Management responses to HIV/AIDS in South African workplaces

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Abstract

There are concerns that HIV/AIDS will impact on South African workplaces. This article reports on some of the findings of a baseline national cross-sectional study of 383 companies, each with more than 50 employees. Issues of HIV/AIDS policies, responsibility for workplace programmes, perceived and measured impact of HIV/AIDS and the response of companies are reported. Findings from this survey are compared with results from four other surveys viewing HIV/AIDS and companies. In line with other surveys, the findings indicate limited responses on the part of workplaces. Unreliability of perceptions and lack of impact measurement are highlighted. We argue that this lack of measurement reflects widespread strategic failure on the part of South African management. This failure is resulting in a *de facto* shift of workplace responsibility for the burden of the disease onto individuals, communities and society.

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1 Background

Private sector companies, notably insurance groups, appear to have been most active in assessing the effects of HIV/AIDS in the workplace. A key focus of this research has been on minimising direct labour costs, rather than comprehensively addressing the impact AIDS will have on the company and its employees. This is despite the acknowledgement that managing affected employees results in enormous stress for managers (Blake & Owen, 1992). The economic impact that is borne by individuals, households and communities as a result of an employed individual being infected or affected by HIV/AIDS is generally not considered. There is evidence that the burden of the epidemic is taken up by individuals, their households and their communities as opposed to being shared between individuals, government and the private sector (Rosen & Simon, 2002).

The workforce is an important target group for HIV prevention activities. Economically active persons, as a sector of the population, can be viewed as being at increased risk of contracting HIV due to their disposable income and ability to afford multiple sexual partners. As Johnson and Budlender (2002: ii) note, 'The individual's socio-economic status determines their ability to attract sexual partners (particularly in the case of men)'. At the same time wage earners may be supporting numerous people within their families, households or communities. Their sudden exit from the formal economy, including their loss of employment benefits, has a ripple effect beyond the individual (Booysen, 2002, 2003; Goudge & Govender, 2000; Rosen & Simon, 2002; Pharaoh & Schonteich, 2003).

Steinberg *et al.* (2002), in reviewing how households cope with the impact of the HIV/

AIDS epidemic, report a number of alarming findings. Almost two-thirds of households experienced a drop in income as a result of having to cope with HIV/AIDS and almost half of households reported having insufficient food at times. About 55 per cent of households had paid for a funeral in the preceding year and had spent, on average, about four times the total household monthly income on a funeral, an average of R5,153.

Households are likely to continue to shoulder the burden of the epidemic in the absence of a clear understanding of the impact of HIV/AIDS and an explicit agreement as to how this burden should be shared between individuals, the government and the state. Bachman and Booysen (2004: 825) note the contribution that free government health care has made in limiting the costs of illness and its economic impact on households. It is evident that the socio-economic impact of HIV/AIDS has fuelled a vicious cycle of poverty and HIV/AIDS (Bachman & Booysen, 2004; Booysen, 2003). The more general question of how costs should be shared between sectors is not new. The debate over payment of reparations following the Truth and Reconciliation Commission provides another example.[3] While government provides social security grants and is increasingly providing treatment for HIV/AIDS through the public health care system,[4] the question remains as to how the private sector should respond to the national crisis that HIV/AIDS presents.

The HIV/AIDS epidemic could undermine the economic growth the country has experienced over the past decade (Booysen *et al.*, 2002: 181). Rosen *et al.* 2004 suggest that for businesses in South Africa the increase in labour costs could be conservatively estimated to be some 1- 6 per cent. Evian *et al.* (2004: 125) argue that absenteeism, illness on the job and labour turnover are having severe effects on labour productivity. They note the escalating costs from HIV/AIDS related health care and benefits from the Old Mutual annual health survey (Old Mutual, 2001) and suggest that it is vital for companies to capture information so as to plan for an affected workforce.

Any response by the private sector needs, if it is to provide a meaningful contribution to a national response, to approach HIV/AIDS from a strategic standpoint. At the very least, this will involve reliable assessments of the impact of HIV/AIDS in the workplace, putting 'best practice' responses in place that respond to HIV/AIDS in the most effective manner and not simply shift the cost onto employees or other sectors of society. Naidu (2003) notes the implications of HIV/AIDS for strategic market planning and the benefits of a company anticipating and creating change rather than reacting to it.

Corporate strategic planning is conventionally understood as the means by which business responds to potential threats and opportunities. Chaffee (1985: 89) argues that one area of agreement on what strategy is, 'concerns the inseparability of organisation and environment' and that 'the organisation uses strategy to deal with changing environment.' Analytical tools have been developed for managers to evaluate their environment and plan strategically. As Mintzberg (1998: 24) *et al.* explain, "Professors, consultants, and planners world wide have filled untold numbers of blackboards and flipcharts with [the] famous notion of SWOT – the assessment of Strengths and Weaknesses of the organisation in the light of the Opportunities and Threats in the environment. Another analytical tool – scenarios – 'aim to stretch thinking about the future and widen the range of alternatives considered' (Porter, 1985: 48).

As so much has been articulated regarding HIV/AIDS as a threat and risk to companies' success and sustainability, we were interested in the kinds of strategic management activities that companies had undertaken. We believed that impact assessments and modeling would indicate financial forecasting that companies would conduct to review their risk; an issue that we return to in the conclusion.

Until recently, there has been limited data concerning HIV/AIDS and the workplace in South Africa. However, in the last few years a number of surveys have attempted to fill this gap, providing a clearer picture of how the private sector is responding to HIV/AIDS. Table 1 summarises the key features of these surveys, including the Centre for Health Policy survey that forms the basis of this article.

Table 1
Summary of recent surveys of company responses to HIV/AIDS

	Save The Children	SABCOHA[5]	UNRISD/ UNAIDS[6]	SABCOHA	Centre for Health Policy
Date of survey (estimate)	2001	Early 2002	Late2002/ early2003	Late 2003 (published 2004)	Late 2002
Size (number of companies and employees)	95 Not specified	110 516,000	28 547,000	1006 192, 000	383 221,000
Average company size	'large'	4,600	19,500	190	580
Population (all South African)	Large companies (convenience sample)	Cross-sector, segmented by size.	Largest 50 companies	Selected sectors, by size (convenience sample)	Cross-sector, over 50 employees. (random sample)
Response rate (from selected sample)	Not specified	Not specified	56%	33%	89%
Date collection	Interview	Telephonic interview	Self-completed questionnaire	Self- completed questionnaire	Telephonic interview

These surveys have a range of strengths and weaknesses in providing an accurate picture of the response of companies to HIV/AIDS. Both the Save the Children (STC) and UNRISD/ UNAIDS surveys focused on larger companies. While the UNRISD/UNAIDS survey collected extensive information on responses, this was largely tangential to the STC survey, which was focused on the role of the corporate sector regarding children. The two SABCOHA surveys provide larger and more diverse samples although response rates are either not reported or are low – with the potential for bias if non-responders share particular characteristics. Self-completed surveys are likely to be less accurately completed than interviews (where responses can be clarified), especially among smaller firms with more limited capacity. The Centre for Health Policy (CHP) survey reported on in this article adds much value to these surveys. Its particular methodological strengths are its relatively large size which was randomly selected across all economic sectors, interview collection of data and the high response rate which provides findings with greater credibility. Additionally, attention has been given to the statistical analysis, including weighting of results to ensure that sectors have not been over/under represented in the final results – something that is not apparent in other surveys.

While the scope of questions asked in these surveys obviously varies, all five covered – to different degrees – a number of core areas, including company policies on HIV/AIDS, the involvement of stakeholders in HIV/AIDS policies and programmes, how HIV/AIDS is understood to be impacting on companies, research on the impact of HIV/AIDS, and the response of companies to HIV/AIDS. This article reports on some of the key findings of the CHP survey and compares these to the findings of the other surveys.

In addition to reporting data, all the surveys have attempted to move beyond simply collecting data on the corporate response to HIV/AIDS to developing particular understandings of the information collected.[7] While diverse in design, it is useful to attempt to compare results.[8] A key focus of this article, when interpreting as well as reporting the data, is the haphazard manner in which the private sector is passing on the burden of responsibility for HIV/AIDS onto individuals, households and communities.

2 Methodology

This article is based on some of the results of a national cross-sectional study conducted in 2002.[9] Ethical approval was obtained from the University of the Witwatersrand committee for research in human subjects. A stratified random sample of 428 companies with over 50 employees was selected from a list of South African companies provided by the Bureau for Economic Research. The sample was stratified by economic sector and province to ensure national representivity. Sectors represented were the manufacturing, mining, trade, transport, finance, automotive, hospitals, agriculture, construction, and hotels and hospitality.

Initial contact was made to establish the manager responsible for HIV/AIDS and an appointment was made with him or her to conduct the interview at a convenient time. Interviews lasted between 30 and 40 minutes, allowing time for questions to be clarified by respondents. Verbal consent was obtained for the interviews. Descriptive and analytical tests were conducted, namely frequency analysis and chi-squared measures. Data was analysed using SPSS and was weighted to compensate for different response rates between sectors.[10]

Telephonic interviews were successfully conducted with 383 managers, a response rate of 89 per cent. In parallel, trade union representatives were surveyed in the same companies and a total of 325 unionists were interviewed, with a response rate of 77 per cent. This article reports on the responses from management.[11]

3 Management responses to HIV/AIDS

This section reviews data collected by the CHP survey and, where relevant, compares this to similar data collected by other surveys. The areas looked at are company policies on HIV/AIDS, responsibility within companies for HIV/AIDS, perceptions and measurement of the impact of HIV/AIDS on companies, and the response of companies, including the provision of treatment.

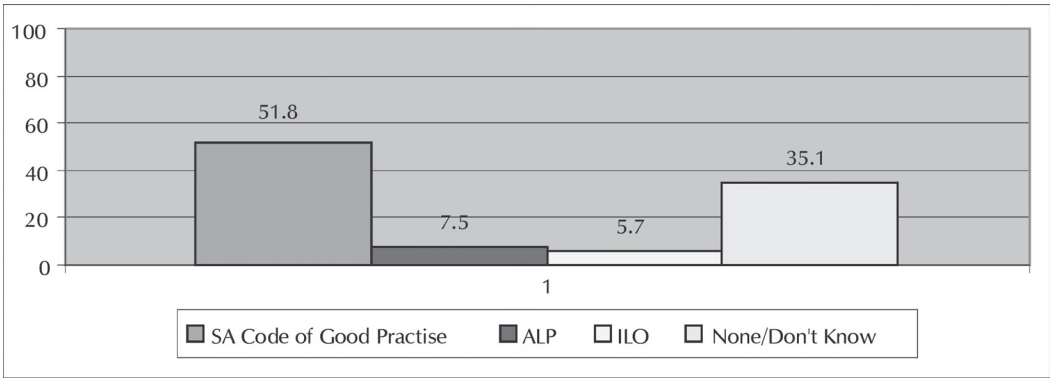
3.1 Company policies on HIV/AIDS

Some 58 per cent of workplaces reported having a workplace policy. The existence of a workplace HIV policy was more frequent in larger workplaces, with 83 per cent of workplaces with more than 1 000 employees having HIV policies, compared to 29 per cent of workplaces with 100 or less employees keeping such policies. Fifty-seven per cent of workplaces with 100 – 499 employees and 75 per cent of workplaces with between 500 and 1 000 employees had policies respectively. This is similar to the total of 53 per cent reported by the Sabcoha 2002 survey. By contrast, the UNRISD/UNAIDS survey of large companies reports that 92 per cent of South Africa's largest companies have polices, while the Sabcoha 2003 survey reports only 26 per cent – reflecting the high proportion of small companies in the survey. The role of company size and the likelihood of having a policy is also supported by the Sabcoha 2002 survey which found that 82 per cent of companies with over 500 employees, but only 6.5 per cent of companies with fewer than 100 employees, had a policy.

However, having an HIV/AIDS policy is in itself not a sufficient indicator that a workplace response is underway. Information on what policies are based on, on who was involved in developing them and how has it been communicated to employees helps us understand the extent to which a policy is a 'real' document rather than merely a 'piece of paper.'

In trying to understand the character of their policies, we asked the 228 companies who had HIV/AIDS policies on which frameworks or codes these were based, in an attempt to review the quality of these policies. Two hundred and twelve companies responded and the choice of framework is reported in Figure 1.

Figure 1
Framework for HIV/AIDS policy



Some 51.8 per cent of companies had based their policies on the South African Code of Good Practice, which can be regarded as representing a 'best practice' basis for company policies on HIV/AIDS. However, almost an equivalent amount, some 35.1 per cent, said they didn't know if their policies were based on guidelines or that their policy was based on no framework. HIV/AIDS workplace policies in these companies are potentially a matter of concern. The basis for company policies on HIV/AIDS is not reported in the other surveys.

HIV/AIDS policies are likely to be effective only if employees are involved in their development. This assists 'buy-in' and dissemination of the policy's content (Parashar, 2004). Encouragingly, 87 per cent or 189 of the workplaces with HIV/AIDS policies reported some form of employee involvement in policy development.The nature of this involvement is shown in Table 2.

Table 2
Employee involvement in policy development

Nature of employee involvement in policy development	**n**	**%**
Unions involved only	53	28.0
Workplace committees only	33	17.5
Attend workshops only	32	16.9
Combination of the above	71	37.6
TOTAL	**189**	**100.0**

Nevertheless, while generally encouraging, it should be noted that the involvement of employees tends to be 'one dimensional' with relatively few companies using multiple ways of involving employees in policy development. Participation of employees in policy development is not recorded in the other surveys. However, the Sabcoha 2002 survey did ask 'Who directs your organisation's HIV/AIDS strategy and policy.' The only response possibly involving workers – 'HIV/AIDS Committee' was given by 16 companies out of 101 respondents to this question.

Policies are likely to be more effective the more they are distributed among those whom they affect. We therefore asked companies whether their HIV/AIDS policy was distributed to employees. The dissemination of the policies throughout was not very thorough, with only 9 per cent of companies reporting that employees had received a copy of the policy. The other surveys did not report on the distribution of the

policy. However, the Sabcoha 2003 study asked whether HIV/AIDS policies had been communicated to employees in some way. The response that only 42 per cent had done so supports our finding of limited dissemination.

3.2 Responsibility for workplace response

Concern has been expressed that unless an HIV/AIDS response (additional to a workplace policy) is led and championed by senior management within a company, it will not be taken seriously (Stevens, 2001). HIV/AIDS is usually the domain of the companies' human resources department, which has limited influence, decision-making power and financial responsibilities. Ideally, there should be shared responsibility for HIV/AIDS programmes in the workplace, which includes the involvement of corporate/executive management, human resources and employee representatives.

As a result we were interested in understanding where responsibility for HIV/AIDS rests in companies. We found that the largest category of responsibility was that of human resources, viz. some 25 per cent. Executive management had primary responsibility in nearly 17.5 per cent of companies. Where executives were responsible, it was usually in smaller companies where separate human resource departments may not have existed. In very few companies the responsibility was carried by workplace committees (3.6 per cent), a forum of employers and worker representatives.

Of the 383 workplaces in the sample, 150 indicated that more than one level of management was responsible for HIV/AIDS. In combination with other categories of employees, some 47 per cent of executives and 30 per cent of workers took responsibility for HIV/AIDS in their companies.

These findings are broadly in line with responses to the question 'Who directs your organisation's HIV/AIDS strategy and policy' in the first Sabcoha survey. In addition to the previously mentioned 15.8 per cent where HIV/AIDS committees were responsible, 34.7 per cent of companies reported HR management being responsible, 13.9 per cent occupational health practitioners, 11.9 per cent the MD or CEO, 5.9 per cent the board of directors and 17.8 per cent other.

3.3 Perceptions and measurement

In understanding the possible impact of HIV/AIDS on South African workers, the perception of managers and measurements conducted are clearly important. We therefore asked managers about both their perceptions and what measurements had been taken.

3.3.1 Perceived impact

Management representatives were asked how they understood HIV/AIDS to be affecting their companies. Their response revealed only limited experience of the epidemic at the workplace, with almost 50 per cent saying that there was no impact and some 13 per cent responding that they did not know what the impact was (see Table 3).

Table 3
Reported impact of HIV/AIDS

None	49.4%
Staff absent	19.7%
Staff pass away	17.8%
Staff take early retirement	6.4%
Don't know	13.1%

Note: some respondents gave more than one answer

However, when managers were asked separately whether they knew of persons in their workplaces who were infected or affected by HIV/AIDS, almost a third (33.2 per cent) knew of someone in that company that was HIV+, while an additional 28.7 per cent knew someone who had died or had left due to AIDS in the past two years.

Further analysis was conducted to establish the relationships between those respondents who knew of an HIV-positive employee; an employee who had died of AIDS or who had left the company due to AIDS; and reported perceptions of the impact of HIV/AIDS (as shown in Table 4).

Table 4
Percentage of companies reported being affected in relation to experience of HIV/AIDS

	Company reported affected (%) (Table 2)	Company reported not affected (%) (Table 2)
Knew someone currently HIV positive in your company	72.1	27.9
Did not know someone currently	39.0	61.0
Colleagues died or left company due to AIDS in past two years	82.7	17.6
No colleagues died or left due to AIDS in past two years	38.1	61.9

In doing a Chi-squared test with the P value <0.0001 the following was found. Of those managers who knew someone who was currently HIV positive in their company, 72 per cent said that their company had been affected as opposed to 28 per cent who said it had not been affected. Similarly, of those managers who said that they had an employee die or leave the company because of HIV/AIDS, 82.7 per cent said that their company had been affected, while 17.6 per cent said they had not been affected.

This data suggest that management is more likely to perceive an impact of HIV/AIDS when death or disability from the disease has occurred, rather than the mere knowledge of HIV-positive workers – whose productivity may not yet be affected. Perhaps of more interest is that while almost half of the sample said there was no impact yet on their company (Table 4), 27.9 per cent of this group knew of one or more employees that were HIV positive and 17.6 per cent had had a colleague die or leave the company because of HIV/AIDS within the last two years. This could be explained by some company managers not wanting to confront the risk posed by HIV/AIDS, by a failure to fully appreciate employees as a critical resource, or by an attitude that saw the observed impact to date as not significant. Evidently there is sometimes a tacit knowledge, through personal experience, that HIV/AIDS is affecting companies, but an understanding of the impact on workplaces – given the long incubation period of HIV – is lacking.

3.3.2 Measuring impact

Given the unreliability of perceptions, we were interested in how companies were attempting to measure the impact of HIV/AIDS in more systematic ways (see Table 5).

Table 5
Measuring the impact of HIV/AIDS by companies

	N	%
Impact assessment on employee benefits	137	35.7
Impact assessment of HIV/AIDS	66	17.2
HIV prevalence surveys of staff	41	10.7
Estimation of HIV-related costs to company	33	8.6

In fact, less than 20 per cent (17.2 per cent) of companies had determined HIV/AIDS in terms of an impact assessment, and less than 10 per cent (8.6 per cent) estimated bottom-line costs in relation to HIV/AIDS and their company. Some 10.7 per cent had done prevalence surveys or modelling studies, with just over a quarter of this taking place in the mining sector. Few knew which model was used for these calculations, four workplaces mentioned the Actuarial Association of South Africa Model (ASSA) and three the Doyle Metropolitan model (DMAL). The most prevalent impact assessment was the evaluation of employee benefits, with some thirty-five percent having completed impact assessments.

3.3.3 Monitoring absenteeism

Much has been said and written about companies experiencing absenteeism in relation to HIV/AIDS (Barnett & Whiteside, 2002: 242; Sanne, 2003; Simon *et al.,* 2000). As a result, we were keen to understand how this was being measured and understood, not least because an accurate measurement of absenteeism will assist managers in assessing the actual and likely impact of HIV/AIDS on their companies. Some 75 per cent of companies said that they record absenteeism, yet many of these companies could not provide an overall absenteeism rate. This may reflect underutilisation of this information. However, when asked why companies record absenteeism the common reasons given were for individual surveillance, i.e. to identify leave abusers and for monitoring payroll systems, as opposed to what we would refer to as 'company surveillance' to measure performance (see Table 6).

Table 6
Reasons reported for recording absenteeism

Reasons reported for recording absenteeism n=287		
Reason given	**N**	**%**
Payroll implications	179	46.7
Identify leave abusers	148	38.6
Performance indicator	125	32.6
Identify sickness patterns	111	28.9
Identify HIV/AIDS employees	15	3.9

Identifying sickness patterns and using them to determine strategic indicators were of less consequence. These practices suggest that management is not using absenteeism rates strategically and that there is insufficient data on absenteeism to support informed discussion on the impact of HIV/AIDS on the economy.

The questionable reliability of managerial perceptions of the impact of HIV/AIDS suggested here is supported by evidence from other surveys. Both of the Sabcoha surveys indicate that managerial perceptions of impact are correlated to company size – something that should not systematically influence the impact of HIV/AIDS on companies. For example, the first Sabcoha survey found that while only 26 per cent of companies with more than 500 employees felt that HIV/AIDS would have little or no impact on the organisation, 55 per cent of companies with less than 100 employees had the same opinion.

This unreliability of managerial perspectives emphasises the importance of measurement. The relatively low levels of assessment found in this survey are in line with that found in other surveys. The Save the Children study reported 24 per cent of companies having conducted a risk assessment, while the later UNAIDS/ UNRISD survey of large companies found that 35 per cent had conducted sero-prevalence surveys, 65 per cent actuarial estimations of prevalence and 58 per cent cost impact studies; 27 per cent had conducted none of these three assessments. While the first Sabcoha study found that only 27 per cent of companies in the survey had conducted some form of risk assessment, among large companies (greater than 500 employees) this was 52 per cent, with only 7 per cent of other companies having assessed the risk of HIV/AIDS in some way. This link between measurement and size of company is again found in the second Sabcoha study.

Only the second Sabcoha study deals specifically with the critical issue of absenteeism. However, the inability of companies to monitor this information for the purpose of assessing the impact of HIV/AIDS is not addressed since the survey asks for the managerial understanding of how HIV/AIDS has affected absenteeism, rather than actual measurement. To the degree that these perceptions can be relied upon, absenteeism and lower labour productivity (a notoriously difficult concept to measure) are rated as the most important HIV/AIDS related cost, with 39 per cent of companies in the survey reporting some impact.

3.4 Prevention activities

Some 73.7 per cent of companies had engaged in prevention activities (see Table 7). Handing out informational material (92.8 per cent), putting up posters about HIV (88.6 per cent),

and arranging outside speakers were very common. These activities are directed at the company level, are relatively cheap and easy to do, but are of limited efficacy. However, activities that are known to be effective prevention activities, such as training employees to serve as peer counsellors (Dickinson, 2003) or educators or providing for treatment of STDs (Williams *et al.*, 2000; Johnson & Budlender, 2000) were not as common (45 per cent and 49 per cent respectively).

Table 7
HIV/AIDS activities undertaken by workplaces

HIV/AIDS activities undertaken by workplaces		
	Yes (n)	**% (weighted by sector)***
Prevention activities in the past 12 months	277	73.7
Handed out informational material	262	92.8
Distribution of condoms on company premises	242	89.6
Put up posters about HIV/AIDS	242	88.6
Arranged for outside speakers or performances about HIV/AIDS prevention	233	84.1
Other educational sessions/workshops	220	76.0
Provided voluntary counselling and testing	180	62.7
Provided occupational health facilities e.g. treatment of STIs	132	49.2
Training employees to serve as peer educators or counsellors	137	45.0
Knowledge, attitudes and practices survey	133	44.0
Sponsored HIV/AIDS prevention activities in the community	79	30.1
Undertook other HIV/AIDS activities	41	10.8

*Weighting accounts for differences in percentages where numbers are the same

Importantly, only seven workplaces (1.8 per cent) said that they provided treatment in the form of anti-retrovirals to employees.[12] While we are clearly at the beginning of the mainstream treatment era, the formal employment sector has a potentially important role in the provision of ARV, especially since the benefits to companies from delayed morbidity and mortality amongst employees are likely to be substantial. The introduction of treatment at workplaces similarly requires planning. The provision of treatment needs to be strategic and well managed and could be disastrous if not implemented well with clear medical support (Sanne, 2003).

The data on company responses to HIV/AIDS collected in this survey differ in some respects to that collected in other surveys. Although these responses are not always strictly comparable in terms of the question asked, a summary of some of the key areas is provided in Table 8.

Table 8
Comparative summary of prevention activities

Issue	SABCOHA	UNRISD	SABCOHA	CHP
Awareness & education	66%	100%	41%	93% (Information)
Condom distribution	n/a	69%	n/a	90%
Treatment of STIs	n/a	62%	n/a	49%
Voluntary counselling and testing	50%	58%	18%	63%
Extended to communities	18%	19% yes 38% partially	n/a	30%
Provision of antiretroviral drugs	n/a	77%	6%	1.8%

Some of the differences between surveys are probably explainable through the size of the companies included, as with the provision of education and awareness programmes. However, others – such as the provision of ART – do not appear to be explicable in this way. One explanation for this may lie in the difficulty of survey methodology (especially when conducted without face-to-face or telephonic contact) in accurately measuring the extent of programmes conducted.

4 Conclusion

The response to HIV/AIDS by managers in South African companies is uneven and poor. Only some 58 per cent of companies surveyed reported having an HIV/AIDS policy and some 44 per cent of these did not know what their policies were based on, if anything. Although there appears to be an encouraging amount of involvement of workers in policy development, this appears to be 'one dimensional' and potentially weak. Certainly, it appears that very few companies distribute their policies to employees.

The perceptions of companies as to how HIV/AIDS will affect them appears to vary widely. More importantly, it is clear that the reliability of managerial perceptions in this regard needs to be treated with caution. This emphasises the need for reliable measurement so as to obtain an objective assessment of what HIV/AIDS will mean for companies. However, it is clear that little is happening in this regard. Even some larger companies appear to have undertaken little research in this regard. The inability of companies to utilise absenteeism data as a measure of the impact of HIV/AIDS is particularly telling in this regard.

Finally, the response of companies appears mixed. While most companies are doing something, this does not seem to be based on effectiveness or strategic planning. The limited provision of antiretroviral drugs to employees is instructive, especially as the survey was conducted when no prospect for government roll out remained.

A central point that needs to be emphasised is the lack of information about HIV/AIDS and company operations that management has to base its decisions on.[13] This lack of data is of concern in itself. However, we would argue that it is reflective of a deeper problem reflecting a lack of management strategy over HIV/AIDS that is resulting in the *de facto* shifting of the burden of HIV/AIDS onto individuals, communities and society. There is also an inherent reliance on government to deal with the chronic cycle of poverty in which the HIV/AIDS epidemic is enmeshed.

In reviewing the kind of information collected, it is clear that companies and

management are acting on poor information. HIV/AIDS is a complex environmental phenomenon due to its sexual transmission and inadequate leadership by government. Dickinson (2004) notes that within the management literature on strategy there is a frequent reduction of the 'environment' to economic issues alone. Given the nature of HIV/AIDS, it is therefore not surprising that business leaders have not responded adequately by strategically costing the comprehensive impact of HIV/AIDS on their companies. However, this failure to measure or to anticipate will not exempt companies from the impact of AIDS. Intervention at the workplace, while important, is not enough. There has to be monitoring and evaluation, which would determine the effectiveness and quality of the programmes in place. It appears as if managers are doing something, yet there is a lack of focus, strategy and responsibility.

Given the discussion for new companies listing on the Johannesburg Stock Exchange (JSE) (GRI, 2003) to report on HIV/AIDS, a significant amount of work and attention needs to be given by companies to indicate their competitive advantage in response to their HIV/AIDS risk.

Finally, what these data reveal in an indirect manner is the haphazard manner in which the private sector is passing on the burden of responsibility to individuals, households and society. The companies in this sample are not choosing a comprehensive set of prevention activities, nor are they incorporating HIV/AIDS into their strategic management activities. Few have chosen to provide treatment for their employees. While companies need to be sustainable and profitable, the burden needs to be shared. Rosen and Simon's (2003: 131) suggestion that countries should make explicit decisions about responsibility for HIV/AIDS is important. While, until recently, there has been little leadership from government in this regard, it is clear from the data presented in this article that the private sector has done little by way of strategic planning, let alone putting forward a clear proposal of what part of the HIV/AIDS burden it is in a position to shoulder.

Endnotes

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[3] Staff reporter. 'Apartheid claims mount'. *M ail and Guardian.* 21 February 2003, Truth and Reconciliation Commission. 1998. 'Institutional Hearing: Business and Labour.' Truth and Reconciliation Commission of South Africa Report: Volume Four. CTP Books. Cape Town. Chapter 2.

[4] See Treatment Action Campaign Website for detailed information www.tac.org.za

[5] South African Business Coalition on HIV/AIDS (SABCOHA)

[6] United Nations Research Institute for Social Development (UNRISD) United Nations HIV/AIDS Agency (UNAIDS)

[7] Simplifying, the Save the Children survey looked at children; the first SABCOHA survey on the limited response of companies and the second on the fact that companies were reporting an impact on their operations; the UNRISD/UNAIDS survey, as developed by Dickinson and Innes (2004), posed questions concerning the potential gap between the policies and practices of large companies, while the global report into which the South African data was incorporated stressed the extent to which large corporations were 'waking up to risk' (Bendell 2003).

[8] Booysen (2003) notes some key challenges in reviewing and comparing studies.

[9] For more information on this research project see http://www.wits.ac.za/chp/

[10] The analysis investigated trends in the different provinces and sectors. However, nothing proved statistically significant.

[11] For an analysis of the response of the trade unionists see Mapolisa and Stevens (2003).

[12] This was widely distributed between sectors – manufacturing 3, mines 1, trade 1 and transport 2

[13] To this we can also add the lack of reliable information that has been collected across all companies. The surveys that have been reported in this article are not easily comparable, making it all but impossible to draw conclusions as to possible changes over time.

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