has primary education, thirty-one percent has secondary education and only three percent hold tertiary diplomas and university degrees (Jane-Bosch, 2001). The relationship between HIV/AIDS and the costs and revenue of employers has rarely been examined systematically up to now. There is bound to be a reduction in profits if companies do not take early measures to prevent the impact of HIV/AIDS (ILO, 2000).

The other side of the coin is that employers are unlikely be affected significantly by HIV/AIDS where those employees that have to leave the labour force can be replaced without loss of productivity. This may happen in countries with high unemployment and underemployment rates (ILO, 2000). Despite modest economic growth, there has been a steady shedding of formal sector jobs throughout the 1990s. There are large provincial differences in unemployment rates, ranging from a low of 19% in the western Cape to a high of 41% in the Northern Province and Eastern Cape (loveLife, 2001). Due to high rates of unemployment, there is likely to be a mismatch of human resources and labour requirements in terms of qualifications, training and experience. Other significant impacts may include a loss of markets where the purchasing power of the population declines. In view of these factors, some companies have already begun to hire or train employees for the same position, if it is feared that employees in key positions may be lost due to AIDS.

Employees can also be replaced by importing labour from neighbouring countries, at the risk of creating a bigger immigration sub-population, which is often more vulnerable to HIV infection (ILO, 2000). Within the mining industry, for example, gold mine employees have borne the brunt of the HIV epidemic, but because there is relatively little task specialisation, production has not been seriously affected (loveLife, 2001).

Human Resource (HR) issues become more critical in crisis situations. A lack of respect for HR fuels the pandemic in at least three ways. Firstly, discrimination increases the impact of the disease on people living with HIV/AIDS and those presumed to have the virus, as well as on their families and associates. Secondly, people are more vulnerable to infection when their economic, social and cultural rights are not respected and thirdly, when their civil and political rights are not respected. It is difficult for civil society to respond effectively to the pandemic. The Joint WHO/ILO Statement adopted at the Consultation on AIDS at the Workplace (Geneva, 1998) came to the conclusion that protection of HR and the dignity of HIV infected persons, including persons with AIDS, is essential to the prevention and control of HIV/AIDS. From an ILO perspective, discrimination-especially discrimination in the world of work-is one of the most significant HR abuses in the area of HIV/AIDS. People exposed to HIV will not seek testing, counselling, treatment or support if this means facing discrimination, lack of confidentiality, loss of employment or other negative consequences. Therefore, several years of experience in addressing the HIV/AIDS epidemic have confirmed that the promotion and protection of HR constitutes an essential component in preventing transmission of HIV and reducing the impact of HIV/AIDS. Experience has also shown that the incidence and spread of HIV/AIDS is significantly higher among groups which already suffer from a lack of respect of their HR and from discrimination, or which are marginalised because of their legal status. These include women, children, people living in poverty, minorities, indigenous people, migrants, people with disabilities, sex workers, homosexuals, injecting drug users and prisoners (ILO, 2000; Davies et al, 1997; loveLife, 2001; Smith, 2000; Heywood, 2000).

4.4. DEVELOPMENT OF A HIV/AIDS PREVENTION AND POLICY PROGRAM

To meet the threat and challenge of the HIV/AIDS epidemic in the work context, it is of absolute importance that workplaces take a stand and are responsible for initiating workplace HIV/AIDS Prevention Policies and Programs. Davies, et al (1997) posits that a workplace policy on HIV/AIDS and STD's is central to developing and implementing an effective workplace program. An HIV/AIDS policy defines one's organisation's position and practices in relation to employees with HIV/AIDS, and to preventing the spread of HIV. According to Evian (1995: 3) the rational and logical way to manage the epidemic is to contextualise it within a Reconstruction and Development Program (RDP) paradigm. He asserts that the approach to the problem and the principles and concepts are embodied in the RDP. The RDP concept itself will in the long run do the most to minimise the impact of the epidemic on the workplace. In addition, he states that monitoring the evolution of the AIDS epidemic and new approaches to its management, assessing potential short, medium and long term impact, instituting appropriate strategies and policies, provision of awareness, education and the like are the cornerstones for the correct and comprehensive management of this threat.

Social norms and political considerations often make it difficult to design and implement effective HIV/AIDS policies. Chief among these factors are denial that HIV/AIDS is a problem, a reluctance to help people who practice risky behaviour, a preference for the moralistic approach and pressure to spend on treatment rather than prevention.

⇒ Denial is typically seen at the earliest stages of the pandemic, when its effects are still hardly visible. It is based on an unwillingness to acknowledge that extra-marital sex and illicit drug use exits in a society. Officials often lack information to evaluate the relevance of the HIV/AIDS threat and are therefore reluctant to initiate effective HIV/AIDS programs. The consequences of this is that programs in some countries do not focus directly on the most vulnerable groups or sectors such as sex workers, drug users, male homosexuals, bisexuals with multiple partners and sectors in which sexual partners tend to be changed frequently. Instead many countries engage in abstinence policies. This is abstinence from

extra-marital sexual relations, homosexual intercourse or drug use. Such policies are widely viewed as morally correct. In contrast, the provision of free condoms and clean needles to injecting drug users is regarded as facilitating immoral activity. Moreover, the view that HIV/AIDS is a problem, which requires exclusive medical attention often serve to exclude effective preventative interventions at an early stage, addressed at those who are most vulnerable to HIV infection.

⇒ Political commitment at the highest levels makes the critical difference. The culture of denial, which prevents effective action in all other fields, can only be overcome by strong leadership and broad partnerships involving among others, international institutions, other nations, government agencies, employers' and workers' organisations and non-government sectors, with a sharing of specialised skills (ILO, 2000).

Moreover, a HIV/AIDS and STD policy demonstrates an organisation's concern and commitment in taking active steps to manage the HIV/AIDS epidemic. The following steps show one how to go about developing a HIV/AIDS and STD policy. There are nine steps involved in this process.

1. Elect the HIV/AIDS and STD committee. This should comprise of shop stewards, supervisors, management, the occupational health nurse and other interested individuals (Davies et al, 1997; UNAIDS, 1998).
2. The HIV/AIDS committee must investigate the needs of the organisation in relation to HIV/AIDS and STD's.
3. The HIV/AIDS committee meets to discuss and formulate a draft policy.
4. The draft policy needs to be circulated for discussion and revision.
5. The organisation must adopt the policy.
6. The HIV/AIDS committee uses the policy to develop the implementation phase of the strategy.
7. The policy and program implementation needs to be communicated to everyone in the organisation.

8. There needs to be on going monitoring and evaluation of the program to determine its effectiveness.
9. The committee must review the policy regularly, in light of new information about the epidemic and treatment for HIV and AIDS (Davies et al, 1997: 29-31; Mason, 1995: 10).

The policy program should cover personnel issues, program issues, monitoring and evaluation, and legal issues.

- Personnel issues include the management of employees who have HIV and AIDS; HIV testing in the workplace; employee benefits and basic principles of employee benefits.
- Program issues embody prevention programs; risk reduction programs; awareness programs; education programs; universal precautions; basic principles of infection control; condom distribution; the role of health workers in prevention; wellness management; counselling people with HIV/AIDS or STDs; caring for people with HIV/AIDS; links with other programs in the workplace and links with health services outside the workplace.
- Monitoring and evaluation of a program looks at why monitoring and evaluating are important; baseline information; how to monitor a HIV/AIDS and STD program; reasons for monitoring and evaluating; indicators for monitoring and evaluating; definition of an indicator; monitoring the impacts of HIV/AIDS in the workplace and evaluating a HIV/AIDS and STD program (Davies, et al, 1997: 29-82; UNAIDS, 1998: 2-8). Moreover, all HIV/AIDS workplace policies should be formulated around the principles of non-discrimination, equality, confidentiality and medical accuracy (UNAIDS, 1998: 5).

Dancaster and Jamieson (1990: 5) advanced several ideas for and against having a written formal AIDS policy. The reasons advanced for having a written policy are:

a. Ignoring the treat until a problem emerges could result in irrational and panic responses.

b. Laid out procedures for handling situations as well as education will reduce the fear and uncertainty in the workforce.
c. By having a policy it sends out a message of caring.
d. The uniqueness of the illness is recognised.
e. If the policy is formulated with the union it could help to justify certain actions in the future.

The authors have also put forth the following reasons against having a written AIDS policy:

a. A comprehensive education program would achieve the same results even without a written policy.
b. A written policy could backfire if it was used subsequently against the company in a legal case (cited in Boulle, 1992: 54-56).

The researcher agrees with both the reasons for having, and the reasons for not having a written policy especially the point regarding a comprehensive education program achieving the same results as a policy. The research has shown that only two of the eight firms had a formal HIV/AIDS policy in place compared to the other six that did not have one. In these six firms education was on going and was not being distracted by them not having formal policies in place. In the two firms that did have formal policies, these policies were instituted a few years ago and had not been revised or checked upon regularly. Moreover, management was solely responsible for the drawing up of the policies.

4.5. SPECIAL MEASURES BY HEALTH INSURANCE PROVIDERS

Certain health insurance providers have established facilities specifically designed for persons with HIV infections, which guarantee and at the same time cap payments for HIV-related treatment. These schemes currently provide enough benefits to cover a significant share of the cost of treatment but employers are already worried that as the proportion of HIV infected workers rise, they will not be able to maintain benefits at

these levels. While the measures taken by health and social security insurance schemes to take into account the specific needs of people living with HIV/AIDS are encouraging, it has to be emphasised that only a tiny fraction of the population in countries most affected by HIV/AIDS is covered by formal health insurance and benefits schemes. A number of employees have begun to develop policies and benefit packages, which meet the needs of people with HIV/AIDS and their families without bankrupting the companies themselves. Companies would like to know the proportion of the workforce they are likely to lose through AIDS. However, increasingly, employers are beginning to recognise the tremendous negative impacts of pre-employment and on-the-job HIV screening. Testing the existing workforce is not only unethical but leads to great hostility and is incompatible with effective HIV/AIDS prevention and care programs at the workplace. Companies are beginning to find that by abandoning testing requirements, conducive climates can be created for workplace prevention programs. A number of employers in the worst affected countries are reaching the conclusion that prevention is much more cost-effective than screening in the long-term and that respect for the rights of workers is a powerful prevention tool in its own right (ILO, 2000).

CHAPTER FIVE

SURVEY FINDINGS

The findings indicate that HIV/AIDS is an overwhelming health problem in the clothing firms surveyed. The ramifications of the virus on firms has meant the loss of employees, increased rates of absenteeism and an increase in the payouts of health benefits to the deceased employee's family. These impacts of the virus are only going to grow in epic proportions in the very near future due to people that have contracted the virus in the last 5-10 years beginning to show symptoms related to the virus. The education that has surrounded the issue of HIV/AIDS has, unfortunately, not transcended the boundaries of the clothing industry. The reasons for this apparent lack of urgency with regards to dealing with the threat of HIV/AIDS are diverse (and will be discussed below).

Table 6: Brief summary of some survey findings

FIRMS	NO. OF EMPLOYEES	KEY INFORMANTS	FORMAL POLICY	PREVENTION PROGRAMS	IMPACTS ON FIRMS	MANAGEMENT SUPPORT
A	1800	Sister (On-site clinic)	No	Yes. HIV awareness during Induction Programs and on going every three months.	AIDS deaths. Illnesses. Increased training of new and old employees	Yes Free HIV testing. On-site clinic. Condom distribution Education awareness.
B	1000	Sister (On-site clinic)	No	Yes but not intensive	AIDS deaths	No
C	700	Sister (On-site clinic)	Yes	Yes. Condom distribution.	AIDS deaths. Illnesses.	Yes Allows time off for workers Purchasing videos and TV. Talks allowed from the union (SACTWU). Financial support.

D	300	Shop steward	No	Yes. Condom Distribution.	AIDS deaths	No
E	380	Shop floor manager	No	Yes. Condom Distribution.	AIDS deaths	No and Yes
F	800	Shop steward	Yes	Yes. Condom Distribution. Slide shows on the facts on HIV/AIDS.	AIDS deaths.	Yes Projectors for screening HIV/AIDS material. Allow lectures during work time. Time off from production.
G	300	Shop steward	No	Yes. Condom Distribution.	AIDS deaths	No
H	200	Shop steward	No	No	AIDS deaths	No

Further analyses of the findings show that:

- Firms were generally not disseminating adequate information to their workforce.
- The lack of information sharing by firms was a consequence of having managerial personnel that were disinterested in HIV/AIDS and who, as yet, did not perceive HIV/AIDS as a threat to their work environment.
- There was a lack of appropriate analysis of the effects of HIV/AIDS at the firm level and on the overall effects of the virus on employees' health statuses.
- The overarching implications of HIV/AIDS on employees' attitudes and behaviours were multi-dimensional.
- Employees' cultural contexts played a very significant role on the way in which the virus was understood and interpreted.
- The lack of adequate information sharing within the boundaries of the workplace has had a ripple effect in that the majority of the firms do not disseminate information regarding the epidemic into surrounding communities.

Thus, the research findings have shown that the sample of Durban clothing firms, generally, do not perceive HIV/AIDS as a 'real' threat to the work environment, which the literature states is a deadly and costly perception to assume (UNAIDS, 1998; Heywood, 2000; Davies et al, 1997; ILO, 2000; Whiteside and Barnett, 1996). This lack of realism associated with the virus stems from the diverse nature of an individual's understanding, or lack thereof, of the epidemic. The key to effecting positive change and understanding the devastating implications HIV/AIDS for each and every person, in the clothing sector, lies with the firms' managerial hierarchy. The responsibility of HIV/AIDS does not lie solely with the unions but is also the responsibility of management (UNAIDS, 1998; Davies et al, 1997; Roberts, 1995).

The researcher interviewed key informants focusing on eight questions. The questions posed were:

i. Who was the initiator of the prevention programs?
ii. What led to the development/implementation of such a program?
iii. What are the impacts of the HIV/AIDS epidemic on the firm?
iv. What are the overall effects of HIV/AIDS on the employees' level of performance?
v. What is the role of management?
vi. Is the program part of a long-term effort to deal with HIV and AIDS?
vii. Are there any significant changes by employees' regarding their perceptions, attitudes and behaviours, after the implementation of the program?
viii. Are firms' disseminating information on HIV and AIDS beyond the firm boundaries and into surrounding communities?

Using the above eight questions as a basis to obtain pertinent responses and after analysing the data, the researcher grouped the survey findings into five themes, namely,

1. Exploration of the impact of HIV/AIDS in the firm context via a Needs Analysis approach
2. HIV/AIDS impacts at the Firm, Employee and Management level

3. Poor commitment to HIV/AIDS prevention
4. The role of traditional norms and values on employees' perceptions of HIV/AIDS
5. Firm support for community HIV/AIDS outreach activities

These themes illustrated issues such as disinterest and a lack of perceiving HIV/AIDS as a real threat and challenge to the work environment. Management, in the firms that were surveyed, generally reflected a non-committed attitude to the fight against HIV/AIDS. The key informants reported that employees too, were not committed to fighting HIV/AIDS and that there were no HIV/AIDS impacts on employees with regards to production levels. The role of tradition and culture was deeply embedded in the attitudes and behaviours of the employees and this emulated the way they interpreted and understood the epidemic. Influences such as beliefs in witchcraft played a significant role in the perceptions of the virus. Lastly, ensuring a successful fight against the epidemic needs all sectors, from grass roots level to national government levels to international help from NGOs', to come together and be educated and take responsibility. Communities are included but they are not being educated and firms generally did not disseminate information and facts beyond their internal boundaries.

THEMES

5.1. EXPLORATION OF THE IMPACT OF HIV/AIDS IN THE FIRM CONTEXT VIA A NEEDS ANALYSIS APPROACH

Exploration of the usefulness of undertaking a Needs Analysis, which is a cost effective solution for the workplace that helps in the reduction and spread of the virus. Key informants indicated that there was a general lack of undertaking a needs analysis due to the stigma and discrimination still prevalent and associated with HIV/AIDS.

Needs Analyses can serve as a way for firms to assess the internal and early impacts of HIV and AIDS in their workforce and it can allow for such firms to implement HIV/AIDS prevention programs and strategies that will assist the organisation to face the challenges of HIV/AIDS (Davies et al, 1997). UNAIDS (1998) states that establishing a HIV/AIDS program and policy in the workplace is a cost-effective solution and will help reduce the spread and impact of the disease.

Undertaking a needs analysis can result in the development of a program that confronts the HIV/AIDS crisis situation and it can represent a proactive strategy to approaching the issue. Implicit within this is the defining of goals and objectives and training HIV/AIDS educators and managers about HIV/AIDS. Moreover, a needs analysis serves the purpose of highlighting to management the seriousness of the virus and that firms should organise themselves for the present and especially the future effects of HIV/AIDS on employees' health.

In addition, the socio-economic aspects should be taken cognisance of when dealing with the issue of HIV and AIDS. Further, needs analysis can help the firms find solutions, not necessarily answers, to issues such as how HIV/AIDS can affect the business (workplace disruption, lawsuits), help to prevent the spread of the virus and to encourage employees to feel comfortable with seeking help on this matter (SHRM, 2001). An important role that a needs analysis can play especially in the clothing sector where the majority of the workers are women, is to make cognisant the unique needs of women. Thus, comprehensive programs should not be gender neutral, or by default, biased against women's particular needs and should include both behavioural and biological interventions (Lamptey, 1994; Heywood, 2000).

The overall findings showed that there was no appropriate Needs Analyses undertaken. Six of the eight firms did not undertake a Needs Analysis of the effects and implications of HIV/AIDS on their operations. The reasons put forth were that firms did not perceive the virus as an immediate threat. More importantly, production was not being affected

and profits were not being hampered with in any way. Moreover, labour was deemed plentiful and this was adding to the lack of interest by firms,

...all management and the company is concerned with is profit, scores and production...

(Factory Sister, Firm D)

...there are so many people looking for work that if we placed an advertisement in the paper, we would get hundreds of people coming to apply for the job. Therefore the company does not see it as an urgent need to train or hire extra staff due to the fact that there will always be a constant supply of labour.

(Factory Sister, Firm B)

Further reasons for the lack of a needs analysis by firms were due to the stigma, prejudice and discrimination associated with HIV/AIDS and this has transcended into managerial hierarchies. Management is aware of the virus but unfortunately they are not in tune with the realism of the devastating effects that the virus will have on production and employees in the very near future. Due to a disinterest there has been a lack of precautionary measures taken to ensure that when the full scale of the epidemic makes its appearance, firms would be ready to face the challenges. UNAIDS (1998: 4) reiterate this point when it asserts that businesses are reluctant to set up workplace HIV/AIDS programs because they feel they lack the resources, they do not have adequate in-house knowledge or because they consider the matter too sensitive.

...Once again the company is doing absolutely nothing. There aren't even condom dispensaries in the workplace.

(Factory worker, Firm D)

...Nothing has been done. As long as production is going fine and they are able to replace the absent workers with other workers they are content and are not doing

anything. The impact of HIV/AIDS has not touched or impacted on the company therefore their uninterested attitude towards HIV and AIDS. (Factory worker, Firm D).

In addition, five of the eight firms management's support for education and prevention programs have been negative. Management has generally shown disinterest. Minimal interests that have been shown stems from management being forced by the union (SACTWU) to ensure that some form of HIV/AIDS awareness are occurring in firms.

To help prepare for such a challenge, initiating an appropriate analysis of the needs of the employees' and organisation is imperative. These needs can be translated as how employees' health and welfare issues can best be addressed, as well as issues of organisational production and profits that would require protection from the onslaught of the epidemic. This protection takes the form of education.

...Only through unremitting exposure to information on AIDS and AIDS prevention can any modifications in behaviour be expected. Given the employer's responsibility to his employees' and his bottom line profit, the only way it can be achieved is through the workplace...(van Niftrik, 1990c: 9 cited in Boulle, 1992: 49)

Education is the key to fighting the epidemic. The education that takes place within the boundaries of the work environment is central, if not the primary conduit for disseminating information on HIV/AIDS. Characteristics of a successful HIV/AIDS education program highlights that (Davies et al, 1997: 57):

- Education should be on going rather than a once-off or annual training course. This allows the effectiveness of the program to be monitored as it takes place and the content changed as necessary.
- Education and awareness raising around HIV can easily be integrated into existing training courses such as industrial relations, personnel management, first aid, occupational safety, literacy and induction.

- Education should take place in small groups in an informal workshop setting, so that employees feel comfortable to ask questions and discuss their feelings openly
- Peer educators can be used in almost any workplace, whether small or large.
- The specific content of an education program should be decided in consultation with the HIV/AIDS committee and/or outside agencies which specialise in workplace HIV/AIDS education

There are a number of issues that should be covered within an education program (Davies et al, 1997: 58-59)[6]:

- Transmission of HIV
- Sexually Transmitted Diseases (STDs)
- Safer sex
- Condoms
- Attitudes, myths and misconceptions
- Universal precautions
- Legal and ethical issues
- Women's rights

Two of the eight firms did undertake a needs analysis of the effects of HIV/AIDS on their work environment. These two firms' (Firm C and Firm F, respectively) characteristics differed from the other firms in the following ways.

- These two firms have managerial support, which is a crucial element for the success of programs that are implemented. Management had realised the effects, both present and long-term, that the virus would have on their work environment and these firms have formal HIV/AIDS policies. Therefore, the establishment of a comprehensive and sustainable HIV/AIDS program with appropriate policies

[6] The outline of the issues are covered in more detail in Davies et al (1997: 58-59)

would appear to depend on the creation of genuine management commitment to the firm. This concurs with the argument presented in UNAIDS (1998).

- The number of deaths that were occurring in these firms was a further factor that warranted a needs analysis. Firm C had eight confirmed cases of employees' that were carrying the virus and knew of one employee that had died from the virus. Firm F fairs worse due to it having ten employees' (nine females and one male) that are sick with the virus and in the year 2000, they had eight female employees' die from HIV/AIDS, that is, these firms were already feeling the impact of the virus.

- The positive and strong initiative from the HIV/AIDS educators was another factor that influenced these two firms to carry out a needs analysis. In Firm C the nursing Sister has taken a very active role in the disseminating of information and facts on HIV/AIDS and she has negotiated with management to allow time off from working hours to allow the educating of employees. In Firm F, the shop steward was very pro-active in her responsibilities in educating the workforce. Peer education is endorsed as being highly efficient and effective. Peer educators that are preferably chosen by their co-workers and properly trained, have often been very effective (UNAIDS, 1998; Davies, 1997: 57).

The workplace is an ideal environment for the implementation of thorough and ongoing AIDS prevention programs (Mason, 1995; Davies et al, 1997). Businesses throughout Africa, Asia, Latin America and the rest of the world are increasingly recognising that HIV infection and AIDS can affect productivity and profitability (UNAIDS, 1998). AIDS prevention and care activities by businesses can maintain and sometimes even increase productivity and profitability. A company, at a fraction of the current, rising financial cost of AIDS to the business, can set up effective workplace programs. Companies should not wait for the government or health sector to take action for them. HIV/AIDS raises the costs of doing business, reduces productivity and lowers overall demand for

goods and services. It therefore makes sense to invest in prevention, care and support programs to stem declining business productivity and profitability (UNAIDS, 1998).

5.2. HIV/AIDS IMPACTS AT THE FIRM, EMPLOYEE AND MANAGEMENT LEVEL

Theme two undertook an analysis of the effects of HIV/AIDS at the firm, employee and managerial levels and the findings indicated that firstly, firms surveyed were generally not experiencing any negative impacts on their work environment. Secondly, employees were being impacted upon through deaths, increased rates of absenteeism and increased levels of multi-tasking. Thirdly, key informants stated that the impacts of HIV/AIDS on management were met with mixed feelings.

The second theme explored issues on what the overarching impacts of HIV/AIDS were at the firm, employee and management levels. The researcher's aim was to investigate whether or not firms, employees and management were experiencing any impacts of the virus and the degree to which they were being impacted upon. This was undertaken to ascertain the actual threat of the virus at these levels. This theme is important because it leads from Theme 1 where the findings highlighted that the firms, generally, did not perceive HIV and AIDS as a threat to their work environment.

5.2.1. *FIRM LEVEL IMPACTS*

Six of the eight firms indicated that they were not experiencing any negative impacts of HIV/AIDS on their work environment. This statement was of particular interest because it brings out contradictions in the way firms have interpreted HIV/AIDS and the implications it has on the workforce and workplace. These six firms have stated that they are not experiencing any problems but these very same firms have experienced HIV/AIDS deaths or HIV/AIDS-related deaths. The informants stated that the reason for assuming that HIV/AIDS is not impacting upon the firm is due to production and profits not being affected.

Ignorance of the impact of HIV/AIDS was also clearly evident for example at Firm D. The informant interviewed stated that the firm was feeling the impact, not of the HIV/AIDS virus, but rather paying out death benefits to the deceased person's family. The managerial levels were complaining that they were presently paying out too many death benefits to families and that it was costing the company a substantial amount of money to do so. Interestingly enough, this is one of the six companies that did not want to work hand-in-hand with the union to implement prevention and education programs. There was blatant refusal to take on a pro-active role and they did the bare required minimum. The only support they provided was allowing the shop steward, who is responsible for disseminating information to the employees, time–off to attend training that was provided by the union. The informant stated that management was aware of the cause of the employees' deaths (HIV-related) but they were only interested in taking action against the large amounts of death benefits they were paying out rather than implementing a full-scale attack on educating their employees. Another comment that was made by five of the eight firm informants was that although the firms were employing extra staff and machinists, it had nothing to do with the effects of HIV/AIDS on employees and the work environment.

Different viewpoints also arose from two firms that highlighted that they were being impacted upon as a direct consequence of HIV/AIDS. This stems from employees dying from the virus and related symptoms. Firm A was starting to feel the negative impacts of the virus and had included an educational package on HIV/AIDS in their formal induction program. The firm also made sure that permanent employees go through the same educational process and that the employees are re-informed every three months. There is total support for HIV/AIDS prevention in the workplace.

Firm F was also pro-active with respect to educating the workforce and the educator had negotiated time-off during working hours to educate the employees. At first management was reluctant to allow time-off but the educator sat down with management and discussed the implications of HIV/AIDS on the work environment and employees. She

pointed out that presently employees were dying as a result of HIV/AIDS. Management eventually understood the threat of the epidemic and allowed one hour off every day for the educating of the workforce.

5.2.2. *EMPLOYEE LEVEL IMPACTS*

The informants acknowledged that employees were dying but the number of deaths was not significant enough to warrant any serious attention from management. Due to the asymptomatic phase (or latency period) of the HI-virus (7-10 years) (Evian, 1995), employees and management has not yet perceived it as a direct threat to their work context. This brings to the surface the issues of prevention versus symptomatic costs. What this means is that prevention measures and costs associated with the virus will be assessed too late due to management needing to see deaths first before actual implementation of prevention programs and policies. Thus, due to the symptomatic phase, deaths will only be occurring several years later after initial infection and the devastating consequence of this 'lateness' of deaths is that companies would not be adequately prepared to meet the threats of the epidemic when it strikes.

There was no impact on employee production and this was a general finding in all eight firms. Rates of absenteeism in these firms were dealt with by having other employees filling in for an absent co-worker. Thus, the training of extra staff and the retraining of current employees in multi-tasks have its advantages in times of high levels of absenteeism.

...Absenteeism rates have increased due to deaths and co-workers attending the funerals. It is especially bad when the funerals are in the farms and with black funerals it can take a whole week or sometimes it takes longer. Thus, there was a need to train extra individuals to cope with absenteeism.

(Factory Sister, Firm A)

Employees can be made to take more of a pro-active role as well as more responsibility for the ways in which they interact with the virus. One way of ensuring this is to have employees' as members of a HIV/AIDS committee. Thus, having employees as members of a HIV/AIDS committee is important and employees must take responsibility as well. These responsibilities are (Davies et al, 1997: 22):

- Taking responsibility for their own health
- Participating in and owning the program
- Respecting the privacy and confidentiality of those living with HIV
- Respecting the rights of those who are HIV-positive
- Taking lessons one had learned at the workplace to one's home community
- Participating in collaborative partnerships

5.2.3. *MANAGEMENT LEVEL IMPACTS*

According to the informants, the impact of HIV/AIDS on management has been met with very mixed responses. On the one hand, management has generally not understood the full extent of the impacts of the virus on the work environment, whilst on the other hand; some management levels have taken on a pro-active stance against HIV/AIDS. Of interest, firstly, is that none of the informants knew of any member of their management team that was reported to be HIV-positive. In addition, management is still a distant entity that exists outside the factory worker environment and this came out strongly in the interviews. Management still maintains the employer-employee dichotomy and communicates to their employees via supervisors and lower level managers. It can be assumed that this is one of the reasons why management does not realise the extent of the threat of the HIV/AIDS epidemic on its workforce.

In South African companies, unfortunately, management is still not on board and in tune with issues regarding HIV/AIDS (Heywood, 2000; Barese, 1995). This was evident in the eight firms, which highlighted that management was not in touch with the needs of their people at shop floor levels. Literature has shown that management is a key link to successful prevention outcomes (Davies, 1997; UNAIDS, 1998; Boulle, 1992; Barese,

1995) and that without managerial support, success rates are reduced (Roberts, 1995). This point is emphasised by the late A.L. Keembe, Personnel Director of Barclays Bank of Zambia (cited in Roberts, 1995: 6).

...At Barclays Bank, we acknowledge that AIDS is a national problem at every employer's doorstep. The threat of AIDS and the problems arising from it cannot be left to government and non-government organisations alone. We are committed to the dire need to control the spread of AIDS and discrimination against people with HIV infection. The way forward is to accept that AIDS is a national problem at every employer's door-it is a management problem.

The importance of having management as part of the HIV/AIDS prevention team is important in the following ways (Davies et al, 1997: 22):

- φ It shows commitment to the HIV/AIDS program
- φ It ensures that the process of consultation takes place
- φ It allows time for employees to take part in the HIV/AIDS program
- φ It ensures that resources are made available to the program
- φ It allows participation in collaborative partnerships
- φ It formalises the job description of anyone who is involved in implementing the program to facilitate their work and increase their credibility

Boulle (1992: 50) adds that management should not only become involved in AIDS programs but they should also acquire a good and up-to-date working knowledge of AIDS.

Secondly, on a more positive note, the findings suggested that in three of the eight firms, management implemented programs that benefited their whole organisation, although the managerial-employee relationship was still strained by the hierarchies prevalent in these firms. In these three firms mentioned above, management had given their full support for these education programs mainly due to these programs being initiated by management themselves. The primary reason for management undertaking such a task of initiating

prevention programs stems from their education on facts about the epidemic. They implemented the programs with the full and educated knowledge that HIV/AIDS would impact on their organisation presently and certainly in the future.

Moreover, other positive interactions by management have included the following:

- Management in Firm C has supported the educator financially by having purchased AIDS videos from Cape Town. At the time of the research the firm was in the process of purchasing a television set and a video machine so that their employees' can view the material and further their education on the virus.
- Management in Firm A is paying the medical costs for their employees' voluntary tests that are being undertaken at Crompton Hospital and are continuously monitoring ill employees at their on-site clinic.
- Management in Firm F had provided the educator with a projector so that she could present her HIV/AIDS slide shows. This same firm's management support was overwhelming in the sense that they together with the employees collect monies to pay for very poor employee's funerals as well as buy groceries for the deceased person's family. This was in response to death benefits taking a significant amount of time to be paid out to the families and these families need the money as soon as possible, especially where the families are too poor to save and the death of a loved one is an unforeseen circumstance.
- In all eight firms, informants pointed out that management was non-discriminatory when they found out that an employee's HIV-status and allowed that particular employee to continue being employed.

This last point of non-discriminatory practices against employees has been enforced legally and there is legislation that prohibits employers from firing/dismissing any employee due to their HIV-status (ILO, 2000; Heywood, 2000).

5.3. POOR COMMITMENT TO HIV/AIDS PREVENTION

This highlighted that the firms' management and employees displayed a general lack of commitment to existing HIV/AIDS programs.

One of the research questions looked at whether or not the HIV/AIDS program was part of a long-term initiative to deal with HIV and AIDS. An analysis of the findings in Theme 3 shows that there is a lack of commitment to these programs. Five of the eight firms management team displayed poor commitment to HIV/AIDS whilst three of the eight firms had their programs initiated by management. These five firms had their programs initiated by the South African Clothing and Textile Workers Union (SACTWU). The union educated the shop stewards on HIV/AIDS and the shop stewards were then responsible for disseminating the education to their workforce. Thus, it was purely the union's initiative and management has not taken any pro-active approaches to working hand-in-hand with the union in the fight against HIV and AIDS. From this the finding is that where the prevention program initiatives came from the union, management has been content in allowing the union to educate its workforce.

Management in these firms has therefore not taken any internal initiatives and has been content with passing the responsibility onto the union and its educator. Therefore, from these findings it can be stated that management has shown a clear lack of commitment to its HIV/AIDS programs and where it get away with doing the minimum, it has done so. This is especially worrying when one thinks of the longer-term effects of the virus and the devastating impacts HIV/AIDS is to have on the socio-economic development of firms and employees. This lack of commitment from firms is concerning. Roberts (1995: 7) states that many programs have failed in the past due to lack of management involvement or over-reliance on externally provided prevention activity. This is disturbing considering the fact that the union has made it a regulation to have HIV/AIDS policies as an essential part of the firms' vision and goals. SACTWU is doing the final revision of such a policy document and after it gets the approval from government; HIV/AIDS policies will be implemented in all firms, across all clothing sectors (interview with Dr Mansoor: July, 2001). Therefore, these firms are misinformed in their thinking that they can get away from the issue of HIV and AIDS and that they can continue to do the bare minimum for their employees.

A contrasting outlook of the firms' commitment to prevention programs was that three of the eight firms were committed to supporting the prevention programs over the long term. These three firms that are committed to HIV/AIDS had their programs initially implemented by management. Thus, management's role in the success of these programs has been crucial in maintaining commitment for the present and future impacts of the epidemic. It is unfortunate that such a small percentage of firms actually realise the overarching implications this epidemic has on every individual. For those firms that want to continue succeeding in maintaining their competitive advantage in the global markets, they first need to perceive the AIDS epidemic as a real threat and as a challenge. As highlighted in chapter two, if they do not prepare adequately for this epidemic, firms will be losing large numbers of employees and the costs to train and re-train employees will be either too late or too costly, or both.

Another survey finding from the research is that employees to a certain extent are also not committed to the programs for various reasons. The most important reason being that some employees do not believe that HIV/AIDS exists or that it is a killer virus. Employees are making the process of education difficult due to their cultural and traditional beliefs.

...it is the older employees that are more adamant and stubborn and do not really believe that the virus exists. Their response to the virus is that it is a 'fairytale.'
(Factory Sister, Firm A)

...however the older men find it difficult to believe and it is very hard to introduce something new due to them being used to the old ways. The reality of HIV is a new concept to them and one they are finding very hard to believe in.
(Factory Sister, Firm B)

...the older workers, especially the men do not believe the virus exists and that it was something that the 'white people gave them.' (Factory worker, Firm D)

Fortunately, as indicated by the key informants, the majority of employees believe that the HIV/AIDS epidemic is real. It has been encouraging to hear that it is the younger employees that have perceived this virus as a real threat and are taking precautions against HIV infections. This applies to employees generally, not to all. However, workplace education programs seem to work positively in most firms interviewed.

...The younger employees are not so difficult to encourage to take condoms and to believe that the HIV/AIDS virus exists.

(Factory Sister, Firm A)

...The responses from the female workers have been very positive but they still complain that they are experiencing problems negotiating condom usage with their partners.

(Factory Sister, Firm C)

5.4. THE ROLE OF TRADITIONAL NORMS AND VALUES ON EMPLOYEES' PERCEPTIONS OF HIV/AIDS

This section highlights in detail the views of condom usage, HIV/AIDS testing, beliefs in witchcraft, myths and rumours surrounding HIV/AIDS and discrimination in the workplace.

This theme explored the extent of the success of the prevention programs on employees' perceptions, attitude, and behaviour. Inclusive in this exploration of employees' psychological changes was a look at how much of a role employee cultural contexts play in their understanding and interpretation of the virus. It is of necessity that when one is formulating a HIV/AIDS policy and prevention program that one is cognisant of the employees' cultural contexts. "Knowledge of the employee culture...is essential for making programmes as relevant and effective as possible," (UNAIDS, 1998: 8). Overall, seven of the eight firms' informants agreed that there were different effects of the prevention programs on employees' attitudes, perceptions and behaviours after the implementation of the programs. A consensus was reached in all eight firms that culture

certainly impacted on the way employees viewed and understood the HIV/AIDS epidemic.

Condom usage, HIV/AIDS Testing, Culture, beliefs in Witchcraft, Myths and rumours surrounding HIV/AIDS, the Belief in HIV/AIDS, Discrimination and Non-discrimination of employees were looked at with respect to ascertaining whether or not there were any changes in employees' behaviour and attitudes after the implementation of the HIV/AIDS prevention programs.

5.4.1. *CONDOM DISTRIBUTION AND PRACTICE*

Regular and correct condom use is essential for the prevention of HIV and other STD's and companies should make the effort to make condoms accessible in the workplace and include condom use in their education programs (UNAIDS, 1998: 6). Education has highlighted time and again that individuals must practice safer sex using a condom, especially where multiple partners are involved. All informants have indicated that there are condom distributions being undertaken in their firms, as outlined below in Table 6.

Table 7: Condom distribution per month

FIRM	NO.OF EMPLOYEES PER FIRM	NO.OF CONDOMS DISTRIBUTED PER MONTH	NO.OF CONDOMS PER EMPLOYEE PER MONTH
A	1800	1000	0.55
B	1000	1000	1
C	700	500	0.71
D	300	UNKNOWN	----
E	380	300	0.78
F	800	1250	1.56
G	300	100	0.33
H	200	150	0.75
AVERAGE	**685**	**614**	**0.89**

The fourth column in Table 7 shows that the number of condoms distributed per employee per month is inadequate. The figures show that there is less than one condom being distributed to each employee. This figure of less than one condom per employee is of major concern due to adult individuals usually having sexual intercourse more than once per month. The number of times an individual engages in sexual activities is positively correlated to the increased rates in people obtaining divorces and with polygamous beliefs in certain religions (such as Islam and traditional African cultures) (www.fortunecity.com/skyscraper/straylight/582/22/21.htm). The number of sexual partners is said to increase as individuals mature and get older thus increasing the number of sexual partners during one's life span (www.valt.helsinki.fi/hypersex/8number.htm). A survey conducted in the USA as well as in twenty-eight countries, revealed in an article entitled **'Americans rated the top bonkers'** that on average, the number of sexual encounters has increased worldwide (www.iafrica.com, 2001). The article stated that South Africans have also increased on average:

> *...most South African's are getting more nooky these days-on average 116 times a year, up from last year's figure of 107 and that 15% of South African adults consider lovemaking their number 1 priority.*

The number of condoms being distributed in these firms is ineffective in the fight against HIV/AIDS and this problem is compounded by the culture of denial and fear. In the event that there are multiple partners involved, the aim and purpose of distributing condoms is defeated unless, or where, the individual goes to a clinic for condoms or purchases condoms at local pharmacies/chemists. Given the general weekly wages earned in clothing firms, one can assume that employees would not spend their wage on the purchasing of condoms.

The researcher telephonically obtained the prices of condoms from four reputable pharmacies from in and around Durban. The four pharmacies were located in the Central Business District (CBD), Bluff, Phoenix and Chatsworth. The prices quoted from each of

these pharmacies for a pack of three condoms were respectively, R4, 87; R2, 50; R4, 00 and R13, 50. If one had to do the math on this, taking the number of sexual partners multiplied by the number of times the average person has sexual intercourse, one can clearly see that the number of times a person indulges in intercourse exceeds the number of condoms used. The price range of the condoms would also not entice individuals to purchase condoms every time they wanted to have intercourse.

Therefore the workplace is the best and most advantageous environment within which to distribute condoms and encourage the practice of safer sex. In addition, employees' are not restricted with regards to the number of condoms they are allowed to take and more importantly, the condoms are free. However, by looking at the averages for Table 6, one can see that firms are not distributing any significant quantities of condoms and that employees are restricted to less than one condom.

Compounding this inefficient distribution of condoms are the problems being experienced by females who are finding negotiating condom practices difficult. The findings have highlighted that women were more prone and vulnerable to HIV/AIDS infections due to physiological and psychological reasons (Evian, 1995; SAPA in The Star, 2001). An imbalance of power within relationships often results in young women not being able to negotiate condom usage. This was made evident by the informants who indicated that women were experiencing huge problems when it came to negotiating condom practices. This was made especially more difficult where the females were married. This can be interpreted as a fear of using condoms or asking one's partner to practice safe sex by using a condom.

In addition, such a request may lead to violence as it can be interpreted as a sign of unfaithfulness on behalf of the female partner, or an accusation that the male partner has not been faithful himself or that he has a STD (Dallimore, 2000; Rasool, 2000: ISS Survey). Women who felt that their spouses or partners were being unfaithful had reverted to using traditional medicine to keep their partners faithful. This practice is

dangerous in itself due to the nature of the application of the medicine. Thus, such problems become compounded due to issues of power within relationships. This point has been strongly put forth by the informant in Firm C,

> *... it is very frustrating for the females because their partners say that they are not being faithful and are having affairs with other men and this leads to problems within the relationship. To avoid all of this conflict they do not use condoms or suggest the use of condoms although the women really want to use them. This is made more difficult if the women are married.*
>
> (Factory Sister, Firm C)

Moreover, the informants commented that employees often stated that wearing a condom was like "eating a sweet with a wrapper on. You just don't do that."

5.4.2. *HIV/AIDS TESTING*

UNAIDS (1998) states that employers should not require HIV screening as part of general workplace physical examinations or when recruiting new staff. Davies et al, (1997: 43-44) adds that the prerequisite for HIV testing is informed consent of the person who is to be tested and that since March 25 1997, pre-employment HIV tests are no longer required for employment in the civil service. However, in the event that testing does take place it is essential that counselling is available as the result of a positive test could be traumatic for the person concerned (Davies et al, 1997; Boulle, 1992, UNAIDS, 1998).

Table 8: Responses of firms to HIV/AIDS testing of new and current employees

FIRMS	HIV/AIDS TESTING OF EMPLOYEES
A	YES
B	NO
C	NO
D	NO
E	NO

F	NO
G	NO
H	NO

Seven of the eight firms indicated that there was no testing of new and current employees and two reasons were specified for this.

- The informants stated that it was unconstitutional and illegal to test any employee who did not provide their consent to being tested.
- The majority of the employees were afraid to go for voluntary testing, even those employees that were showing symptoms of the virus. Fear, discrimination and stigma were the most often cited words used to describe employees' feelings when it was suggested that they go for a voluntary HIV/AIDS test (to the Bolton Hall union clinic). They felt that they would be discriminated against if their HIV-status were known.

Firm A is an exception in this regard. The informant answered positively to the testing of employees. HIV/AIDS testing was however, done only via voluntary testing and the reason testing was so successful had to do with the firm paying for the costs of these tests. Moreover, the education that is being disseminated has resulted in a positive understanding of the virus and these employees actually want to know their HIV-status. There has been such an overwhelming response that it has become expensive for the firm to pay. The firm is now sending their employees to Open Door Crisis Centre and they are undertaking the testing for free.

5.4.3. *CULTURE*

Informants from all eight firms have stated that the employees' cultural contexts have been a factor that has influenced their understandings and interpretations of HIV/AIDS. However, firms' A, B, D and G have been specifically referred to due to the insights and information being more valuable. The majority of the workforce in these firms is African.

The African population in South Africa is generally more heavily steeped in their cultural and traditional ways due to a larger number of African people still living in the rural homelands, which was a consequence of the Apartheid regime.

- The informant from firm A stated that the problem being encountered was how to change the employees' cultural and traditional beliefs regarding HIV/AIDS. Currently, it is encouraging to see that the younger employees are taking condoms and they do believe that the HIV/AIDS virus exists (although their behaviours do present a risk and a challenge). Unfortunately, it is the older employees that are more adamant and stubborn and do not want to believe that the virus exists. To try and 'modify' this thinking, because changing it is still a long way off, HIV-positive people and union representatives such as Dr Mansoor came in and spoke to the employees. This firm's main weapon against this HIV/AIDS fight is their ongoing educational program.

...it is the key to getting through such thinking and to changing the way people view this disease.

(Factory Sister, Firm A)

- The informant from firm B stated that their composition of the workforce was also mainly African. Thus, their African employees preferred to go to their Traditional Healers in the rural areas or in the towns. Management has been understanding in allowing employees a few days off, provided that they phone and inform the firm before hand.

- Firm D's informant indicated that the majority of the employees were African as well as female. These women are posing as a challenge to the informant who is also their educator. Individuals believe that HIV/AIDS is a reality and that anyone can die after contracting the virus. Unfortunately, the realism of the effects of the virus has not penetrated their mindsets yet and the full implications of the virus have not hit home yet. The informant has noted disturbing conversations among

these African female workers. These conversational tones centre on the use of muthi (traditional medicine) to keep their partners faithful to them.

The informant explained that the muthi is obtained from a sangoma (traditional healer) who is operating in Russell Street, Durban. The muthi is described as a 'love-potion' that is supposed to keep the male partners of these women faithful to them only. It is used in the following way. The muthi is applied into and around the vagina of the woman and during sexual intercourse the muthi will begin to work. The colossal problem with this is that there needs to be skin-to-skin contact between the partners if they want the muthi to work. Thus, the possibility of a condom being used is non-existent. The irony of this is that these women know that their partners are not being faithful therefore the need for the muthi in the first place.

Thus, the belief in traditional healers and medicines as means to curing HIV/AIDS is a hindrance in the fight against the epidemic. This belief is not specific to the context of South Africa but resonates throughout Africa as in the case of Zambia. Many people in Zambia seek help for medical problems from both traditional healers/doctors as well as from formal health services workers. A study performed at the University Teaching hospital in Lusaka showed that more than 75% of inpatients had also sought advice from traditional healers and 68% of those attending for HIV counselling and testing had seen a traditional healer. People do believe that traditional healers can cure HIV/AIDS as this quote from a Zambian demonstrates (Baggaley, Sulwe, Burnett, Ndovi, 1995: 10):

...I am seeing an African doctor because he has had a good success with people with the virus. He has even got one patient whose test has become negative, but he says the disease has to be in the early stages. If I get sick with coughing or diarrhoea I go straight to the clinic for antibiotics...

Moreover, people saw no contradiction in seeking help from traditional healers and from health services workers simultaneously. Therefore the importance of involving healers in

HIV prevention programs has been recognised and there has been training provided for these healers in other African countries such as Kampala and Uganda. Training has included enabling healers to give peer support and education to people with HIV (Baggaley et al, 1995).

Another problem that exists side-by-side with the one above has to do with individuals in the townships spreading the virus deliberately. Individuals that have been accused of this deliberate spreading of the virus continue to spread it out of anger,

...if they know about it they get angry and say that the person who gave them the virus did not care about them so why should they care about who they spread it to. They go around sleeping with people knowing full well that they are infecting the next person...such Africans have "a dirty heart."

(Factory worker, Firm D)

- Firm F's informant also stated that culture is a huge problem in their factory and problems are being experienced with all age groups. The younger people in the company believe that HIV/AIDS exists and that it can kill you, but they still do not practice safe sex and there have been refusals to wear a condom because they want "flesh-to-flesh". Jabulani Ngcobo (the Senior Prosecutor in Pinetown) stated that,

...It is very disturbing to find people who still believe in 'inyama enyameni' (flesh to flesh). They say you need to remove the paper that wraps the sweet in order to enjoy it: this is the 'sex without a condom' mentality. (Nyathikazi, 2001: 16).

5.4.4. *WITCHCRAFT AND MYTHS*

Firms' A, F and G have had incidents whereby employees reported that witchcraft was responsible for persons acquiring the HIV/AIDS virus. Unfortunately, placing the blame on bewitchment allows the infected person to displace the burden on another entity

beside themselves. Thus, that person avoids facing reality head-on and dispenses some of the responsibility on to others by blaming others for their virus. Reports of witchcraft are also hampering the efforts being made to educate employees' on the facts of HIV/AIDS because to deal with witchcraft requires traditional medicine. Since there is no cure for AIDS, these traditional medicines cannot help an ill person from not dying. The swallowing of traditional medicines can counteract the intake of medication given by hospitals, clinics and doctors. In firm B there are employees that are spreading myths and rumours about the way one can contract HIV or AIDS. For example, one myth that has been passed on is that one can get AIDS through mosquitoes.

Many people still believe that HIV/AIDS does not exist and they feel that it is not their problem and therefore they do not feel compelled to do something about changing their attitudes (Nyathikazi, 2001). The summary from key informants responses of whether or not employees believed that HIV/AIDS existed is summarised in Table 9 below.

Table 9: Summary of employees' acceptance of the existence of HIV/AIDS at the surveyed firms.

FIRMS	**DOES HIV/AIDS EXIST?**
A	YES
B	YES & NO
C	YES
D	YES
E	YES & NO
F	YES & NO
G	YES & NO
H	YES

This type of response (YES and NO) to whether employees believe in HIV/AIDS is particularly concerning. These are adult men and women that continue to be bombarded with educational material, such as billboards, radio, television, the print media, fellow

workers, as well as the deaths of fellow workers and family members and yet still there is doubt as to the reality and impacts of the virus. There is definitely a mindset that is not being penetrated by the educational campaigns around KwaZulu Natal, if one can report that adults do not believe in the virus' existence.

Moreover, misconceptions of the origins of the virus are evident in most firms surveyed but it is strikingly so in Firm F and table 9 shows this clearly with respect to Firm F's response. The informants pointed out that some employees believed that the virus existed whilst others did not believe in HIV/AIDS. The older generation-employees believe that it is a disease brought by the white man and given to them in order to prevent the African population from reproducing offspring. The informant also spoke to King Zweletini personally and a challenge was metered out to him regarding condom usage and to urge his people to practice safer sex. For education to be successful regarding HIV/AIDS one has to lead by example but this is not so with King Zweletini. King Zweletini has many wives and each year he takes on another and the message he is sending to his people, especially the men, is that it is all right to continue taking many wives and partners. The reason that he was challenged stems from the African people's worship of him and the god-like status they afford him. Unfortunately no fruit came to bear regarding this challenge.

5.4.5. *DISCRIMINATORY PRACTICES*

When a person is known to be HIV-positive he or she is frequently the subject of stigmatisation, discrimination or even hostility in the community and at the work place, particularly where people have little understanding of HIV/AIDS. The consequence of this is that the individual is forced to leave their job and becomes isolated in their communities. Some prefer to leave their communities and they hide their HIV status as long as they can to avoid this stigma and discrimination (ILO, 2000). Thus, HIV/AIDS emerged initially as a workplace issue as a result of concerns relating to stigma and discrimination (Heywood, 2000). The research findings indicated that employees that were suspected of carrying the virus were discriminated against and that employees were

afraid to go for testing due to the stigma, fear and denial still associated with the virus. It is important that both employees and employers work in unison to prevent unfair discrimination and stigma (Heywood, 2000). The general uncertainty about HIV/AIDS and the fear of infection may undermine staff morale (Whiteside and Barnett, 1996; UNAIDS, 1998).

Discrimination because of an employee's HIV-positive status is impermissible in terms of common law and would also be regarded as an unfair labour practice (Boulle, 1992: 42). Durban's Unicity Council's HIV/AIDS policy indicates that no person with HIV/AIDS shall be unfairly discriminated against within the employment relationship or within any employment policies or practices (Nyathikazi, 2001: 16). Within firm D there are still plenty of stigmas attached to HIV/AIDS. The employees are afraid of being discriminated against if their status is known or found out. For example, the deaths that have occurred within the firm were not acknowledged as HIV-related even though it was clear to all that HIV/AIDS symptoms were being displayed. There are problems being encountered due to the men (about 50 of them) not wanting to acknowledge the existence of the virus. They refuse to hear about any issue related to HIV/AIDS. Compounding this issue is the gender issue. The educator (who was also the informant) is female and speaking to the men on the subject of sex and condom usage is a subject that is taboo in an African culture. When condoms are offered to them their answers are, "we do not use that rubbish plastic." Moreover, it is these same men that come from the farm areas and dwell in hostels. The informant knows for a fact that these very men have girlfriends or other sexual partners and that they are not practicing safe sex. These men then go back to the rural areas during the weekends or on holidays and it is assumed that they are carrying some type of disease, STD, at worst the HI-virus.

Unfortunately, firms' A and F have experienced worker discrimination due to employees assuming the status of a fellow employee. In the case of firm F, the person that accused a fellow worker was formally charged by the firm and was handed a final-written warning. Firms' C, E and H have indicated that there have been no incidences of discrimination,

on any grounds, towards fellow employees. In fact, firm E had known the HIV-status of two of its employees and the management team allowed the employees to continue working. As these employees became ill, the managers allowed them time-off and lighter work loads were allocated to them as well.

These discussions point out that an individual's cultural context influences his or her perceptions and interpretations of the world and his or her actions within it. The culture of thinking needs to be changed first and foremost. Firms can begin to initiate prevention programs, policies and strategies and pour thousands of rands into the educating of their workforce but all of this would be deemed unbeneficial and ineffective if individuals do not want to change their mind-sets about the disease. Firms can spend huge amounts of money on buying condoms and telling their employees how condom practices can decrease the spread of HIV/AIDS but it will be ineffective if employees continue to believe that the virus does not exist or that they are immune to being infected by the virus. Thus, this is a really important point to bear in mind; that prevention programs must be formulated with culture and traditional beliefs at the forefront of strategies. Therefore, employees from all races must be represented in HIV/AIDS committees in firms. Boulle (1992: 51) reiterates this point by stating that:

...any education should be conducted in the trainees' own language and their customs; taboos and value systems must be recognised...for most credibility the 'black-to-black' approach is best (for the training of blacks)...

5.5. FIRM SUPPORT FOR COMMUNITY HIV/AIDS OUTREACH ACTIVITIES

The analysis showed that there was a general lack of information and facts dissemination on HIV/AIDS to surrounding communities.

When addressing HIV/AIDS where the culture of denial and social attitudes towards prevention and care take on such importance, it is extremely difficult to change attitudes and practices in the workforce in isolation from the community as a whole. Effective

prevention and care in the world of work therefore has to be aimed at the community through the workforce (UNAIDS, 1998). The general findings were that firms were not actively participating in community outreach activities for varying reasons and that firms did not fully comprehend the necessity of working in partnership with communities; the advantages of which are invaluable. This point is supported by UNAIDS that assert that "there must be links with business and the wider community, otherwise the business sectors will miss out on ways in which community and other outside groups could help them in dealing with HIV/AIDS issues, and vice versa" (UNAIDS: 1998: 4).

An analysis of the findings indicated that seven out of eight firms; A, B, C, D, E, G and H did not extend their HIV/AIDS prevention programs beyond the boundaries of the firm. The main reason for this lack of information sharing as stated by the informants stemmed from general disinterest and lack of support structures from management. Firm A stated that it was not company policy to disburse information into the surrounding communities. This is unfortunate considering that Firm A has the resources (they provide free testing for their employees' and they have an on-site clinic) to be able to maintain an outreach program in communities. The informant commented that although the firm did not educate the communities the workers came from; the shop stewards did take the initiative out into communities.

Firm F was the exception and it supported the shop steward in undertaking the task of educating the surrounding communities. Management is behind her in all that she is trying to accomplish within the firm and outside as well. The shop steward together with employees is going out into communities such as Lamontville and Umlazi and is educating the people. This educating process is often met with frustration due to these people being tired of hearing about HIV/AIDS. However, according to the informant this 'tiredness' stems from 'fear'. People are afraid to go for testing especially if they have had many sexual partners. Denial is another stumbling block due to people not wanting to know their HIV-status. The shop steward from Firm D is also taking on the initiative by herself to go out into her community and to educate people.

Firms need to ensure that their employees' families and communities are aware of the epidemic and that medical advice is being sought. Firms that do provide medical coverage for their employees must take cognisance of the fact that there are employees that do not follow the full course of their medication. This is due to them sharing their medication with their family members. Thus, it is important that firms go out into communities to assess the extent to which they are being affected by the virus. Firms can work in conjunction with the health and education departments to raise HIV/AIDS awareness levels.

The ILO's (2000) experience of prevention programs in other related areas, such as drug and alcohol abuse, shows that NGO's and community organisations can be extremely valuable partners for government agencies, employers and workers in helping to extend preventative action to the community as a whole. The following paragraph makes explicit who should count as role players/stakeholders in HIV/AIDS prevention and what the responses of each stakeholder should entail.

5.5.1. The Role of Stakeholders in HIV/AIDS Prevention

The responsibility to effectively fight the epidemic lies with each and every person. The effects of the virus has in some way touched the life of every individual of all ages, races and walks of life. AIDS is a democratic virus (Heinzen, 1995) and each person is at risk of contracting the virus. The findings indicated that management did not feel responsible for the virus, and employees to different degrees felt that HIV/AIDS was not their responsibility and did not feel threatened by it, which led to their refusal to wear condoms, or to their belief that the virus did not really exist. Ultimately, each person is responsible for his or her own life and they are responsible for the curbing and prevention of the virus. In the same instance, individuals must be assisted by various functioning organisations such as the government, trade unions, non-government organisations, employer organisations, employee organisations, health departments, education

departments, health workers and the like, and all should unite to fight the HIV/AIDS virus.

5.5.1.1. *The response of government*

It is evident that governments have a pivotal role to play in instigating awareness and prevention programs and in determining the policy framework for co-ordinated measures to combat the pandemic. Government can take three broad and interconnected approaches to respond effectively to HIV/AIDS.

1) Supporting and promoting broad partnerships for prevention and action. It includes public agencies, the private sector, and workers' representatives and community bodies with civil society. These bodies will respond to HIV/AIDS ethically and effectively.
2) Improving co-ordination between the public services and authorities responsible for responding to the pandemic and
3) Reforming legislation and support services focusing on anti-discrimination, public health protection, privacy and criminal laws and improving the status of women, children and marginalised groups. Government's important role in developing a legislature includes health and safety laws listing AIDS as a communicable disease, legislation creating institutional reaction teams, such as, National AIDS Councils and the prohibition of workplace discrimination based on HIV infection. Over 30 countries have addressed the policy considerations of HIV/AIDS from the point of view of the world of work. Even though this is occurring, only in a few cases are Ministries of Labour, employers' and workers' organisations represented and involved in these plans (ILO, 2000).

Some of the principle challenges facing policy-makers in responding to HIV/AIDS in the workplace include:

- How to cover workers in the informal sector who are often excluded from existing labour legislation, social services and representation?

- How to cover mobile working populations including migrant workers whose situation may fall outside national legislation, social services and representation structures?
- How to strengthen already stretched enforcement mechanisms, such as labour inspectorates and labour courts, which may have little or no experience of HIV/AIDS-related matters?
- How to develop effective co-ordination between national institutions in general and particularly in such fields as health care and social protection (ILO, 2000)

5.5.1.2. *The response by employers and their organisations*

Some of the responses to the HIV/AIDS pandemic that have been adopted by employers' and their organisations are encouraging. An increasing number of employers have been developing HIV/AIDS prevention and care programs. It has been designed not only to protect the infected workforce but also to takes into account the rights and problems of those living with HIV/AIDS. Some employers have started prevention programs in the workplace at their own initiative with a view to protecting their investment in human capital. The programs vary according to company size, resources, structure and employee culture as well as public policy (ILO, 2000).

5.5.1.3. *The response by workers' organisations*

Specific issues taken up by workers organisations include the fight against stigmatisation and discrimination against people living with HIV/AIDS and their families, relationship between low salaries, bad working conditions and HIV infection, the danger of HIV infection in situations of conflict and the provision of treatment to persons with HIV/AIDS, for whom the availability of affordable medication is essential (ILO, 2000).

5.5.1.4. *Response at the community level*

The driving force behind many HIV/AIDS prevention and care activities at the community level is provided by non-governmental and community based organisations (CBOs). In many countries the community response has preceded the government

response. In almost all cases it has proved essential to a successful national response particularly in the areas of awareness raising, prevention, advocacy, policy and legal changes and family or community care and support (ILO, 2000). It is clear that no-one sector alone can make a significant impact in the fight against the epidemic. A true partnership involving the government, the private sector and the community is essential to face the problem (Davies et al, 1997).

5.5.1.5. *The response by Trade Unions*

Although the trade union movement has passed numerous resolutions on the need to 'fight AIDS', for a long time very little was actually done. During 1999, there was a very dramatic quickening of interest in and commitment to HIV prevention by trade unions In January 1999 the Department of Health facilitated the formation of a 'Trade Union task team'. The task team has met frequently since then and has started to train and expand a cadre of trade union leaders with a more detailed knowledge of HIV/AIDS. During 1999 it played a part in organising and assisting several important interventions by trade unionists. These included (Heywood, 2000: 14-15)

(1) The drafting of a 'model' trade union policy on HIV/AIDS in the workplace
(2) The drafting of an AIDS policy for the South African Clothing and Textile Workers Union (SACTWU). The national Bargaining Council for the clothing industry later adopted this policy
(3) The organising of a trade union AIDS train, which in August 1999 travelled across South Africa providing information and raising awareness about HIV/AIDS.
Although still falling short of what is needed and what is possible, the trade unions are now in a far better position to begin to actively impact on HIV as a workplace issue.

5.5.1.6. *Health workers*

A number of steps can be taken to involve health workers in the HIV/AIDS prevention program. Health workers should be trained in diagnosing and treating or referring cases and also in counselling about safer sex. Health workers can also be responsible for

maintaining statistics on the numbers of cases seen every month in the workplace (Davies et al, 1997: 62).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

The aim throughout this dissertation was to draw attention to the threats and challenges of HIV/AIDS to the world of work, particularly in the Durban clothing sector. The following eight key questions were used as a basis to obtaining responses that culminated in the data being grouped into five themes that were discussed in detail in Chapter Five. To reiterate, the eight questions posed were:

i. Who was the initiator of the prevention programs?
ii. What led to the development/implementation of such a program?
iii. What are the impacts of the HIV/AIDS epidemic on the firm?
iv. What are the overall effects of HIV/AIDS on the employees' level of performance?
v. What is the role of management?
vi. Is the program part of a long-term effort to deal with HIV and AIDS?
vii. Are there any significant changes by employees' regarding their perceptions, attitudes and behaviours, after the implementation of the program?
viii. Are firms' disseminating information on HIV and AIDS beyond the firm boundaries and into surrounding communities?

A review of the informants' responses revealed that the clothing sector had not as yet begun to feel the threats of the virus on their work environment. The high levels of unemployment coupled with disinterest by management are the reasons for this non-threatening view that has been adopted by such firms. Although prevention programs are being implemented in the workplace the rates of success are at a minimum due to a diverse range of factors that are impacting on these programs. The most important factor is culture. Employees are influenced to a greater extent than one would expect as to how they understand and interpret HIV/AIDS. The research findings have indicated that employees' cultural contexts are impinging on the success of HIV/AIDS education in the workplace. It would be senseless to spend huge amounts of money on education without

first trying to adopt a policy or program that deals with cultural and traditional views of life. Moreover, management needs to take on a more pro-active initiating role in the fight against HIV/AIDS, which includes greater awareness and commitment. However, difficulties lie with management needing to see deaths first before realising the actual negative reality the virus will have on the organisation as a whole. Unfortunately, by the time the realisation occurs it would be too late to curb or prevent the deaths that would be happening in the work environment.

A summary of the salient points in the dissertation chapters will be provided, which will then be followed by recommendations as to how industry can begin its arduous task of more effectively fighting the epidemic.

Chapter One: Introduced the research area of study, which was HIV/AIDS in the Durban clothing industry. From the introductory discussions, it was clear that South African firms, generally, did not perceive HIV/AIDS as a 'real' threat to their working environment. This was particularly evident in the eight clothing firms surveyed. The chapter explored, further the effects that HIV/AIDS would have on industries, such as,

* Increased deaths
* Increased absenteeism
* Increased rates of labour turnover
* Decreased levels of production and profits
* The loss of skilled employees

Moreover, the discussions highlighted that due to the clothing sector employing a majority of female workers and females being more prone to risks and being more vulnerable to infection and death than males, the effects on the clothing sector are significant. Thus, the clothing sector in Durban is under serious threat if no initiative is undertaken to challenge the virus and its impacts. The initiative that would be successful is implementing HIV/AIDS education awareness programs that educate employees on HIV/AIDS prevention, care and responsibility. Management needs to be part of this

endeavour to ensure its success in curbing the spread of the disease and the deaths of valued employees. The methodology section highlighted the research method utilised and the reasons for choosing that particular technique. The semi-structured interviews proved useful in acquiring relevant and knowledgeable data responses from the eight key informants.

Chapter Two: The theoretical framework section described in detail the epidemiology of the HIV/AIDS virus with references being made to Table 1 regarding the different stages of HIV and its transformation into AIDS. The theory that was discussed in-depth was holistic, that being, the impacts/effects of HIV world-wide and in the South African context were presented. Statistics and tables were offered that helped provide further evidence of arguments that were put forth. Section 2.4 placed the epidemiology of the virus within a specific framework, namely, the Behavioural framework. This framework posited that the spread of the virus could only be curbed if individuals changed their behaviours. However, a contrasting view is offered that counteracts this framework. Evian (1995) asserted that behaviour alone could not curb the spread of the virus but other factors such as relationships; social and economic aspects of life must be taken cognisance of. The survey findings highlighted that behaviour and one's social circumstances (culture/tradition) influenced the way in which one perceived the virus.

Moreover, theory on KZN and the implications of the epidemic on this sector was explored and discussed in length due to the research being undertaken in the Durban clothing industry. The chapter ended with reasons being presented as to why KZN has the highest rates of infection in South Africa.

Chapter Three: Represented an extension of Chapter Three with respect to discussions on KZN and Durban and the impacts of the epidemic on the province. Therefore, this chapter is specific to the context of South Africa. Explorations of the threats and challenges of the virus on the manufacturing/clothing sector were outlined in detail and the consequences of the virus being left unchallenged were also covered as well.

Chapter Four: The discussions were centred primarily on the world of work and the overarching implications that the epidemic could have on the work environment. Thus, developing and initiating HIV/AIDS prevention programs and policies is an important strategic tool that can help curb the spread of the virus and challenge the underlying effects of HIV/AIDS.

Chapter Five: Provided a detailed descriptive analysis of the research findings. The main finding was that HIV/AIDS was an overwhelming health problem in the clothing firms surveyed but the reality of the disease had not penetrated the different mindsets of the employees and employers. The consequences of the devastating and lasting effects of the virus have not been realised by the firms interviewed. To bring the threat of the virus to the forefront, and give it the respect and attention it deserves, requires that all stakeholders/role players from all walks of life, unite and fight this epidemic.

The greatest weapon in the fight against HIV/AIDS spread is education but even this is proving more difficult in practice than in theory. There are prevention strategies but there needs to be, more than anything else, a shift in thinking about this virus. Individuals need to change their attitudes and behaviours regarding the danger of HIV infection. It is these small but powerful changes that are the stepping-stones to affecting greater change in the reduction of HIV/AIDS. The following "best practice" recommendations are in respect to possible prevention and policy programs that firms in general, and especially the clothing sector, can utilise as a basis for planning and implementing programs that can be amended to suit the need of the specific work context.

RECOMMENDATIONS:

...The first step is for a company to adopt a policy on AIDS. This will guide behaviour when AIDS affects the company and assist people to behave coherently according to a rationally thought-through policy. (De Villiers, 1991: 6 cited in Boulle, 1992: 53)

UNAIDS (1998), (www.unaids.org), Roberts (1995), Davies et al (1997) and ILO (2000) posit that the components of an effective HIV/AIDS program needs to take cognisance of the following:

- Ongoing formal and informal discussions and education on HIV/AIDS for all staff,
- An equitable set of policies that are communicated to all staff and properly implemented, including protection of rights at work and protection against any discrimination at work,
- The availability of condoms,
- Prevention and rehabilitation programs on drugs and alcohol,
- Diagnosis, treatment and management of STDs for employers' and their sex partners, and
- Voluntary HIV/AIDS testing, counselling, care and support services for employees and their families.

In addition, Loewenson, Michael, Whiteside and Khan (1999) in their book, Best Practices: Company Actions on HIV/AIDS in Southern Africa, provide substantial details of case studies highlighting companies efforts in dealing with the issue of HIV and AIDS. Their book highlights five sections that deal with (1) HIV Prevention; (2) Managing ill health; (3) Human resource development and Industrial relations; (4) Employee benefits and survivor support, and lastly, (5) Monitoring and Planning. In each of these sections the authors provide a case study summary of what each of the companies are doing to prevent HIV transmission within their employees. South African companies that were researched and were seen as making significant contributions on the issue of HIV and

AIDS (to name but a few) were Mondi Kraft (Development of information/training materials and training based on company needs); Woolworths (Peer educator programme); AMCOAL (HIV prevention and management with central co-ordination and local action) and Illovo Sugar Ltd-Umfolozi Mill (Surveillance of workers health and prophylactic early treatment of pneumonia, TB and sexually transmitted infections).

Principles for policy development

The following principles are important because they have been shown to have a significant impact on whether or not a HIV/AIDS program is effective (Davies et al, 1997: 23-24):

- HIV/AIDS issues must be integrated into everyday activities of the organisation. Induction programs for staff should include a module on HIV/AIDS to raise awareness
- Thorough consultation of the whole organisation is necessary for developing the policy and implementing the program
- The management of the organisation should demonstrate a clear commitment to the HIV/AIDS strategy. It is very important for people to see this commitment in concrete form through non-discrimination and support for people with HIV/AIDS. Concrete commitment will go far in developing mutual trust between employers and employees and facilitating an atmosphere where people are willing to undergo voluntary HIV testing and possibly disclose their HIV status.
- Transparency is necessary. Policy documents should be available and the documents should be written in a way that is accessible to employees
- Any component of the strategy must be thoroughly investigated and an implementation plan developed on the basis of this investigation

The objectives of an AIDS policy must be defined prior to a policy being developed. Some objectives to bear in mind are (Boulle, 1992: 53-54):

- To limit the spread of the virus
- To minimise disruption at the workplace as well as productivity losses

- ➢ To avoid emotional and panic responses when problems occur
- ➢ To minimise fear and ignorance among the workforce

The Department of Health (2000: 16) has put forth a HIV/AIDS and STD strategic plan, as well, for South Africa for the years 2000-2005. The primary goals are to:

- ⇒ Reduce the number of new HIV infections (especially among youths); and
- ⇒ Reduce the impact of HIV/AIDS on individuals, families and communities.

The general strategies that would be stressed upon include, firstly, an effective and culturally appropriate information, education and communications (IEC) strategy. Secondly, an increase in access and acceptability to voluntary HIV testing and counselling. Thirdly, improving STD management and promoting increased condom use to reduce STD and HIV transmission; and lastly, an improvement in the care and treatment of HIV positive persons and people' living with AIDS to promote a better quality of life and to limit the need for hospital care. These strategic plans are structured according to four areas, namely Prevention, Treatment, care and support, Human and legal rights; and Monitoring, research and surveillance (Department of Health, 2000).

SACTWU can adopt the above strategic plan and changes can be made to adapt it to the specific needs of the clothing sector, thus catering for the special needs of women. In adopting the above strategy, it is recommended that the clothing sector:

- ✓ Promote improved health seeking behaviour and safer sexual practices.
- ✓ Broaden responsibility for the prevention of HIV to employers, employees' and communities.
- ✓ Improve the access to and use of condoms, especially amongst 15-25 year olds.
- ✓ Provide services for needlestick injuries and occupational exposure
- ✓ Increase the number of voluntary counselling and HIV testing sites.
- ✓ Increase treatment, care and support for people living with and affected by HIV/AIDS.
- ✓ Review and revise policies and programs

- ✓ Talk about HIV and AIDS; the facts and how HIV is transmitted
- ✓ Promote a culture of learning about the epidemic, especially for management
- ✓ Promote awareness and commitment amongst stakeholders

Unfortunately, the results of the survey undertaken during the course of this research suggest that the "best practice" recommendations will prove extremely difficult to implement. The social nature of the virus and its associated cultural and political dimensions render low management commitment to HIV/AIDS programs, as well as worker apathy/ignorance. Changing these basic elements, prior to the implementation of "best practice" programs is clearly central to the success of firm-level HIV/AIDS prevention programs.

REFERENCES

Baden, S and Velia, M (2000). **Trade policy, retail markets and value chain restructuring in EU clothing** sector, Research Report for the International Development Research Centre, Canada.

Badri, M. (1997). **The AIDS crisis: a natural product of modernity's sexual revolution,** Islamic Medical Association of South Africa, Qualbert, South Africa.

Baggaley, R; Sulwe, J; Burnett, A and Ndovi, M (1995). **Joint training for Traditional Healers and Formal Health Workers in Zambia,** AIDS Analysis Africa (Southern Africa Edition), 6(1) June/July 1995, p10-11.

Barese, P (1995). **AIDS in Botswana: a summary of AIDSCAP Case Studies,** AIDS Analysis Africa (Southern Africa Edition), 6(1) June/July, 1995, p8-9.

Bosch, S.J (2001). **Adult educator**, Cape Times, March 25, 2001 (www.iol.co.za/index.php?)

Boulle, P.E (1992). **Dealing with AIDS-The Response of Management Planners of Medium to Large Companies,** School of Business Leadership (MA Thesis), University of South Africa.

Crewe, M. (2000). **How do we make sense of President Mbeki?** AIDS Analysis Africa (Southern Africa Edition), 11(1) June/July2000, p10-11

Dallimore, A (2000). **Adolescent Risk Taking Behaviour in an era of HIV/AIDS Infections: A Case Study of youth in KwaZulu-Natal Province, South Africa,** Development Studies (Master in Social Science Thesis), University of Natal, Durban.

Dancaster, L and Jamieson, E (1991). **Company policies on AIDS- The Answer?** in AIDS Analysis Africa, Southern African Edition 2(6).

Davies, S; Schneider, M; Rapholo, G and Everatt, D (1997). **Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs,** Community Agency for Social enquiry (CASE), March 1997.

Department of Health (2000). **HIV/AIDS & STD Strategic Plan for South Africa: 2000-2005.**

du Toit, J.D (1996). **AIDS Prevention in KwaZulu-Natal,** AIDS Analysis Africa (Southern Africa Edition), 6(5), Feb/March 1996, p8-9.

Evian, C (1995). **AIDS, Reconstruction and Development, and Corporate Response,** AIDS Analysis Africa (Southern Africa Edition), 6(1) June/July 1995, p1-3.

Halweil, B and Brown, L.R (1999). **Mbeki's Challenge: The HIV Epidemic consuming South Africa,** Worldwatch News Brief "Mbeki's Challenge: The HIV Epidemic" June 7 1999.
(www.worldwatch.org)

Heinzen, B.J (1995). **The Business Exchange on AIDS and Development (BEAD),** AIDS Analysis Africa (Southern Africa Edition), 5(6) April/May 1995, p4-5.

Heywood, M. (2000). **HIV/AIDS and the World of Work in South Africa,** A Report for the International Labour Office (ILO), April 2000, p1-26.
(www.hri.ca/partners/alp/resource/report1.shtml)

ILO (International Labour Office) (2000). **HIV/AIDS: a threat to decent work, productivity and development,** Geneva.

Jones, N. (2001). **Unequal gender relations are deadly, HIV/AIDS Economic Dependence makes Women Vulnerable,** Daily News, Monday 2 July 2001, p6.

Kaplinsky, R and Morris, M (1999). **Trade policy reform and the Competitive Responses in KwaZulu Natal Province, South Africa,** World Development vol.27, no.4, p717-737, Elsevier Science Ltd.

Lamptey, P (1994). **HIV Prevention: Is it working?** AIDS Analysis Africa (Southern Africa Edition), 4(4) Dec93/Jan94, p7-8.

Loewenson, R ; Michael, K; Whiteside, A and Khan, N (1999). **Best Practices: Company Actions on HIV/AIDS in Southern Africa,** Organisation of African Trade Union Unity, Health Safety and Environment Programme, First Edition, February 1999.

loveLife (2001). **Impending Catastrophe Revisited: an update on the HIV/AIDS epidemic in South Africa,** Henry J. Kaiser Family Foundation 2001, p2-36.

Mason, B. (1995). **AIDS Programs in the Workplace: a Case Study (Part 2),** AIDS Analysis Africa (Southern Africa Edition), 5(6) April/May 1995, p10-11.

Morris, M; Barnes, J and Dunne, N (1998). **Globalisation and the Restructuring of Durban's Industry,** KwaZulu Natal Industrial Restructuring Project (IRP), Center for Social and Development Studies, University of Natal, Durban Conference, July 1998.

Nyathikazi, T. (2001). **People don't talk...Let's Talk.** Metro beat, September-October 2001, Issue 32.

Parker, W. (1994). **The development of Community-based Media for AIDS Education and Prevention in South Africa: Towards an Action-Based Participatory Research Model,** Center for Cultural and Media Studies, University of Natal, Durban, South Africa, (Master in Arts Thesis), p1-6.

(www.und.ac.za/ccms/articles/aids.htm)

Pernice, R (1996). **Methodological issues in unemployment research: Quantitative and/or qualitative approaches?** Journal of Occupational and Organisational Psychology, vol.69.

_____. (2001). **Qualitative Research Measures,** chapter 13. (www.polyglot.Iss.wisc.edu/socwork/SW650/Lecture 10.ppt)

Rasool, S (2000). **Violence against women survey: summary of main findings,** Nedbank ISS Crime Index, vol.4 2000, no.4, July-August. (www.iss.co.za)

Roberts, M (1995). **The Impact of HIV/AIDS on Business in Africa,** AIDS Analysis Africa (Southern Africa Edition), 6(1) June/July 1995, p6-10.

____, SAPA (2001). **AIDS in SA could hit six million in 10 years.** The Star, August 16, 2001. (www.iol.co.za/index.php?)

Sehgal, J.M. (1999). **The labour implications of HIV/AIDS,** International Labour Office, Geneva, November 1999, p1-9. (www.ilo.org/public/english/protection/trav/aids/labour_impl.htm)

SHRM (Society for Human Resource Management) (2001). **HIV/AIDS: A Guide for employers and Managers.** (www.shrm.org/diversity/aidsguide/default.asp?page=employers.htm)

Smith, A (2000). **HIV/AIDS in KwaZulu-Natal and South Africa,** AIDS Analysis Africa (Southern Africa Edition), 11(1) June/July 2000, p6-9.

UNAIDS (1998). **HIV/AIDS and the workplace,** July 1998, p2-8. (www.unaids.org)

Whiteside, A and Barnett, T (1996). **Integrating HIV/AIDS into Sectoral Planning,** AIDS Brief, USAID.

Wilkins, N (1995). **The Response of South African Companies to HIV/AIDS,** AIDS Analysis Africa (Southern Africa Edition), 6(3) Oct/Nov 1995, p10-11.

(www.fsacontact.co.za). (2000). **Few South African Companies geared for AIDS Epidemic,** Ballad and King Communications, p1-2.

(www.fortunecity.com/skyscraper/straylight/582/22/21.htm) . **Does Islam promote Polygamy?**

(www.iafrica.com/love and sex/ news/854473.htm) . **Americans rated the top bonkers,** 28 November 2001.

(www.valt.helsinki.fi/hyperse/8number.htm) .**The number of sex partners.**

Appendix 1: Interview Schedule

DATES OF INTERVIEWS	FIRMS
2 JULY	DR F. MANSOOR
11 JULY	A
12 JULY	B
12 JULY	C
25 JULY	D
25 JULY	E
7 AUGUST	F
4 SEPTEMBER	G
6 SEPTEMBER	H