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**SOCIAL CAPITAL, STIGMA AND HIV/AIDS IN THE  
WORKPLACE: A CASE STUDY OF THE GAUTENG  
DEPARTMENT OF HEALTH (GDOH)**

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## **Introduction**

As the world enters the third decade of the AIDS epidemic, it has spread with great speed. The epidemic has claimed more than three million lives in 2003, and an estimated five million people acquired HIV, bringing to 40 million the number of people globally living with the virus (United Nations Joint Programme on AIDS (UNAIDS, 2003). According to UNAIDS and the World Health Organization (WHO) report (2002:16), the annual number of new infections has remained steady, but it hides dynamic trends in the economy and population.

In some countries, the epidemic is still spreading in both scope and severity. Others face a growing danger of explosive growth. Nowhere has the impact of HIV/AIDS been more severe than sub-Saharan Africa. The region is now home to 28.2 million people (adults and children) living with HIV/AIDS. Approximately 3.4 million new infections occurred in 2003, while the epidemic claimed an estimated 2.4 million lives in the past year. There are ten million infected young people (aged 15-24) and almost three million children under 15 years of age (UNAIDS, 2002).

In South Africa, HIV prevalence among pregnant women under 20 years of age attending antenatal clinics (ANC) reached 24.8% in 2001, on par with the 24.5% level in 2000 (Department of Health). Extrapolating from the survey, Grant et al (2002:13) estimate that 4.74 million adults were infected with HIV – of which 2.65 million are women between the ages 15 to 49, and 2.09 million are men in the same age group. In 2002 the prevalence rate was at 26.5% viewed showing any significance difference when compared to the 2001 prevalence rate (Department of Health: 2002).

Contrary to the Department of Health study in 2002, the Human Sciences Research Council (HSRC) conducted the first household survey in South Africa on HIV prevalence, behavioural risks and mass media. The study provided the first comprehensive national data on prevalence in the general population.

The study estimated an overall HIV national prevalence in the population at 11.4%, with a rate of 15.2% in the 15-49 age groups. The highest prevalence was found in the 25-29 age groups, followed by 30-34. Urban populations had higher rates of infection than rural (Shisana & Simbayi, 2002). The HSRC study has examined a representative cross-section of South African society but uses a relatively small sample. The study had a low response rate, but it gives an idea of HIV prevalence levels amongst groups not taken into account by the ANC such as the children and elderly.

The Department of Health and the HSRC study produce different estimates of HIV prevalence. The DOH study shows a higher prevalence rate because it looks at the sexually active population. This does not mean that the rate will be as high amongst younger or older sections of society, or amongst men. The HSRC study looks at the whole population, but because it includes young and old people (who are less at risk of infection), the overall prevalence rate is consequently lower.

The Department of Health study took data from antenatal clinics, and as a result draws conclusions about HIV prevalence amongst sexually active women, which cannot be applied to other groups in the population, such as the elderly or children. The estimates, however, do provide a good indication of prevalence rates amongst sexually active members of the population than viewed alone (Fredriksson & Berry, 2003).

### **Problem Statement**

Given the statistics stated by the ANC and HSRC study, it becomes understandable that HIV/AIDS is mostly concentrated amongst young adults as also reported by the International Organisation of Employers (IOE) and UNAIDS (2002:08) that,

‘according to significant research focused on the AIDS pandemic ..., the virus generally targets the working-age population. Affecting people in their most productive years of life, it leads to reduced earnings, as well as increased care demands, higher expenditure on health care and premature death’.

Steinberg et al, 2000 also points that, HIV is a disease that mostly affects younger people with around half of all adults who acquire HIV becoming infected before turning 25 years. Young people typically die of AIDS before their 35<sup>th</sup> birthday. In high prevalence countries it is estimated that, by 2020 the labour force will be between 10 and 30 percent smaller than it would have been without AIDS (Smith, 2001).

In due course HIV/AIDS deaths will be the number one killer, threatening political, social, and economic security in the public or private sector of South Africa. Walker and Gilbert (2001:76) were of the opinion that by 2003 the HIV prevalence rate in South Africa will be 12% among highly skilled workers, 20% among skilled workers and 27.2% among low skilled workers, thereby robbing the country of critically needed resources with irreplaceable skills and experience. The human resource is at greater risk in the present scenario of HIV/AIDS pandemic.

Even though there is a risk in human resources, Whiteside & Sunter (2000:103) states that the cost of the disease will depend on the type of company, the skill levels and replaceability of employees, the sector it operates in and the benefits it provide. For instance, both authors' mentions that in Zimbabwe a bus company documented that HIV and related absenteeism together contributed 89% to overall AIDS costs. Absenteeism for reasons of ill health, care for sick relatives or funeral attendance, rather than employee deaths, appear to be the most significant AIDS related cost to the workplace overall.

Vass (2003:02) using the ING Barings model has also indicated that depending on the type of sector rate and impact of HIV/AIDS differ. Sectors such as mining, general government transport and storage, agriculture, construction and accommodation, and catering appear to be high risk as opposed to metals; retail and chemical which are medium and financial, business services and communication are low risk (Vass, 2003). In South Africa studies that have been done in the workplace showed increased costs in illness, health care, retirement, absenteeism and recruitment (Whiteside & Sunter, 2000:102-103), much alluded to as direct, indirect and systematic costs.

However, studies on HIV/AIDS in the workplace are concentrated on the economic impact, using models projecting the cost to the company, without factoring much on issues such as stigma and discrimination which are social to employees. HIV/AIDS affects every fragment of global society, the home, the school, the religious institution, and the workplace.

Parker & Aggleton (2003:13) states that ‘for nearly two decades as countries all over the world have struggled to respond to the HIV/AIDS, epidemic, issues of stigma, discrimination and denial have been poorly understood and often marginalized within ... programmes and responses’. The authors say concern about HIV/AIDS related stigma are damaging such that their effects have been voiced since the-mid 1980s. In addressing the United Nations General Assembly in 1987, Jonathan Mann, the founding director of the United Nations Global Programm on AIDS has been cited (Parker & Aggleton, 2003; Policy Project & Centre for the Study of AIDS in South Africa) as saying HIV/AIDS can be described in three phase;

- The first phase of HIV infection, often unnoticed and silent;
- The second phase of the epidemic, with a range of infectious diseases and the disease becoming more visible; and
- The third phase, potentially the most damaging of all, with an epidemic of social, cultural and political responses to AIDS, including stigma, discrimination and denial.

As HIV/AIDS and stigma continue to be a challenge in society, the paper will try to look at stigma in the workplace. The research will try to look the following questions;

- how HIV/AIDS stigma is manifested in the workplace,
- how stigma and HIV/AIDS affects social capital in the workplace,
- look at peoples experience and issues of HIV/AIDS stigma and the way they are being addressed.

The Policy Project & Centre for the Study of AIDS literature (no date) shows that the HIV/AIDS epidemic has already impacted significantly (nearly 5 million people infected with HIV) on South African society and means at least one out of every nine people

could already have experience some form of discrimination based on their HIV status and have been subjected to stigmatisation, rejection and prejudice.

Over the year's stigma has appeared to be a problem difficult to addresses as it is mixed with diverse and complex issues that make it difficult to grasp in a programmatically useful way (Parker & Aggleton, 2002, Policy Project & Centre for the Study of AIDS, no date). It becomes a complex issue because it is used interchangeable with discrimination and has cultural differences.

Parker & Aggleton (2002:14) say to understand stigma it is important not to dwell much on its complexity and specificity but to look at some settings that will make us better understand them.

In understanding stigma, Goffman's work (1963) is often taken as a point of departure. Goffman (1963:03) defines stigma as an attribute that is deeply discrediting, seen as special kind of relationship between attributes and stereotype. From UNAIDS, 2000 in the Policy Project report stigma has also been defined as an attribute or quality which 'significantly discredits an individual in the eyes of others ... Importantly, stigma is a process. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable'. A person with stigma is believed not to be quite human because the person is seen to possess a spoiled or polluted identity that is considered different or deviant to societal norms, deserving sanctioning (Goffman, 1963:05; Policy Project, no date).

Stigma as socially constructed by individuals or groups in society creates or social inequality and people with HIV/AIDS may ultimately feel left out, have negative attitudes especially in workplaces as it becomes a form of discrimination.

Central to HIV/AIDS, stigma and discrimination, social capital can be seen as an added variable, where existing ties between colleagues maybe destroyed. The idea of social capital is that relationships can serve as a resource for support. Fine (2003:33) says

explaining social capital is through something of people's own making, being 'who you know' and 'not what you know'. Field (2003:40) also showed that proponents of the concept (Bourdieu, Coleman and Putman) in their work lie in its focus on networks and relationships.

Lin (2001:23) who drew the definition from Coleman (1990) sees social capital as an aspect of a social structure facilitating certain actions of individuals within the structure. Social capital is the resources, real or potential, gained from relationships. What seems to arising from the explanation given by Lin (2001) is that social capital is transferable across social relationships or networks and can promote good behaviour and facilitate change. Field (2003:40) states that for Coleman social capital is a means of explaining how people manage to cooperate and perhaps to understand one another.

By looking at social capital, stigma and HIV/AIDS in the workplace, the research will try to try to accumulate knowledge, which will contribute to the sociology work. The sociological perspective is of the understanding that human behaviour is largely shaped by the groups to which people belong and by the interaction that takes place within these groups, be in society or workplaces which involve a way of life, entrenched habits which are hard to change.

### **Literature Review: Understanding the Impact of HIV/AIDS in the Workplace**

HIV/AIDS has emerged as a serious issue in the workplace and a major threat to development. The pandemic has manifested itself by lowering performance, productivity, depleted human capital, and challenged social security in the workplace and society at large.

Found mainly among adults between 20 and 40 year old, HIV has a direct impact on the workforce and the most productive years of a person's life. At the household level and workplace the effects of HIV infection are obvious; the cost of medical care and related areas will increase. The impact of HIV infection will result from the illness and death of

individuals and the consequent effect on the family, community and broader society. Obviously critical to this impact will be who fall ill and dies in terms of their role in the family and community. The death of an adult male, who is an income earner, will affect the family's access to resources. The death of an adult female may result in children receiving less care and females being taken out of school. HIV/AIDS is threatening to reverse a generation of achievements in human development.

While ignoring the problem, the disease will become dangerous and to manage it in the long run will be profound to the employer. Jackson (2002:295) says "how AIDS affects the workplace can be looked at from the employees' and employers' view points". She states that in some areas the needs of the employer and employee overlap, in others they diverge. For example, employees' needs for improved medical care, sick leave benefits, and death-in-service and pension benefits increase while employers faced with escalating costs, need to limit expenditure.

As HIV/AIDS continues to spread throughout the world, the impact of the epidemic in the workplace between employers, employees, and communities is becoming clearer (Jackson, 2002). The prevalence of the disease is threatening productivity and in some cases stability in business, government, communities and other organisations worldwide and more so in South Africa. In some cases, however management, employees, shareholders and other stakeholders are not attentive of, or deny, the actual and potential impact of the disease (ILO,2000; Commission on HIV/AIDS). HIV/AIDS has become a pressing problem characterised by economic and social impact that needs to be addressed.

### **Economic Impact**

The economic impact of HIV/AIDS has been looked at in terms of the direct, indirect, and systematic costs (Barnett & Whiteside, 2002, Whiteside & Sunter, 2000). Whiteside and Sunter (2001:109) identified those reverse as three types of costs that exist and will create problems in the workforce, being: 'direct costs' which refer to impacts that involve

increased financial outlays by the company. 'Indirect costs' which reflect reduced workforce productivity (less output for a given level of expenditure on labour). These include reduced productivity by both the infected employee and by other employees who are diverted from their normal responsibilities. And finally, 'systematic costs' refer to costs that result from the cumulative impact of multiple HIV/AIDS cases.

Stevens (2001:06) states that direct costs usually refer to direct bottom line and obviously measurable costs of, for example, benefits package, training and recruitment. In this instance, the employer will have increased need of benefit package as employees will need to take care of themselves, family, relatives and friends, more money to recruit and train new staff, when they are sick or there is a sick person to look after at home. Where employees may be infected, the impact or burden will be experienced in many areas of direct, indirect and systematic cost discussed below.

### **Direct costs**

- **Benefits package** – Employers and employees will feel the impact as the cost of employee benefits increases. Costs in medical aid, health insurance, disability insurance, death benefit and life insurance, funeral expenses, subsidised loans will be used more. Employers will run into more direct costs of running health clinics for sick employees.
- **Demands for services** - Demands for services particularly health and welfare services, is likely to increase dramatically. This will have major implications for departments that provide these services and even more so if they already face capacity constraints or are short staffed.
- **Recruitment** – Employers have to incur costs of getting new people to replace those who are very sick or have died. Posts have to be advertised and interview those to be on board.
- **Training** – Employers also have to carry costs of pre-employment education, in-service and on the job training costs.
- **HIV/AIDS programmes** - Direct costs of prevention programmes (materials, staff, etc.) will be needed, and time for employees to spend in prevention programmes.

Furthermore, there will be a need for studies, surveys, and other planning activities in the workplace vital for informing employers, whether they are winning or not in order to intensify their interventions.

Indirect costs refer to costs that are not as obvious and which can be difficult to calculate; they refer to absenteeism, morbidity on the job and industrial action (Barnett and Whiteside, 2002:253). In this case, employers are experiencing reduced productivity and faced with the risk of; increased absenteeism (for ill health, looking after relatives, attending funerals), increased deaths among workforce at all levels, including managers and employees, morbidity due to reduced performance, sickness and efforts by the employer/management to control the situation.

#### **Indirect costs**

- **Morbidity and absenteeism** – As infected employees become ill they will take additional sick leave. This will disrupt the operation of the institution for which they work. The disruption will be amplified when the more qualified and experienced employees are absent. Increases in deaths will lead to increased absenteeism, as employees attend funerals for family members, friends and colleagues. Women employees, due to their socially defined roles as caregivers, will have to care for sick children and partners, which may involve time off from work. Reduced performance in the job will also become evident as sickness progresses due to HIV/AIDS.
- **Mortality or retirement** – The impact of the death or retirement of infected employees is similar to morbidity, although the problems are permanent. The loss of an employee requires an appropriate replacement to be appointed and trained. For highly trained staff this is often difficult, particularly in developing economies with skills shortages. Training and recruitment are costly and disrupt operations. Due to training and recruitment of old and new staff the employer encounter direct costs as the two are expensive in terms of advertising and interviewing and loss of profit that could have been made in a vacant post.
- **Management resources** - Managers' time and effort for responding to workforce impacts, planning prevention and care programmes, will be more and diverting focus

from more direct things. Legal and human resource staff time for HIV-related policy development and problem solving will be needed and will become more demanding.

Another cost is systematic, which is said to result from cumulative impact of multiple HIV/AIDS cases. Individual employees face potential difficulties at work if they have HIV and colleagues will face difficulties of loss. Such difficulties include counselling or support loss of confidentiality, discrimination, including possible non-recruitment by the employees and employer (Barnett and Whiteside, 2002:253).

### **Systematic costs**

- **Staff morale** – The epidemic has a negative impact on the morale in the workplace. There is a fear of infection and death, which may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are off sick, away from work or newly recruited and not yet fully functional. Staff morale will be reduced if they work with fear and suspicion causing a disruption in their work schedule and teamwork. Subsequent to that there will be a reduction in average level of skill, performance, institutional memory, and experience of workforce.
- **Workplace performance and experience** – On the overall employers will loss skilled employees.

**Figure 1. Economic Impact on workforce of HIV/AIDS**

<b>Direct costs</b>	<b>Indirect costs</b>	<b>Systematic costs</b>
<p><b>Benefit package</b></p> <ul style="list-style-type: none"> <li>• Company run health clinics</li> <li>• Medical aid/health insurance</li> <li>• Disability insurance</li> <li>• Death benefit/life insurance payout</li> <li>• Funeral expenses</li> <li>• Subsidised loans</li> </ul> <p><b>Recruitment</b></p> <ul style="list-style-type: none"> <li>• Recruiting expenses (advertising, interviewing, etc)</li> <li>• Costs of having positions vacant (profit the employee would have produced)</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>• Pre-employment education and training costs</li> <li>• In-service and on-to-job training costs</li> <li>• Salary while new employee comes to up speed</li> </ul> <p><b>HIV/AIDS</b></p> <ul style="list-style-type: none"> <li>• Direct costs of prevention programmes (materials, staff, etc.)</li> <li>• Time employees spend in prevention programmes</li> <li>• Studies, surveys, and other planning activities</li> </ul>	<p><b>Absenteeism</b></p> <ul style="list-style-type: none"> <li>• Sick leave</li> <li>• Other leaves taken by sick employees</li> <li>• Bereavement and funeral leave</li> <li>• Leave to care for dependants with AIDS</li> </ul> <p><b>Morbidity on the job</b></p> <ul style="list-style-type: none"> <li>• Reduced performance due to HIV/AIDS sickness on the job</li> </ul> <p><b>Management resources</b></p> <ul style="list-style-type: none"> <li>• Managers' time and effort for responding to workforce impacts, planning prevention and care programmes, etc</li> <li>• Legal and human resource staff time for HIV-related policy development and problem solving</li> </ul>	<p><b>Loss of workplace cohesion</b></p> <ul style="list-style-type: none"> <li>• Reduction in morals, motivation, and concentration</li> <li>• Disruption of schedules and work teams or units</li> <li>• Breakdown of workforce discipline (slacking, unauthorised absences, theft, etc.)</li> </ul> <p><b>Workforce performance and experience</b></p> <ul style="list-style-type: none"> <li>• Reduction in average level of skill, performance, institutional memory, and experience of workforce</li> </ul>
<p><b>Direct costs</b></p> <p>▶</p>	<p><b>Indirect costs</b></p> <p>▼</p> <p>Total costs of HIV/AIDS in the workforce</p>	<p><b>Systematic costs</b></p> <p>◀</p>

Source: Whiteside and Sunter, 2001.

All the mentioned costs make total costs to the workplace on HIV/AIDS and have an impact on the composition of the labour force. If left alone the number of people falling ill or dying will continue to rise and create more costs to employers and adding immense problems to other employees, families and community. As mentioned before other than the economic impact, the social impact of HIV/AIDS is manifested in the form of stigma and discrimination ranging from include;

- Emotional or social effects of shame to social isolation,
- Altered family responsibilities, (such as grandparents caring for children, orphans living alone and working),
- Gender specific tied to Women

### **The Social Impact**

- **Emotional or social effects ranging from shame to social isolation**

At individual level, the impact is felt when they have to deal with issues of stigma and discrimination, changing requirements for health care benefits, training of replacement staff, and loss of skills and knowledge among employees. The impact begins as soon as the HIV status of an individual is known and worsens when he or she starts to suffer from HIV related illnesses (ILO, 2000:08; Kinghorn & Steinberg, no date).

When left alone the number of people falling ill or dying will soar in and create more immense problems to other employees, as they will experience death and loss of skills from colleague. Not only will the effects be felt in the workplace, individuals and families are also affected.

Where a person is and is known to be HIV positive, he or she is often the subject of stigmatisation, discrimination, or even hostility in the community and at work, especially where community members and colleagues have little understanding of HIV/AIDS. Sometimes due to ignorance, people living with HIV/AIDS (PLWHA) are often forced to leave their jobs and are isolated from their communities. In such circumstances it is very difficult to provide PLWHA with the necessary assistance and support or to enable them

to work in conditions of freedom, equity, security and human dignity (ILO, 2000:08; Policy Project Report).

- **Altered family responsibilities, (such as grandparents caring for children, orphans living alone and working)**

Family members, including children are often forced to work. As a result, the number of children engaged in income activities in high prevalence countries increases significantly. Those children, in turn, are not able to attend school and do not receive proper care and guidance. The family composition and role distribution change dramatically. There will be pressure on the household often preventing family members from finding decent work, and they often have to migrate, or may be forced into homelessness and living in the streets as they are stigmatised and discriminated against (ILO, 2000:09; Kinghorn & Steinberg, no date).

The role-played by the extended family as a safety net is by far the most effective community response to the AIDS crisis. Affected households in need of food send their children to live with relatives. Relatives are then responsible for meeting their children's food and other requirements.

However, as the member of multi- generational households, which lack a middle generation, increases, the ability of families and social networks to absorb these demands is bound to decline (ILO, 2000:09). In relation to the argument it has also been shown that as the extended families absorb these children, time will come when the full effects of the epidemic become apparent, and reach a point where the extended family cannot cope (Barnett and Whiteside, 2002:187). In the household, people may also be stigmatised if other members have not accepted the others HIV positive status, be isolated and not have access to health care and food.

## **Women**

Again, women are particularly affected and infected by HIV/AIDS. The burden of caring for children orphaned as a result of the pandemic is borne mainly by women. Loss of income from male income earner may force women and children to seek other sources of income, putting them at the risk of sexual exploitation. If a woman living in an agricultural community in which women are responsible for subsistence farming become infected and falls ill, the cultivation of subsistence crops will fall, resulting in an overall reduction in the food available to the household (ILO, 2000:10). Often women are scolded and accused of bringing the disease and husbands sometimes beat and leave them.

## **How to deal with HIV/AIDS in the workplace**

Given the increase and known impact of HIV/AIDS and its effects, it is of outmost importance to protect the workforce, individuals, families and the community at large. Protecting people against HIV/AIDS can only be realised by working together, the public (government), private sector and community can make a contribution.

There are ways in which the response to HIV/AIDS can be compassionate but cost-effective to balance the responsibility to employees, employers and society. The King report on governance for South Africa (2002:12) states that one of the key characteristics of good governance is responsibility pertains to behaviour that allows for corrective action ... and when necessary put in place what it would take to set the company on the right path and be responsible to it stakeholders, be employees and the community at large in an inclusive manner.

Looking at the both economic and social impact to individuals and the workplace, employers are being challenged to address HIV/AIDS in the workplace. In the midst of these problems, there is a chance for employers to give employees productive lives and to be supportive of one another. Workplace interventions are of outmost importance to protect the lives of employees, families and the community at large. For the employer

and the employees to deal with issues of HIV/AIDS, HIV/AIDS prevention programmes that are sensitive to PLWHA, and women need to be developed and implemented.

To curb HIV/AIDS, programmes should be adopted and include an Employees Assistance Programme (EAP). Masi (1990:64) describes EAP as ‘a professional assessment and referral and/or short-term counselling service offered to employees’ alcohol, drug, or mental health problems that maybe affecting the workers’ job. In her description of EAP Masi goes further to state that because AIDS affects people who are in the workforce, whether the person with AIDS is the actual employee or the employee’s loved one, the EAP is the umbrella under which the issue of AIDS in the workplace will fall. Such a service of EAP will help employees to cope with anxiety, fear, and other emotions.

EAP can serve as a resource in developing an AIDS policy in the workplace.

To address issues of HIV/AIDS in the workplace, it is important to put key legal policies and programmes in place. To do this, is to protect the employer (business), employees and the community.

Van Dyk (2001:404) says “although we need laws that will guide us to make the right decisions about people living with HIV/AIDS, we should be guided as we attempt to do the right thing, not so much by various laws (however valuable they may be), but by our own common sense, our own ethical and moral values, our compassion and our basic respect for the human rights and dignity of all people”.

The way in which HIV/AIDS is treated/handled has legal implications. The legislation act directly and indirectly affecting the rights of employers and employees. The South African Constitution (Act No. 108 of 1996) is the supreme law of the country and all other laws must comply with its provisions. The bill of rights in the constitution sets out a number of rights, which protects employees. People living with HIV/AIDS have the same rights and responsibilities as those, which apply to all citizens of the country. A

number of labour legislation has been passed and adopted to protect employees if treated unfairly due to their HIV status.

- The Employment Equity Act (EEA) prohibits discrimination against people on the basis of their HIV status,
- Labour Relations Act deals with good practice on dismissing people for incapacity due to ill health,
- The Occupational Health and Safety Act also deal with HIV/AIDS in the workplace. An employer is indebted to give as far realistic a safe workplace,
- The Medical Schemes Act provides that employees with HIV/AIDS may not be unfairly discriminated against the allocation of employee benefits (Department of Labour).

The passing of the legislation enforced the development of HIV/AIDS policies and programme in the workplace. The workplace policy should deal with, amongst others:

- The risk, if any, of occupational transmission within the particular workplace,
- Appropriate training, awareness, education on the use of universal control measures so as to identify, deal with and reduce the risk of HIV transmission in the workplace, and
- The procedure to be followed in applying for compensation for occupational infection (Van Dyk, 2000).

The International Labour Organisation (ILO) (2001:03) pointed out that, 'HIV/AIDS is a workplace issue, and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, ... has a role to play in the wider struggle to limit the spread and effects of the epidemic'. Because of this, the ILO programme on HIV/AIDS and its Code of Practice on HIV/AIDS in the workplace attempt to build a partnership between employers and employees to fight HIV/AIDS. This is a call to look at strategies or policies that will help protect the workforce. In this instance employees need compassion from the employer.

It is therefore necessary that the workplace becomes one of the many areas where intervention, to combat the spread of HIV/AIDS, are implemented. The workplace constitutes an important target for programmes aimed at increasing awareness and educating people about HIV/AIDS. Here, large numbers of people can be reached, monitored and evaluated rapidly and inexpensively. Even more importantly, support networks can easily be established with the help of trade unions and the intervention of EAP. As workplace interventions will also target working parents, this will mean that health promotion will filter down to the family unit. Thus, intervention programmes can easily be structured thereby cutting costs of the health care system and the employee in general.

Grant et al (2002:75) mention that, a workplace programme should have two core branches:

- Programmes that aim to prevent or reduce new HIV infections; and
- Programmes that provide treatment care and support to employees and their families who are infected or affected by HIV/AIDS.

In support of what the Grant et al (2002) states, the UNAIDS (2002) put forward that, addressing the problem of HIV/AIDS in the workplace there are required set universal standards in the programme. These would include:

- Widely communicated and properly implemented equitable HIV/AIDS policies to counter stigmatization and discrimination;
- Ongoing formal and informal HIV/AIDS preventive education for all staff, particularly through peer education;
- Promotion and distribution of condoms;
- Diagnosis, treatment, and management of sexually transmitted infections, for employees and their sexual partners; and
- HIV/AIDS voluntary counselling and testing.

In view of the above-mentioned cores and set standards, Hyde (2001:10) stated that a suggested first step in a workplace programme is management response. Hyde (2001)

considered this to be ‘... a key element in shaping the level and quality of company interventions’. According to Hyde (2001) a company/organization should take the following steps as the starting point:

- Educating management to make informed decisions.
- Training of shop stewards in order for them to be involved in the process.
- Development an AIDS policy with the help of professionals in the field.
- Setting up a steering committee (or AIDS action group) to drive the programme and to report on progress.
- The process has to be on going and making consultations and interactions as the AIDS programme cannot be a one-off activity.
- Creation of a climate of openness among workers about their HIV status. This would mean fostering destigmatization the disease, developing trust, and respect for those infected. This would entail setting strict rules against breach of confidentiality.

As management has to play a leading role, as Hyde (2001) stated, Grant et al (2002:75) indicated that a comprehensive workplace response should include management strategies to provide direction. At this stage management has to put an AIDS workplace policy. Secondly, a workplace programme is put in place being informed by management. In the programme, awareness and training on HIV/AIDS, and educating employees about the disease has to be done through a prevention programme.

Awareness does not have to be a once off thing, information should continuously be communicated to employees. Internal systems have to be in place, to create a non-discriminatory environment. Care and support of employees has to be there, and they need to be provided with Employees Assistance Programmes (EAP). There must be prevention and treatment of Sexually Transmitted Infections (STI's). Condoms also need to be distributed and their use be promoted. Furthermore, Voluntary Counselling and Testing (VCT) through EAP's is a necessity. If HIV/AIDS is not taken serious, Barnett & Whiteside (2002:315) are of the opinion that it will erode the capacity ... to govern. It

may also change the environment in which manager/employers seek to exercise their authority.

### **Gauteng Provincial Government Workplace Programme**

As the epidemic became widely recognised, the Gauteng Provincial Government (GPG) also saw the major impacts it will have on the government economy. In 1997 the GPG commissioned a study to investigate the potential impact of HIV/AIDS on GPG employees. The study projected that, based on the then profile of GPG employees, the impact of HIV/AIDS will escalate if no intervention occurs. Around 8.5% of employees in 1997 were estimated to be HIV infected, with the figure expected to rise to 20% by 2005. The study concluded that HIV/AIDS will have a major impact in Gauteng and called for the need for a multi-sectoral approach to reduce the impact.

In response to this impact study, the Gauteng Executive Council (GEC) mandated provincial government departments to set up workplace AIDS programmes. In 1998 a policy was drafted and training programmes set up. This mandate was reviewed in 2001 and each department was tasked to develop a policy and plan to ensure that effective workplace programmes were implemented per department.

In 1998 the Inter-Sectoral AIDS Unit was set up to provide support to departments on HIV/AIDS issues, and HIV/AIDS workplace programmes, including policy formulation, programme planning, and training. The Unit provided support also to the private sector and links experience across civil society sectors. The Unit is tasked to meet the challenges of AIDS in Gauteng, by giving advice on HIV/AIDS issues in the workplace in working together with department to formulate and adopt policies on HIV/AIDS.

According to the guidelines drawn the Department of in 1998, the programme has to be focused on awareness, education, condom distribution, universal precautions and STI management as well as wellness management which looks at care and support of employees.

Since 1998, some visible activities taking place are concentration on awareness programmes, training and recruiting officials as coordinators in the workplace.

Since the recognition of the pandemic, there has been a low response against it. There is pressure for information about the *status quo*, government, companies and other organisations are increasingly pressed to disclose their performance and policies on HIV/AIDS management. Information regarding action on HIV/AIDS is inconsistent and incomplete. As a result, it is difficult to compare and benchmark performance on HIV/AIDS and to verify the accuracy of reported information. The absence of reliable information makes it difficult to report, as needed early to give a systematic response. With this realisation also the researcher took an interest to see how HIV/AIDS is addressed in Gauteng Provincial Department of Health (GDOH).

### **Rationale and Objectives**

The aim of this study is to look at how stigma related to HIV/AIDS is addressed in the GDOH. The study will explore and describe the processes that were undertaken to manage the spread of the disease in GDOH.

The specific objectives for the study are:

- To highlight the social impact of the epidemic in the workplace,
- To find out people's experience about stigma and HIV/AIDS in the workplace,
- To look at how other issues of HIV/AIDS are being addressed like cultural beliefs and gender.
- To look at policy and programmes in addressing HIV/AIDS in the workplace.

### **Methodology**

The work of this paper will be achieved by means of qualitative evaluation research design. de Vos (1998:366) describes evaluation research as the systematic application of social research procedures for assessing the conceptualization, design, implementation

and utility of social intervention programmes. In other words evaluation researchers use social research methodologies to judge and improve the ways in which human service policies and programmes are conducted, from the earliest stages of defining and designing programmes through development and implementation.

A more qualitative nature will be adapted to gather information and gain insights about stigma and HIV/AIDS in the workplace. Marshall (1987) in Marshall and Rossman (1999:15) say qualitative methods help to identify and describe the complexity of social problems and identify unanticipated outcomes.

Data will be collected by means of in-depth semi-structured and unstructured interviews from programme managers, experts, and key informants in the field of HIV/AIDS in the workplace, and employees in focus groups in three health regions and the head office. A non probability sampling approach will be adopted in the study.

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