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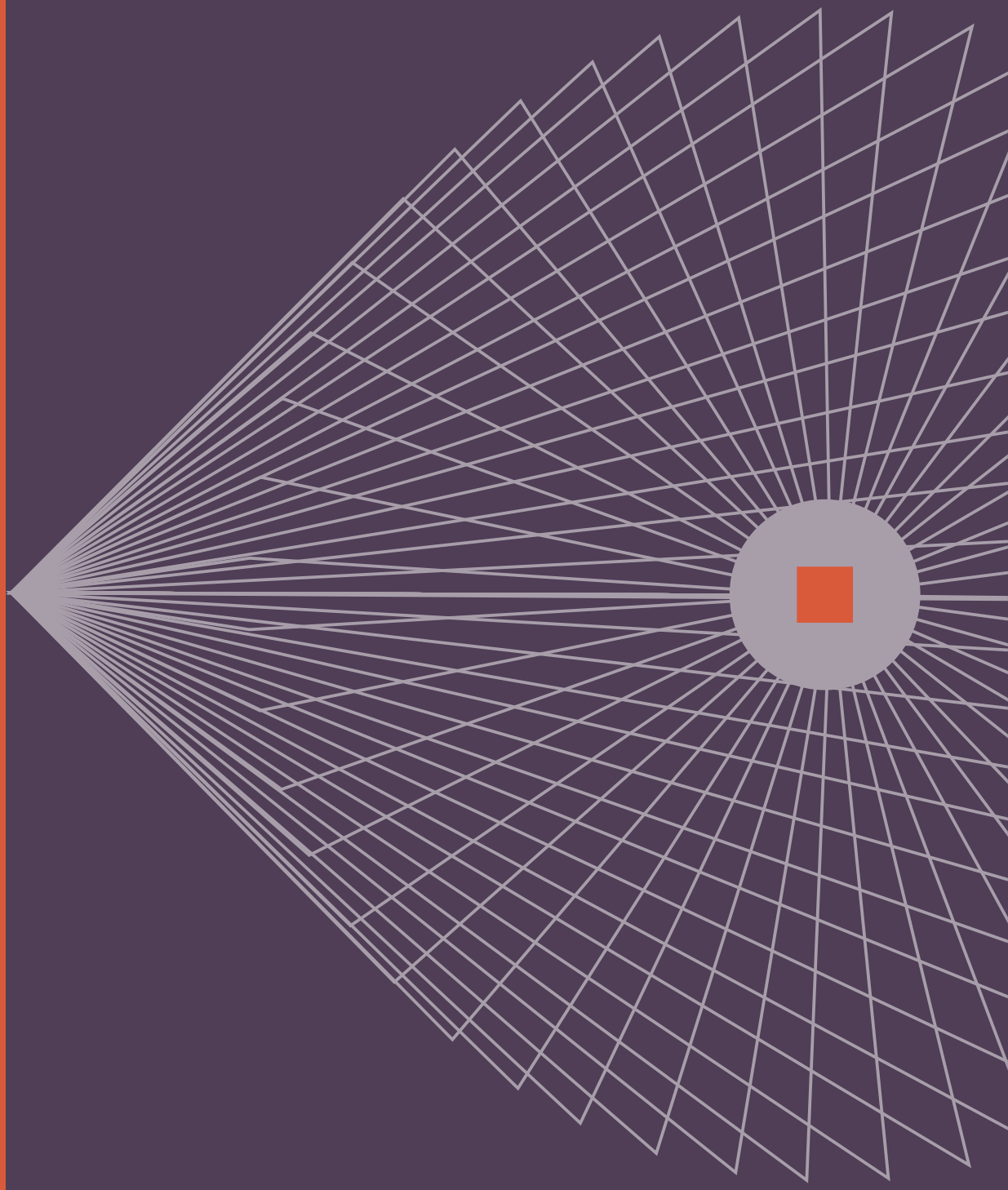
Marion Stevens



AIDS AND THE WORKPLACE WITH A SPECIFIC FOCUS ON EMPLOYEE BENEFITS: ISSUES AND RESPONSES

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ABBREVIATIONS

ARV	Anti-retrovirals
ART	Anti-retroviral treatment
ASSA	Actuarial Society of South Africa
COSATU	Congress of South African Trade Unions
CSIR	Centre for Scientific and Industrial Research
EAP	Employee Assistance Programmes
GDP	Gross Domestic Product
HR	Human Resources
PLWA	Person/People living with HIV/AIDS
MTCT	Mother to Child transmission
NGOs	Non-governmental Organisations
SABCOHA	South African Business Council on HIV/AIDS
SMME	Small and Medium Micro-enterprises
STDS	Sexually Transmitted Diseases
TAC	Treatment Action Campaign
VCT	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

This report reflects the first activity in a three-year research project, funded by the European Union, which is part of a programme of support to NGOs which are working with communities to combat discrimination against and provide support for people with HIV/AIDS. The aim of the project is to investigate, using a variety of methods, the world of AIDS and the workplace with a specific focus on employee benefits. These benefits include medical schemes and other health benefits, death, disability and pension funds. The research will concentrate on the experience of formally employed, unskilled or semi-skilled workers who are vulnerable because employers consider them dispensable or replaceable should they get ill or die, and whose employee benefits may be eroded in the face of HIV. By creating workplaces which are supportive of individual employees, one sustains households and, in turn, the broader society. This report presents the findings of an initial situational analysis of responses to HIV in the workplace, using a policy analysis methodology, which combined documentation review and key informant interviews with 27 players in the field.

The report starts with a review of the South African literature and documentation on HIV/AIDS and the workplace. Available evidence on the direct and indirect impacts of HIV on workplaces and the current models used to project impacts are presented; the legal and policy frameworks relevant to AIDS in the workplace are summarised; and a chronology of key events and processes that have informed this area are noted.

The main body of the report outlines responses to HIV/AIDS of the three major players: government, the private sector including NGOs, and trade unions. In each sector consideration is given to the areas of: leadership and organisational responses, networking and policy processes, and workplace policies and programmes including health care.

While a legal framework and a set of legal precedents for a rights-based orientation to HIV in the workplace have been established, prohibiting, for example, pre-employment HIV testing, a consistent and sound response to HIV in the workplace has yet to emerge. The report concludes that there is a need for strong, bold and coherent leadership in all sectors of society.

Responsibility for workplace HIV/AIDS programmes has generally been delegated to human resource departments, rather than being seen as a core management issue. The overall view noted by stakeholders was of strategic failures in managing HIV/AIDS in the workplace due to the lack centralised responsibility and commitment within organisations. The business sector and the trade union movement need to ensure that HIV/AIDS is fore-grounded as an issue and that it is the concern of the most senior leaders in their sectors. Many interviewees also felt that there was a need for better alliances and networking on workplace issues, and that government needed to play a leadership role in this regard.

Respondents across sectors called for planning to be informed by better data. These data need to be independent, open to scrutiny and separate from private interests.

Workplace benefits have undergone considerable restructuring in response to HIV. In the early-nineties schemes changed from defined benefit to defined contributions, motivated by the perceived impact of HIV on risk benefits. During the late-nineties some schemes evolved from group schemes to individualised packages, anti-retroviral drugs became more available in medical schemes, the outsourcing of unskilled functions appeared as a particular response to HIV and new HIV insurance packages became available for workplaces. During

2001, several companies announced their intentions to provide anti-retroviral treatment for semi-skilled and unskilled employees. These changes have been in response to assessments of direct and indirect HIV-related costs and the requirement to adapt to the reforming legal framework. Developments in the field have prompted the emergence of a range of new players dealing with disease management and impact assessments.

The effect of this restructuring has been several fold. Individuals often have to negotiate for benefits directly with insurance companies, as opposed to their companies taking responsibility for this. This has left employees more vulnerable. While routine pre-employment testing is no longer legal, it is apparent that many individuals are losing cover through pre-benefit testing. As a contrary trend, there is a growing realisation, in the face of declining drug prices, that HIV/AIDS treatment is affordable and cost effective in managing the health of employees. However, there is the danger that anti-retroviral therapy, for example, will be offered to some employees and not others. This is clearly of concern in terms of equity and discrimination.

Finally, there is a need to counter the notion that businesses will be able to cope with the HIV/AIDS pandemic because of 'the ease of substitution' . This rationale is neither positive nor constructive. Businesses need to balance their fiduciary duties by remaining profitable and viable yet being fair and socially responsible.

BACKGROUND

The majority of HIV/AIDS infections are found in adults at the prime of their economically active lives – between 20 and 30 years. HIV/AIDS affects their lives as individuals, and as members of households or families, but the impact also ripples outwards and affects the broader society and economy. This research views an employee or worker not as an autonomous entity, but as linked into a web of relationships, which form the basis of our society. Should HIV infection prejudice an individual's ability to continue to engage economically, the household and societal level are deleteriously affected.

HIV/AIDS is impacting on the workplace in a multi-faceted way. Many employees do not feel confident enough to disclose that they are infected or affected, as they fear discrimination or not being able to access benefits. Managers have to deal with employees not being able to work due to their own illness or illness within their families. Productivity is affected. Employers are also compelled to hire and train new staff who may on hiring be infected or affected by the disease then or at a later stage.

The impact of HIV/AIDS on the workplace varies, depending on skills mix, geographic location and social context. It will also be affected by the prevalence of other illnesses, for example tuberculosis and cholera, which may give rise to higher morbidity or mortality in HIV-infected people. Similarly the impact of HIV/AIDS will be affected by people's access to quality health services and the forms of treatment offered. Again, it will be influenced by the degree of stigma and discrimination people experience (Heywood 2000a:7).

The HIV epidemic confronts South Africa at a time that its economy has shown growth averaging 2% per annum (1995 and 1999), and inflation averaging around 7% a year. Manufacturing is the largest contributor to gross domestic product (GDP) in South Africa, followed by community, social and personal services (ABT Associates 2001: 12). It is difficult without a comprehensive analysis to know what is the effect of HIV/AIDS on the economy and what is related to other economic factors such as rationalisation, capital-intensive labour, affirmative action or even globalisation (Whiteside 2001).

At the same time the context of labour relations in South Africa is dynamic. Historically labour relations have changed where the dominance of the employer or business owner has been reduced and labour has gained a stronger voice at the negotiating table. Health and safety issues have become one of the issues discussed. Employers have devoted little time, money or effort to these issues and the labour movement has had to assume responsibility for seeing that these issues are addressed. However, HIV/AIDS appears to have been an issue of lower priority for the trade unions. In recent years growing unemployment and other 'bread and butter' issues have been the focus of the trade union movement.

Some have suggested that this situation is changing. Business is being forced to take action about HIV/AIDS when it sees costs rising and realises that bottom lines are tight or when employers experience the deaths of colleagues and family members. Many respondents in this study noted that the epidemic is getting to the terminal AIDS phase now with people ill and dying, and so 'it is becoming visible'.

Some businesses have noted that as a result of HIV/AIDS the target markets to which they sell their products could shrink. An example of this is the decision by the South African JD (Joshua Doore) group, which realised that its target market in South Africa would involve excessive bad debt, as customers would be dying as opposed to paying off their debts

(Whiteside and Sunter 2000). It was therefore decided to focus on expansion of operations in Eastern Europe.

The interest of this research is in the individual employee in as far as s/he belongs to a household and a community, which s/he supports. Once ill, a cycle of instability sets in following the employee's loss of benefits. As ABT Associates argue: 'Initial effects on the household can include loss of insurance and medical benefits, as well as the costs of pre-AIDS treatments or attempts to find a cure. Once a household member develops AIDS, increased medical and other costs, such as transport to and from health services, occur simultaneously with reduced capacity to work, creating a double economic burden. Members who would otherwise be able to earn or perform household and family maintenance activities may now spend their time caring for the person with AIDS' (ABT Associates 2001: 9).

Clarke and Strachan (2000:xiii) suggest that the impact of HIV on the economies of African countries has been far less than imagined but its long-term effect on the development of the continent has been overlooked. The epidemic has gained a grip on the poorest sections of society and left them even poorer, more dislocated, and therefore even more vulnerable to the disease. Chambers in Goudge and Govender (2000:11) concur with this idea, noting that 'sickness in poor households is more likely to lead to impoverishment than in a wealthy household. The poor are vulnerable to further deprivation due to the lack of "buffers" or extra resources that they are able to call upon when in need.' And as Goudge and Govender (2000:3) suggest, 'meeting the health needs of the poor is an important means to preventing the increase in poverty'.

Treatment – apart from prophylactic treatment of opportunistic infections -- has until recently been entirely unaffordable for most of the population. With the landmark activism of the Treatment Action Campaign in supporting the South African government's court case against the pharmaceutical industry, medicines have become significantly cheaper. The pharmaceutical industry was opposed to local South African companies manufacturing the drugs and the government simultaneously importing the same drugs made more cheaply in other countries. Because of bad publicity many international pharmaceutical companies have drastically reduced prices. This action has allowed for government and the private sector to obtain quality drugs at favourable prices. The challenge now remains how to provide these drugs within a disease management programme. Many actors have said that treatment is not possible in a developing country due to poor compliance by patients. Treatment is also difficult when there are limited laboratory facilities to monitor the HIV progression of individuals. Similarly, persons with HIV who are on treatment need to be assisted to maintain a good nutritional status (Harvard Consensus 2001). However, in June 2001 academics at Harvard University released the Harvard Consensus, which argued that anti- retroviral treatment (ARV) is possible in a low resource setting. The document gives examples of how to implement and sustain treatment in such settings.

The Harvard academics note, 'Past objections to AIDS treatment in poor countries fall into several categories. First, poor countries lack the adequate medical infrastructure to provide AIDS treatment safely and effectively. Second, difficulties with adherence to complicated medication regimens would promote and spread drug resistance. Third, anti-retroviral drugs are expensive, and the treatment cost is too high for the United States and other wealthy countries to finance without siphoning resources away from HIV prevention programs and

other worthy development goals. Finally, commitment from political leaders in Africa and other poor regions is not sufficient to underpin a major international effort towards providing AIDS treatment.' However, the document argues, 'We believe that the objections to HIV treatment in low-income countries are not persuasive and that there are compelling arguments in favour of a widespread treatment effort. Through large-scale, scientifically monitored programs, the development and sustainability of highly effective AIDS treatment strategies remains promising in settings of poverty and high AIDS prevalence' (Harvard Consensus 2001).

From mid 2001 a few private companies, for example Anglo American announced that they would provide treatment for employees in the form of anti-retroviral drugs. The challenge remains as to how this will be implemented.

For workers in the formal sector, employee benefits are a vital form of social security for themselves and their families. This is especially so for the individual who may be the only person in a household or extended family who is formally employed. Such benefits commonly include death and funeral benefits (lump sum pay-outs to surviving family members to cover funeral costs), pension and provident funds, group life insurance (against premature death), emerging policies on ART programmes and some form of medical insurance. There are 6 million beneficiaries of registered medical schemes and another 1 million members of exempted schemes (mostly primary health care and the military, etc.) (Van den Heever 2001). While these beneficiaries are a small percentage of the population, it is believed that these people support many others within their households and as a result are a major source of support.

This study presents a broad overview of available information to ascertain trends regarding employee benefits. While informing broader work in this area, the intention of this study is also to review what positive action can be taken. As Evian (2000: 166) argues, 'Damage control and minimising the impact on employees will be the order of the day for the medium-term future. In the long term, the workplace must see its role in stabilising the lives of its community – promoting community well-being and refraining from past practices which have promoted family dislocation and inequality.'

Modelling the epidemic

There is a lack of information in a number of areas regarding the epidemic. Firstly, the antenatal data from which modelling of the epidemic's effects is done does not reflect the working population (Van den Heever 1997). Secondly, as private companies wish to ensure privacy and confidentiality, HIV prevalence rates in most workplaces are not yet in the public domain. Efforts are, however, being made to gain access to this data, to pool it and to model a bigger data set, which will be reflective of the working population.

Two main models are used to project and understand the pattern of the HIV/AIDS epidemic. The Actuarial Association of South Africa (ASSA) has developed a series of models, the most recent being the ASSA 2000. The Metropolitan Life Doyle Model was developed in the early 1990s to make projections about HIV/AIDS prevalence using government antenatal data. Although imperfect, these data are one of the few comprehensive sets of public domain data

available to estimate the current and future size of the epidemic. Mortality patterns can be observed in the death data collected by the Department of Home Affairs, although this is complex. There is some data on sexual behaviour patterns in the Demographic and Health Survey conducted in 1998. These models are continually reviewed in the light of new demographic and population statistics.

The following table gives a summary of the projections made from the ASSA 2000 model. It comprises a change scenario and a no change scenario. The change scenario is included not because this is a likely scenario but in order to break away from the tradition of only showing what is expected to happen if nothing is done. The change scenario makes the following assumptions: (www.assa.org.za)

- no anti-retroviral therapy (ART) is provided
- mother-to-child transmission intervention takes place (phased in from 40% of births in the year starting 1 July 2001 to 90% in five years' time, and assumed to be 50% effective)
- treatment of sexually transmitted diseases (STDs) is provided , such that there is a 15% reduction in the rate of HIV transmission between people who regularly are infected with STDs, and phased in over the five years starting 1 July 2001
- a doubling in condom usage occurs over the next five years
- a decrease of 15% takes place in the number of new sexual partners over the next five years.

Table 1

ASSA summary of HIV/AIDS projections

No change scenario	2000	2005	2010	2015
Total population	45 078 805	47 485 369	47 392 059	46 599 840
Total HIV infections	5 263 841	7 594 403	7 252 801	6 297 502
Deaths:				
Non-AIDS deaths	387 667	404 749	406 095	404 846
AIDS deaths	139 009	510 079	779 098	695 041
Prevalence rates:				
Adult women (ages 20-65)	19.6%	26.5%	25.4%	22.2%
Adult men (ages 20-65)	20.5%	27.5%	26.0%	22.7%
Adults of both sexes (ages 20-65)	20.1%	27.0%	25.7%	22.4%
Total population	11.7%	16.0%	15.3%	13.5%
Life expectancy: female	58.9 years	46.6 years	40.8 years	42.0 years
Life expectancy: Male	52.7 years	44.0 years	40.4 years	41.6 years
Change scenario				
Total population	45 078 805	47 516 461	47 591 195	47 311 669
Total HIV infections	5 263 841	7 086 851	6 030 322	4 949 359
Deaths:				
Non-AIDS deaths	387 667	404 830	406 445	407 669
AIDS deaths	139 009	488 006	712 535	553 893
Prevalence rates:				
Adult women (ages 20-65)	19.5%	25.2%	22.1%	18.2%
Adult men (ages 20-65)	21.2%	26.7%	22.7%	18.7%
Adults of both sexes (ages 20-65)	20.3%	22.6%	22.4%	18.5%
Total population	11.7%	14.9%	12.7%	10.5%
Life expectancy (both sexes)	56 years	47 years	43 years	46 years

Source: www.assa.org

Based on the most recently available statistics the Metropolitan-Doyle Model makes the following projections:

Table 2 Metropolitan-Doyle summary of HIV/AIDS projections

	2000	2005	2010
Percentage of SA workforce which is HIV+	13.5%	20%	22.5%
Percentage of SA workforce which is AIDS sick	0.5%	1.65%	2.74%
New AIDS cases per annum	191 000	397 000	541 000
Number of AIDS orphans	153 000	1 000 000	2 000 000
Life expectancy of SA population: female	52 years	43 years	37 years
Life expectancy of SA population: male	49 years	43 years	38 years

Kramer (2001:3)

While these models are helpful in making demographic projections, the formulae are based on key assumptions and not on facts. As a result there is a chance of error. The assumptions underlying the models can be challenged in the case of the ASSA 2000 model which is in the public domain. Another recent development by ASSA is the ASSA multi-state model. This is a model that can be used specifically to project the impact of the epidemic at a workforce level. The model shows the projected demographic impact of AIDS as well as the resulting financial impact on employers. At the time of writing the model was not yet ready for release.

The 2000 antenatal data suggest that approximately 15% of all South African adults aged 20-64 years are currently infected with HIV. HIV is a disease that mostly affects younger people, with around half of all adults who acquire HIV becoming infected before they turn 25. Over 50% of these young people will die of AIDS before their 35th birthday (ABT Associates 2001: 5).

Methodology

This project aims to investigate, using qualitative and quantitative methods, the world of AIDS and the workplace with a specific focus on employee benefits. Benefits mainly involve membership of medical aid schemes and retirement funds but can also include disability benefits, sick leave, death benefits, funeral policies and emerging anti-retroviral drug policies. Because of the apparent burden of claims on the insurance industry, it is thought that the pool of benefits for employees may in future become more limited and benefit arrangements for employers may need to be restructured. The report will investigate this area and motivate for limiting unfair reductions in employee benefits.

For this initial phase, before conducting national cross-sectional studies and case studies of employee responses, a situational analysis was completed. The methodology for this situational analysis was qualitative in nature, and took the form of a literature review, interviews with key informants and networking. Some 27 key informant interviews took place with a range of actors in the field to determine opinions (see Appendix 1). Information was gathered to determine opinions from key actors on:

- how AIDS has impacted or is likely to have impacted, on the workplace;
- who the key actors in this field are;
- how employers and employees have responded to the epidemic;
- how employee benefits have been affected; and
- what opportunities there are for positive action.

Other data sources included: AIDS Consortium meeting minutes, the South African National AIDS Council's task team on treatment, care and support, the Council for Medical Schemes' prescribed minimum benefit process, participation and observation of a Metropolitan Life seminar on AIDS and workplace issues, an Institute for International Research – Human Dynamics workshop on employers and medical aids, and a course on planning for HIV/AIDS in sub-Saharan Africa facilitated by the Health Economics and HIV/AIDS Research Division (HEARD) of University of Natal in Durban.

Analysis took the form of policy analysis and triangulation. Within a human rights framework the data was reviewed under the categories of context, content, process and actors involved. The analysis used the Walt and Gilson (1994) policy analysis framework. A chronology was also developed to gain insight into processes over time. The data was organised in terms of responses from the public sector, the private sector and the trade union movement under the following headings:

- leadership and organisational responses;
- networking and processes;
- workplace policies and programmes;
- health care; and
- gaps.

LEGAL AND POLICY FRAMEWORK

Many respondents noted that while there is a good legal framework to protect the rights of persons with HIV/AIDS, in reality there is discrimination, little respect is shown for confidentiality regarding HIV status and people with HIV are often dismissed or put on early ill-health retirement.

There is limited legislation which pertains directly to the employee benefit sector. In this section the formal legislation and court rulings regarding HIV/AIDS and the workplace are outlined.

Confidentiality

All patients have a legal right to confidentiality regarding HIV status and medical treatment. This ruling was given in Jansen van Vuuren and Another v Kruger (1993). The case is better known as the 'McGeary case', and found that a doctor cannot disclose the HIV status of a patient to other doctors without the consent of the patient.

Employment equity

Section 54(1) of the Employment Equity Act, No. 55 of 1988 contains the principle that no person may be unfairly discriminated against on the basis of his or her HIV status. Section 7(2) prohibits testing of employees unless permission has been obtained from the Labour Court to do so.

Pre-employment testing and exclusions

Pre-employment testing for HIV has been ruled as unfair. In the Constitutional Court case of Hoffman v South African Airways (SAA) (2000), it was ruled that SAA had infringed on an employee's right as a PLWA not be unfairly discriminated against and that its practice of testing employees for HIV was unjustified.

In 1988 the Life Offices Association attempted to exclude people with HIV from private insurance policies, including medical aid schemes (Heywood & Cornell 1998:64). Individuals joining a medical aid, whether it be a group or an individual scheme, do not have to be subjected to testing for HIV today. This has been a significant gain in terms of human rights and needs protection.

Testing does, however, continue in the form of other pre-benefit testing. The recent case of NS v Old Mutual, in which an individual was excluded from particular benefits due to her HIV status, was settled out of court. The area of pre-benefit testing could mask pre-employment testing and needs careful monitoring.

Section 34(1) of the Promotion of Equality and Prohibition of Unfair Discrimination Act (Act No. 4 of 2000), requires the Minister of Justice and Constitutional Development to give special consideration to HIV/AIDS as a prohibited ground of discrimination. A schedule attached to the Act names discrimination on the grounds of HIV/AIDS in the provision of insurance as an example of unfair practices in the insurance sector.

Medical aid and prescribed minimum

The Medical Schemes Act, which governs medical benefits, was passed in 1998. With regard to medical aid cover for HIV, the legislation provides for patients covered by medical aid to receive the same cover and treatment that they would receive in a public hospital. In relation to the prescribed minimum benefits for HIV/AIDS, code 168S provides for medical aid cover for the diagnosis of HIV- associated disease for first admission or subsequent admissions. The treatment that is covered is the medical and surgical management of opportunistic infections and localised malignancies. While these are the legally prescribed minimum benefits, medical aids can provide wellness management and more comprehensive benefits. 'Aid for AIDS' is one such example. It is affiliated to Medscheme and seeks to provide a comprehensive disease management programme for beneficiaries. The details of the prescribed minimum benefit are reviewed regularly and there is a process currently underway reviewing the benefits in relation to HIV/AIDS. Efforts are being made to alter the benefits for chronic illnesses (such as diabetes and hypertension) out of hospital and to include HIV/AIDS in this category. Due to the fall in drug prices for HIV treatment and the success of disease management schemes, HIV/AIDS, benefits may become more affordable and manageable.

Policies and codes of good practice

A number of policies and codes of good practice concerning HIV and the workplace have been developed which reflect a commitment to human rights. These include:

- the AIDS Law Project Code of Good Conduct, 1994;
- the Southern African Development Community (SADC) Code, 1997;
- Cosatu Special Congress Statement, 1999;
- the Namibian United Nations Platform for Action, 2000;
- the South African Code of Good Practice, December 2000; and
- the International Labor Organisation Code of Practice on HIV/AIDS and the World of Work, 2001.

Many of these statements are similar in upholding the principles of human rights and non-discrimination. More information on these policies and codes is contained in Appendix 2.

CHRONOLOGY

This section presents a chronology of significant processes or events which relate to HIV/AIDS and the workplace from 1987 to the present. Those processes which are legal precedents or which have be considered successful and significant have been noted with an explanation. However many processes and events have not been taken forward nor sustained and these have been included in the table without an explanation.

Table 3 Chronology of events in relation to HIV/AIDS and the workplace

Year	Process or event	Significance[1]
1987	National Union of Mineworkers (NUM) articulate link between migrancy, housing and HIV/AIDS as AIDS-sick workers are repatriated to Malawi	Early trade union activity regarding HIV/AIDS
	Exclusions from group life policies due to HIV/AIDS status	Discriminatory practice noted in benefits
1989	Cosatu resolution on HIV	
1990	AIDS Consortium conferences	Networking and capacity building
	Doyle HIV/AIDS model	Benchmark for projecting prevalence rates
	AIDS Analysis first published	Sectoral base for collation of material
1991	Cosatu special congress on HIV/AIDS	
1993	AMA is first medical aid to treat HIV	
	McGeary confidentiality court case	Legal precedent
1994	National AIDS plan	
	AIDS Law Project – code of good conduct in the workplace	Legal precedent
1995	NUM protest Old Mutual increasing contributions for death benefits by 30%	
	ASSA model	Public domain independent benchmark for proj ing prevalence rates
	Metropolitan insurance policy	First insurance policy specifically for HIV-positive clients

1 *For legal precedents also see the legal and policy framework section.*

1996	World Bank and Chamber of Commerce conference on mining	
1997	Department of Health guidelines for developing workplace policy on HIV/AIDS	
1998	Medical Schemes Act	HIV/AIDS testing illegal for medical AIDS. Persons who are HIV positive cannot be excluded from medical aid schemes
	AIDS Analysis bought by Metropolitan Life	Sustainable publication but no longer neutral
	Employment Equity Act	Legal precedent
	Partnership against AIDS launched	
1999	UN publishes *Best Practices series on Company actions on HIV/AIDS in southern Africa*	
	Gauteng HIV/AIDS workplace programme facilitator's guide published	
	South African Clothing and Textile Workers' Union (SACTWU) policy and programme on HIV/AIDS commenced	First real sustained trade union effort
	Cosatu special congress on HIV/AIDS	
2000	Presidential panel of experts formed	
	South African National HIV/AIDS Council (SANAC) formed	
	Government strategic five- year plan launched	
	Health Economics and HIV/AIDS Research Division (HEARD) publishes 26 sectoral briefs	Relevant material for sectors published and disseminated
	Hoffman versus SAA case	Legal precedent

	UN Platform of Action on HIV and the World of Work - Namibia	Legal precedent
	SA Code of Practice	Legal precedent
	South African Business Council on HIV/AIDS (SABCOHA) launched	
	Sunter and Whiteside book published – in 3rd print run	Popular material disseminated, demand indicates information need
	National Economic Development and Labour Council (NEDLAC) meeting specifically on HIV/AIDS	
	13th International HIV/AIDS Conference on HIV/AIDS, Durban	International focus on South Africa
2001	Department of Health produces clinical guidelines	
	Re-launch of The Employment Bureau of Africa (THEBA)	Efforts to increase employment opportunities
	South African government and pharmaceutical companies court case	Drugs can be made cheaper
	Mining and manufacturing companies announce treatment plans	Workplace treatment possible
	Harvard Consensus	ARV treatment argued to be possible in a low resource setting
	ILO Code of Practice on HIV/AIDS and the World of Work	Legal precedent
	NS versus Old Mutual court case on pre-benefit testing	Settled out of court – pre-benefit testing still an issue
	Life AID introduced by Capital Alliance	Emergence of new insurance models dealing with HIV/AIDS

The impact of HIV/AIDS on workplaces

This section describes the impact of HIV/AIDS on workplaces and later discusses the issue of employee benefits.

There is a paucity of rigorous independent data on HIV/AIDS and the workplace. Most of the responses in interviews conducted for this study were qualified as being anecdotal. As a policy respondent noted, 'one can list issues but it is anecdotal and we don't know the significance, nor can we quantify'. An academic activist respondent supported this observation and further cautioned, 'that which is presented with a pretence of being scientific evidence is problematic. There is no real scientific evidence or longitudinal work'. A representative of the trade union movement repeated the sentiment, noting 'there is no scientific evidence on which to base the projected prevalence - that which is there is done by companies. [There are] actuaries who make up these projections, employers buy in to it, think about viable benefits and cap it or increase premiums. Meanwhile employees usually don't know what benefits are available, how the policies or benefits work, and it is usually the left-behind wives who have no idea [of the benefits payable to them on their husbands' deaths].'

One of the academic respondents, when answering the question, 'What do we know about the impact of HIV/AIDS?' questioned who the 'we' could be. He noted that there are a range of data varying in quality and accessibility. There are for a variety of reasons exclusive data sets which are not in the public domain. He also noted the naïveté in interpreting data and spoke of how measuring prevalence, incidence and impact involve quite different calculations.

Direct and indirect costs

In the calculations regarding the costs of HIV/AIDS to companies, data are loosely categorised into direct and indirect costs. Direct costs usually refer to direct, bottom line and obviously measurable costs of, for example, benefits packages, training and recruitment. Indirect costs refer to costs that are not as obvious and which can be difficult to calculate: these can refer to absenteeism, morbidity on the job and industrial action. These categories are loosely defined and measured, and there are no standard definitions of direct and indirect costs. The measures of indirect costs have not been afforded much attention and arguably are the greatest cost to a company. Figure 1 is an attempt by Simon *et. al.* (2000) to diagrammatically account for direct, indirect and systemic costs to a company. They add another component which they name systemic costs which can also be considered indirect costs

Figure 1 **Direct, indirect and systemic costs** source: Simon *et.al.* (2000)

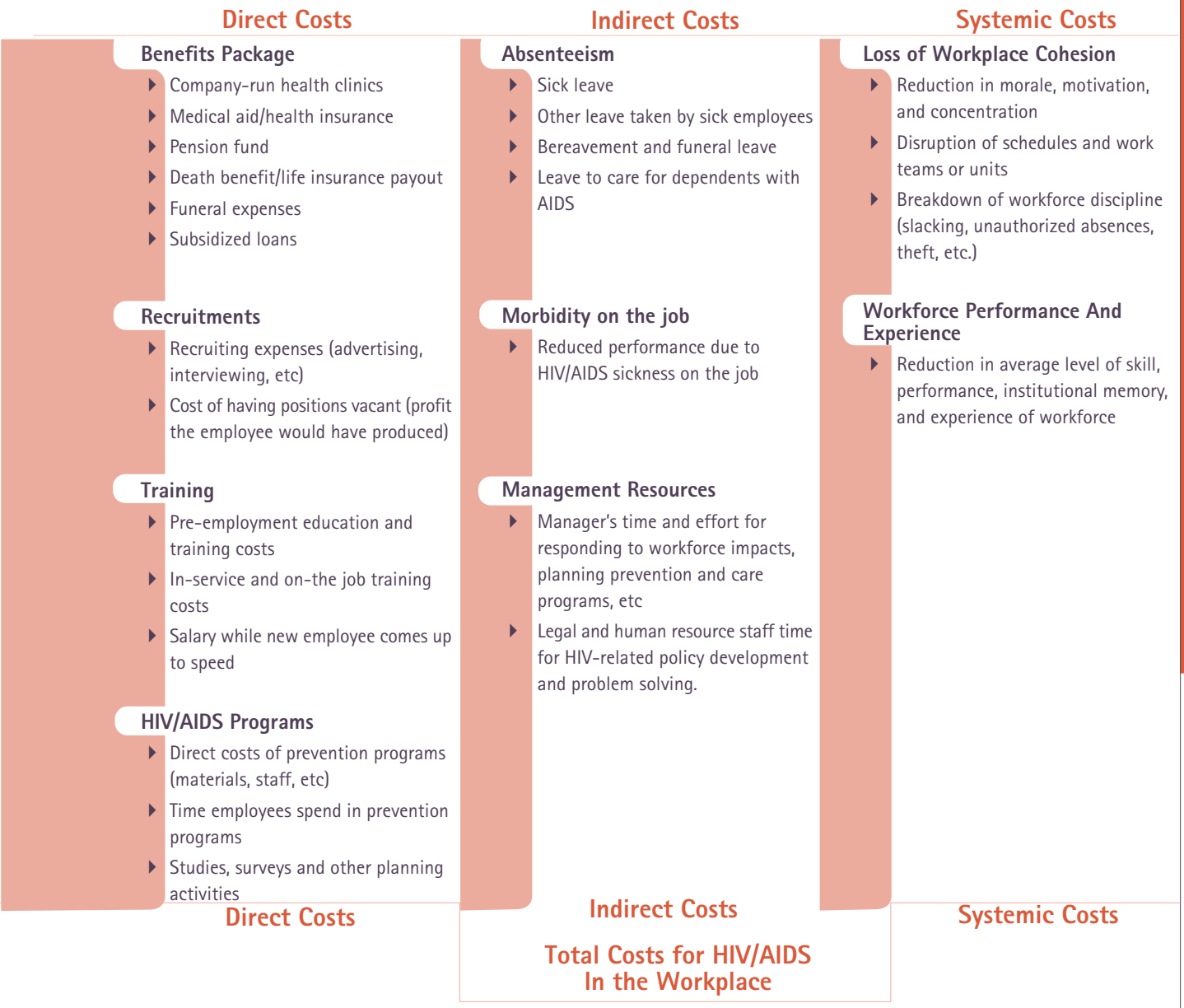

Figure 2 Internal progression of employees in relation to HIV/AIDS within a company. source: Simon *et.al.* (2000)

Progression of HIV/AIDS in the workforce	Economic impact of individual case	Economic impact of all cases
Employee becomes infected with HIV virus	▸ No costs to company at this stage	▸ No costs to company at this stage
HIV/AIDS-related morbidity begins	▸ Sick leave and other absenteeism increase ▸ Work performance declines due to employee illness ▸ Overtime and contractor's wages increase to compensate for absenteeism ▸ Use of company's on-site health clinics increases ▸ Payouts from medical aid schemes increase ▸ Employee requires attention of human resource and employee assistance personnel	▸ Overall productivity of workforce declines ▸ Overall labor cost increase ▸ Additional use of medical aid benefits causes premiums to increase ▸ Additional medical staff must be hired at the company health clinics ▸ Managers begin to spend time and resources on HIV-related issues ▸ HIV/AIDS interventions are designed and implemented.
Employees leaves workforce due to death, medical boarding, or voluntary resignation	▸ Payout from death benefit or life insurance scheme is claimed ▸ Pension benefits are claimed by employee or dependents ▸ Other employees are absent to attend funeral ▸ Funeral expenses are incurred ▸ Company loans to employee are not repaid ▸ Co-workers are demoralized by loss of colleague	▸ Payouts from pension fund cause employer and/or employee contributions to increase ▸ Returns to training investments are reduced ▸ Morale, discipline and concentration of other employees are disrupted by frequent death of colleagues
Company recruits a replacement employee	▸ Company incurs costs of recruitment ▸ Position is vacant until new employee is hired ▸ Cost of overtime wages increases to compensate for vacant positions.	▸ Additional recruiting staff and resources must be brought on ▸ Wages for skilled (and possibly unskilled) employees increase as labor markets respond to the loss of workers
Company trains the new employee	▸ Company incurs costs of pre-employment training (tuition, etc) ▸ Company incurs costs of in-service training to bring new employee up to level of old one ▸ Salary is paid to employee during training.	▸ Additional training staff and resources must be brought on
New employee joins the workforce	▸ Performance is low while new employee comes up to speed ▸ Other employees spend time providing on-the-job training	▸ There is an overall reduction in the experience, skill, institutional memory, and performance of the workforce ▸ Work unit productivity is disrupted as turnover rates increase

Figure 2 is an attempt to detail the internal progression of employees in relation to HIV/AIDS and costs within a company. It notes patterns of infected and affected employees and how management might attempt to deal with human resource issues concerning HIV/AIDS.

Whiteside and Sunter (2000) argue that the largest element of costs related to HIV and AIDS is absenteeism. Based on studies in a number of sub-Saharan countries they estimate the distribution of increased labour costs due to HIV/AIDS (see Table 4 below):

Table 4 Distribution of HIV/AIDS-related labour costs incurred by workplaces

Distribution of labour costs	Percentage
HIV absenteeism	37%
AIDS absenteeism	15%
Burial	16%
Recruitment	9%
Training	7%
Funeral attendance	6%
Labour turnover	5%
Health care	5%

Source: Whiteside and Sunter (2000)

Kramer of Metropolitan Life (2001:5) estimates the indirect costs of HIV/AIDS to the workplace (see Table 5 below). He further estimates that indirect costs could add a further 10% to the remuneration budget of a typical manufacturing company by 2005 and 15% by 2010.

Table 5 Breakdown of indirect costs

Source of cost	Percentage
Loss in turnover/profit	45%
Management and labour meetings	20%
Recruitment and training	10%
Legal costs	10%
Sick and compassionate leave	10%
Motivation/Productivity loss	5%

Source: Kramer (2001)

Reviewing an individual case study in South Africa, Whiteside and Sunter (2000) report on the impact of HIV infection and AIDS deaths on a sugar mill with 400 workers, of whom 96% are male. They describe how the disease affected workplace behaviour and calculated costs for the employer using the company's health clinic data (see Table 6 below):

Table 6 Distribution of direct costs in a sugar mill

Direct costs per worker	Percentage
Replacement workers	28%
Lost productivity	28%
Training	5%
Hospitalisation	1%
Clinic and Physician visits	10%
Absenteeism	28%

Source: Whiteside and Sunter (2000)

Whiteside (2001) suggests that employers should view HIV/AIDS as a tax, which could add 7-8% to the cost of doing business, and work to minimise exposure to this tax. He argues, 'The best way to minimise exposure for businesses is to ensure that their staff remains negative.' Whiteside adds, 'While pre-employment testing is unconstitutional staff should be made to pass an HIV/AIDS awareness test before being employed or promoted' (Whiteside 2001).

Evian (2001) provides estimates of the following HIV prevalence rates: amongst unskilled people it is about 25%; amongst moderately skilled people it is about 12-20% and amongst skilled workers it is about 5-12%. However, he notes that we are only in the first phase of the pandemic, where we are exposed to the first 10% of the impact. A private health sector respondent related that he had one client in KwaZulu-Natal who had a workplace HIV positivity level of 60%.

A few respondents noted the racial manifestations of the epidemic. One said, 'you see photos of black people in the canteen while the medical aid profiles show that white people are accessing anti-retrovirals'.

Employee benefits

Kramer (2001) argues that the direct costs of AIDS will be felt through escalating employee benefits and medical scheme costs. He notes, 'The cost of an average set of benefits is expected to double for many schemes by 2005 and triple by 2010. In schemes where the employer is fully responsible for increases in risk benefit costs, we project that this could add around 15% to the remuneration budget of a typical manufacturing company (i.e. a company where 80% of the staff are blue-collar workers) by 2005 and 30% by 2010. In schemes where this risk is passed onto members, life, disability and medical benefits are likely to be halved (when compared with 1999 figures) by 2005, and by one third of their 1999 level by 2010' (Kramer 2001:3). These estimates were made prior to the decrease in drug prices. The percentages could be less, depending on companies' commitment to disease management programmes.

The Centre for International Health at Boston University has conducted research on two companies in South Africa and postulates that HIV infections may cost companies between 2% and 6% of salaries per year. In addition, each HIV infection is likely to cost companies between 1 and 6 times the employee's annual salary, depending on the company's benefit structure (Rosen *et. al.* 2001). ABT Associates, using Metropolitan Life data, argue that HIV/AIDS is already resulting in rising costs of employee benefits in South Africa and the cost of an average set of risk benefits is expected to double over the next five to ten years, unless they are restructured. Projected cost increases for specific benefits are illustrated in Table 7 below.

Table 7 Projected costs of risk benefits as a percentage of salaries in South Africa, 1997–2007

	1997	2002	2007
Lump sum or disability benefit	1.5%	2.9%	4.5%
Spouse's pension	4.0%	5.9%	7.5%
Disability pension	1.5%	2.1%	2.6%

Source: ABT Associates using Metropolitan Life data (2001:14)

While the costs reflected in Table 7 are direct costs, ABT Associates argue that the most significant costs are likely to be indirect costs. It is estimated that by 2010 some 15% of highly skilled employees will have contracted HIV. As most of these calculations are made by traditional economists the costing is based on obvious bottom line equations. The conclusion reached is that 'these costs are most striking for skilled workers, where instant substitution is more difficult' (ABT Associates 2001:13). The assumption is that unskilled or lower skilled workers can be substituted and that the ease of substitution is the only concern and cost.

Most respondents did not know how employee benefits were being affected by HIV/AIDS, but some thought that they were being 'bashed, costing more, being decimated or becoming unaffordable'. One respondent in the insurance industry argued that testing doesn't make sense as a policyholder could become positive later on. Respondents also noted that for disability cover and group life insurance it is more costly to administer tests and to exclude people. However, for pension or medical aid schemes, even though it is illegal to test for medical aid schemes, it is seen as cost effective to test. Another respondent in the insurance industry countered this initial argument, suggesting that later sero-conversion still gives some time for an individual's insurance policy to accumulate some capital and argues that exclusions are economically expedient. A respondent representing a disease management concern argued that companies that are "infested" become uninsurable in terms of group benefits.

A number of respondents in the trade unions spoke of the paucity of information regarding employee benefits and how they function. One said, 'There is a lack of information on the ground regarding benefits. We need an impact assessment of how HIV impacts on employee benefit funds. We are still at a policy level. There is an agreement to examine these issues but it is not being tackled as a priority issue at this point.' Other concerns raised include how decisions regarding the increases in premiums or capping procedures are made and poor understanding of how benefits work and how they can be accessed by those who are insured.

understanding of how benefits work and how they can be accessed by those who are insured. A gender issue arises here, where employees, usually men, do not talk about financial issues to their partners and after they die, the survivors usually women are left disempowered. One respondent thought that most dependants do not claim benefits due to ignorance.

The rising incidence of claims in the context of discrimination was raised by another trade unionist, who said 'this issue can paralyse the retirement industry'. Respondents noted that there was a rising incidence of death claims and the costs of insurance benefits would be a problem for sustainability. At the same time they added that it was difficult to disclose in the present climate of discrimination and that workers would not want to disclose if they did not know what benefits were available. Respondents spoke of a number of Cosatu affiliates reporting increases in HIV/AIDS-related claims. One respondent reported that the National Education Health and Allied Workers' Union (Nehawu) funeral fund had had such a significant rise in claims between 1997 and 2000 that it had carried out a forensic audit. Respondents also noted that the National Union of Mineworkers (NUM) funeral benefit fund was decimated in six months because of HIV/AIDS.

A number of respondents noted that new structures for insurance would have to be developed. It was noted that there is a remunerative burden in that the costs of insurance are increasing. The dilemma is to quantify exactly what they are and who is to bear them. Respondents noted that the increase in costs varies according to age, geography and sex and that essentially there has been a 5-10% increase in mortality annually. Kramer (2001) adds to this discussion, arguing that those who will bear the greatest financial burden to the direct costs of AIDS will be:

Employees who have recently converted from a defined benefit arrangement, where the employer is fully responsible for increases in risk benefit costs, to a defined contribution arrangement, where increases in risk benefit costs result in a decrease in benefits. In particular, middle-aged members of retirement funds will have spent their youth subsidising risk benefit costs of the older members, and are likely to spend their future years subsidising the risk benefit costs of younger members, where the incidence of HIV and AIDS is significantly higher' (Kramer 2001:4).

A few respondents noted that the human resources departments of organisations usually negotiated employee benefits. Concern was expressed that employee benefits are often so complex that human resources managers do not understand complete benefit packages and how they work, and are therefore unable to explain benefits to employees. When employees start needing to find out about their benefits concerning HIV/AIDS or to get the best value for their benefits, they are unable to determine this and aren't assisted by the human resources department. A trade unionist expressed this dilemma cogently: 'With HIV management schemes as top ups it becomes all the more complex; firstly individuals aren't case managed, rather drugs are distributed. And secondly people end up using their dental benefits to pay for HIV treatment, as the benefit coverage is unclear. This also occurs within a context of stigma and discrimination and concern that disclosure might mean the end of benefits.'

One of the issues that surfaced was the fact that companies are looking to support some employees who are HIV positive but not others, depending on how valuable the employee is to the company. This clearly is discriminatory and of concern. A trade unionist pointed out that 'certain HIV management plans are discriminatory, they are based on people's incomes

by Rosen *et. al.* (2001) suggests that it is more cost effective economically to provide anti-retroviral therapy to those employees above the level of supervisor and that below these levels it would be more economically prudent to outsource lower level functions. This would pass the costs and burden on to the individual worker. In terms of South Africa's commitments to human rights and non-discrimination on the one hand and to economic growth on the other, these issues need careful consideration.

During May 2001 the case of NS versus Old Mutual was heard in the Cape Town Labour Court. This case concerned a woman who was denied benefits due to being HIV positive. The case was settled out of court. While this case establishes no legal precedent, a future case could provide a legal precedent to oppose pre-benefit testing as discriminatory.

Another approach to benefits has been facilitated by Capital Alliance. In August 2001 Life Aid was launched by Capital Alliance as a way for employers to take out insurance against the risk of their employees contracting HIV/AIDS. Should the employees become HIV positive the insurance payout would cover anti-retroviral treatment. It is unclear whether employees will have to have a pre-benefit test and how issues of exclusion and confidentiality will be dealt with (Bisseker 2001). This shows the development of a new generation of insurance policies in the employee benefits field.

Historically it appears that there has been a quagmire of misunderstanding regarding employee benefits for a number of years before the HIV/AIDS epidemic reached South Africa. In 1983 Cornell conducted a study on workplace health services and employment in the manufacturing industry of greater Cape Town. She notes, 'The confusion evidenced in answers to questions about schemes reflects a situation of general lack of information and knowledge about the conditions of these schemes, on which workers are dependent in times of sickness. These schemes clearly need a thorough analysis in terms of their relative costs and benefits' (Cornell 1984: 58). Many years later this conclusion still applies, and there is a need for careful examination and regulation to ensure that policies are consistent with approaches to human rights and our constitution.

Trends in employee benefits

In tracking the evolving nature of employee benefits in relation to HIV/AIDS the following is a typology describing their emergence and key features of their restructuring (see Table 8 below):

Table 8 | **Typology of emerging employee benefits in relation to HIV/AIDS**

	Players	Nature of restructuring	Object of restructuring
First generation (mid-1990s)	Intermediaries or advisors	▸ Defined benefit to defined contribution (group schemes) ▸ Exclusions	▸ Direct costs ▸ Mis-specifying of risk ▸ Oriented towards general benefit restructuring
Second generation (from late 1990s)	▸ Disease benefit management company and consultants ▸ Consultants on impacts and responses ▸ Employee assistance programmes ▸ Financial services industry orientated towards employee benefits	▸ From group schemes to individualised packages (more complex with higher transaction costs) ▸ ARVs for medical scheme members (low risk high income) ▸ Outsourcing of unskilled functions ▸ New HIV insurance packages for workplaces	▸ Direct and indirect costs ▸ Adapting to changes in legislation and legal precedents ▸ Cost avoidance
Third generation (2001)	As above	Access to ARVs for semi-skilled and unskilled employees (low income high risk and dependents)	Management of unavoidable costs

RESPONSES AND IMPACT

This section reviews the responses to HIV/AIDS of the major players: government, the private sector including NGOs and trade unions. Responses will invariably differ, depending on the positioning of different actors and their various contexts and motivations. While there is a clear focus on bottom-line direct costs in most sectors, it is important to note the challenge of measuring and recording indirect costs to obtain a more realistic idea of the impact of HIV/AIDS. Doing so, brings in a rights-based perspective, which has been fostered by the government/public sector and civil society. In each sector consideration will be given to the areas of: leadership and organisational responses, networking and processes, workplace policies and programmes, health care and gaps.

GOVERNMENT/ PUBLIC SECTOR

Leadership and organisational responses

Many respondents took the view that government as a key actor within society should be leading with regard to HIV/AIDS and the workplace, and regretted that this was not happening. There is a perceived need for constructive and positive leadership. During the period of transformation, government in partnership with civil society put in place a human rights framework. However, there has been a mushrooming of criticism of government's lack of coherent leadership in the HIV/AIDS pandemic.

In order to lead one needs information to make informed decisions. Clearly there is a paucity of workplace information for application in this area. It is not even clear what information would be helpful. Prevalence data from government is often criticised for not being methodologically sound. It is difficult and expensive to determine HIV incidence from prevalence blood samples. The findings of the samples are not generalisable to the working population, which is often a criticism made of the Doyle model.

Respondents were asked who the leading actors were who were engaged in championing HIV/AIDS and the workplace, but no figure was clearly identified. Most actors named were conducting research in the area or were associated with business and provided products related to HIV/AIDS.

A respondent from an employee assistance programme contended, 'Business runs South Africa regardless of which party is in power. So who should take leadership when government isn't providing leadership? Government is taking leadership and business follows government. So if it is not an issue for government then it is not an issue for corporates, and we are left with a circle of confusion.'

Networking and processes

Leaders need fora and space in which to act. A number of respondents noted that most information sharing about HIV/AIDS and the workplace occurs informally between actors. It is anecdotal and not yet formally co-ordinated. Some respondents noted the difficulty of the HIV/AIDS programme being situated within the Department of Health, in that it was then just regarded as a health issue. Involvement of all line departments is needed to manage the epidemic and there is also the need for co-ordination and information sharing between departments at all levels. One respondent spoke of the South African National AIDS Council (SANAC), an initiative in the President's Office, which he said should be viewed as a lead project. He added that he was a chair of a task team but was never given terms of reference for the team. Many respondents suggested that SANAC was inaccessible and not a group that they were able to relate to.

One of the fora for bringing leaders from all sectors of society together is the National Economic Development and Labour Council (Nedlac). A trade unionist respondent commented on a Nedlac seminar on HIV/AIDS that was held in 2000 and which involved government, labour and business. None of the participants had yet received minutes of the proceedings and there was no process for follow up, nor ongoing collaboration.

Mention was made of a workplace forum that was housed within the national Department of Health. It served to share information but was hampered by funding, as it did not have a budget for national operations. A number of respondents thought that this forum was still in existence, but were unsure of what it was doing. A government respondent commented that the forum had come to an end and she had then heard of the South African Business Council on HIV/AIDS and was relieved, as essentially it was taking over the government workplace forum function. Subsequently she had found it quite difficult to make contact with the council and work out what the council was doing. Again, it is essential that fora are created that make the work of HIV/AIDS an issue for all line departments and not just the Department of Health.

It is interesting to track the progress of a number of individuals, arguably leaders in this field who previously worked for government-based ATICs (AIDS training and information centres). Many of these individuals are now working in different circumstances, and no longer for government, and clearly are providing leadership in workplace settings based on their earlier experience in government. There are also clear informal networks for information and contract sharing. Where people have worked together before and trust each other, processes are developed more effectively. This is helpful, especially when these processes are across traditional sector boundaries.

A government respondent noted that he was not able to comment on processes and networks as government had not completed an audit of activities concerning HIV/AIDS and the workplace, and were about to start working in this area. The Gauteng provincial government has a workplace forum within the Department of Health and during the process of this project had advertised a provincial process and resource person 'to get AIDS issues and policy on your workplace agenda'. However, it emerged that the person employed to do this job had left government and was now working as a consultant. It is evident that in this sector the employment environment is very dynamic and professionals are highly mobile[2].

[2] *The Department of Health related that it had a dedicated person in the HIV/AIDS Directorate working with the trade unions. One key objective was to publicise in the labour movement that pre-employment testing is illegal. None of the other respondents within the labour movement commented on this work.*

In trying to track the relationship between government, labour and business in dealing with HIV/AIDS, it became apparent that there was mistrust and poor collaboration. One respondent who had been working within government said, 'We do not do a lot, nor do we want to do much with the private sector – they are very arrogant and self-sufficient... very slow and not doing what they should. They pay lip service to policy issues and get irritated very quickly.'

Workplace policies and programmes

It is important to note government's role as an employer with its own workplace policies and programmes and as a leader in regulating and providing the benchmark for other sectors in terms of policies and programmes.

Government has, as noted in the legislation section, made key strides in setting out a legal framework supportive of employees infected with, and affected by HIV/AIDS. The challenge is to implement these legal and policy frameworks. One respondent asked the question, 'Who is in charge of business and workplace issues in terms of HIV/AIDS in government? Is there such a person?' It appears that there are a few focal points within government, yet co-ordination is not evident. Within the Department of Labour there is a Chief Directorate that deals with the Employment Equity Act and other workplace legislation and implementation, such as the Code of Good Practice. There is also the Occupational Health and Safety section, which would deal with occupational health and safety issues. The inter-departmental Committee has been operational for a few years and many departments have workplace policies. Yet most respondents in government could not comment on the different line-departments activities or on an overall framework. There is a need for guidance and leadership in this area. It is unclear even within the public service how employees infected with, and affected by, HIV/AIDS are being guided as to internal public service protocols.

During October 2001 the Department of Public Service and Administration (DPSA) held a 'Public Service HIV indaba'. At this indaba it became apparent that there have been various processes of research and committees formed to develop a programme of action to deal with HIV in the workplace since January 2000. In a report dated August 2001 it was recommended that the government should not test employees HIV status, for employee benefits. It was also noted that a HIV/AIDS and the workplace policy still needs to be developed and that the programme of action should be ready for implementation by 1 April 2002

Of concern was the reality that there was not a programme to assist government employees to deal with HIV/AIDS. As one government respondent noted, there is an HIV co-ordinator in each national line department and then an interministerial committee on HIV. The co-ordinator was situated in the human resources part of the line department and he was unsure of its programme. This points to human resources not being a respected and prioritised component of departments. During 2001 the National Population Unit in collaboration with the United Nations Population Fund (UNFPA) launched a primary HIV/AIDS capacity development course for 1 500 government planners from national, provincial and local government. Responses are now needed at the different levels of government – national, provincial and local – to put in place plans, policies and programmes.

Government has led the process making pre-employment HIV testing illegal. There were various arguments concerning pre-employment testing. Most respondents supported the idea of it being illegal. They thought that more should be done to reduce discrimination and protect employees' rights. Some respondents however thought that pre-employment testing was economically wise and also advocated pre-training and pre-promotion HIV testing. Pre-benefit testing is generally taking place now in all sectors and those who test positive are being excluded from group benefits. What is commonplace is that employees are employed without being tested, yet are required to test for HIV for retirement and disability benefits after being hired. Should they test positive they are not accepted onto schemes and generally forfeit such benefits. These processes are changing fast and government needs to monitor and regulate them carefully for all sectors of society.

One of the key roles of government in this regard is to ensure that the broader population is educated about the legal framework for HIV/AIDS in workplaces. One government respondent said that there was still ignorance about the impact of HIV/AIDS, and noted, 'the relationship between HIV and AIDS is confused. When you are positive you can work for a while, it is only when you have AIDS that it becomes a problem and chronic and people can't work or perform well.' Clearly there is still ignorance in believing that people with AIDS diagnoses cannot work well. Those in government with responsibility for dealing with HIV/AIDS in the workplace need to be empowered with accurate information.

Loewensen (2001) argues that 'tax and incentives to encourage companies to take effective action against AIDS would help stop the spread of AIDS.' This could be a positive step that government could legislate. Loewensen continues: 'A percentage of pre-tax profits could be deducted to finance community action'. Similarly government could make it a requirement for companies that apply for government tenders to have met specific requirements with regard to HIV/AIDS. This could take the form of having an HIV/AIDS policy, executive level representation of people living with HIV/AIDS or support for a home-based care project, orphan project or hospice project etc. These activities could involve the Departments of Finance, Labour, and Trade and Industry in a leadership role by regulating tax and company law. In this regard government needs to think ahead regarding the challenges and opportunities that the epidemic brings with it. Similarly government needs to lead in terms of its regulatory role, for example, in reviewing new insurance models.

Health care

Not all government employees are at a skills level which makes them eligible for medical aid scheme membership. Government has outsourced some of its less skilled activities such as cleaning and catering, so that government is not directly responsible for benefits for employees in these areas. One respondent noted that if eligible for benefits in government one could choose whether or not to be a member of a medical aid scheme, and as a result he thought that some 50% of public service employees did not belong to medical aid schemes. The problem then arises as to what happens when employees become sick and cannot afford treatment.

A government respondent added that workplaces are unprepared to deal with the experience of bereavement, noting the death of two colleagues in his department. He emphasised that bereavement counselling, assistance with immediate issues of illness and restructuring of leave provision needed attention.

Gaps

Many academic and NGO respondents mentioned that HIV/AIDS is not being viewed as an economic development issue. There is a need to view the workplace as an integral part of society. A number of respondents noted how the country was not preparing for the impact of a large orphan population. Again, many respondents called for strong government leadership.

Collaboration between government and trade unions was also noted as an area of concern. Trade union respondents complained of government's poor leadership and arrogance. Yet they expressed the desire to work together and improve conditions.

Business respondents argued that the present employee benefit model won't cope and that it will be too costly for companies. New insurance instruments, legislative frameworks and a treatment plan are needed and government needs to play a regulatory role in this regard. Some respondents spoke about corporate politics undermining action, as well as government interfering in business. A respondent gave the example of government cautioning Anglo American not to provide anti-retrovirals drugs to its workforce.

PRIVATE SECTOR INCLUDING NGOs

Leadership and organisational responses

A number of respondents spoke of lead organisations as those which were prepared to allocate funds to HIV/AIDS issues and have senior and financial management who take on the issue of HIV/AIDS. In reviewing the private sector's response it is important to note both the role of individual companies and the role of business as a collective and in various alliances.

Examples were given of Anglo American, Daimler Benz and Ford as organisations which had taken the lead in dealing with HIV/AIDS through announcing treatment, care and support programmes. In contrast, one respondent noted that it took a number of years for a major insurance company to demonstrate executive commitment to HIV/AIDS despite being viewed as a leading organisation in this field. Executive commitment is essential to leadership. A thread running all the way through this research has been the frustration that respondents have expressed, insofar as responsibility for HIV/AIDS is often left to the relatively powerless human resource domain. The challenge is to get top management actively engaged in HIV/AIDS issues.

As an employee assistance manager related, 'Businesses don't want to pay for AIDS, they are not looking at the cost benefit issues. The corporate white fifty year olds who are the directors have the perception that HIV is for black unskilled people. There is a failure in understanding, they are not dealing with the real issues of company sustainability and their future.' The argument that HIV/AIDS will deal with unemployment is not terribly useful. As another respondent pointed out, 'the unemployed work pool will also become infected'.

Old Mutual conducted health care surveys in the years 1994, 1995, 1997, 1999 and 2001. Each survey was based on a sample of some 60 companies, considered sufficiently representative of the South African private sector. The survey has a section relating to the impact of HIV/AIDS, asking in particular about actions taken by employers to minimise the impact on the market. In terms of actions taken some could be viewed as prevention, while others would be considered general workplace programming. The survey considered in particular:

- provision of education and awareness programmes
- restriction of HIV/AIDS benefits
- screening of new employees
- taking no action at all
- case managing HIV/AIDS[3].

In terms of education and awareness programmes, in 1994 some 32% of the companies surveyed provided programmes. This rose to 83% in 2001. However, there is no indication of the quality, length or sustainability of these programmes. Table 9 below indicates actions taken by companies to minimise the cost impact of HIV/AIDS.

Table 9 Actions taken to minimise cost impact of HIV/AIDS

	1994	1995	1999	2001
Education and awareness	32%	69%	85%	83%
Screen new employees	6%	13%	Not measured	Not measured
Case managing HIV/AIDS	Not measured	Not measured	17%	48%
Additional AIDS benefits	10%	Not measured	15%	2%
Restrict AIDS benefits	11%	28%	11%	17%
Reinsured AIDS risk	Not measured	Not measured	9%	3%
Create a separate fund or AIDS	Not measured	Not measured	4%	13%
Nothing	44%	22%	23%	10%

Source: Old Mutual Health Care Surveys: 1994, 1995, 1999 and 2001

In 1994 the Old Mutual survey found that some 44% of companies were taking no action or preventative measures to deal with HIV/AIDS in the workplace. This has declined to 10% of companies not doing anything in 2001. Case managing HIV/AIDS was not recognised as an option until 1999 when some 17% of companies surveyed were noted as doing so. This rose rapidly to 48% in 2001. In 1994 some 6% of employers screened new employees for HIV/AIDS. This rose to 13% in 1995. The distinction between screening for benefits and employment is not made in the survey. The data were not collected for the later years. This was probably due to the promulgation of the Medical Schemes Act of 1998, which stipulated that medical schemes could no longer exclude from membership persons with HIV/AIDS and due to the restrictive legal provisions for pre-employment testing. While not surveyed here, it would be interesting to know the percentages of new employees being tested for eligibility for other benefits such as retirement and disability benefits.

Table 10 shows the percentage of employers who restricted benefits to employees. It is not clear which benefits are being measured, as in medical aid schemes versus life cover, etc. The provision of a disease management benefit is a prevention strategy. In maintaining an employee on a disease management programme with a low viral load one reduces the chance of the virus being spread. It also increases the chances of such employees accumulating capital in their insurance policy base, which keeps such schemes viable.

[3] *A definition for case managing HIV/AIDS was not provided*

Table 10 Percentage of employers restricting HIV/AIDS benefits

Year	Percentages
1994	10%
1995	28%
1997	21%
1999	12%
2001	17%

Source: Old Mutual Health Care Surveys: 1994, 1995, 1997, 1999 and 2001

Arguably, providing treatment or case managing HIV/AIDS is a form of prevention. Employees have to know their status before receiving treatment and by knowing their status HIV-positive employees can be motivated to change their behaviour and then ensure that they or their partners do not spread the virus. ARV treatment reduces viral load and the chances of transmission. The employee is able to continue a productive work life and is prevented from entering a cycle of illness, which in turn reduces the chances of low productivity. In recent months a number of companies have been mentioned in the media as choosing this option. In doing so they are aiming to prevent the ill health of their workforce. Providing accessible, free and confidential sexually transmitted disease (STD) care is also a way of preventing HIV in the workplace. However, a survey conducted in 1997 suggests that the opportunities in this regard are largely being missed (Schneider *et. al.* 2001).

Mining sector

Most of the initial research on HIV/AIDS and the workplace was in the mining sector. One respondent in an employee assistance programme noted that data from the mines had been used to calculate the financial impact of the epidemic on South African businesses, but cautioned that 'we are weary of using mining data as it easily leads to discrimination. Most of this data are also not in the public domain. It panders to comfort and denial of those who think they are unaffected.' An academic respondent also related the problematic predominance of mining data, 'one never really hears of anything besides the mines'. Indeed, in terms of workplaces and HIV/AIDS, research has been conducted on HIV/AIDS, migrant labour and mining since the mid-eighties. Many of the conclusions, however, remain the same in 2001 as they were in 1988: 'Further questions concern the experience of women migrants living in single-sex hostels, squatter camps and neighbouring farms. Some women may resort to prostitution owing to low paying jobs or unemployment. Also of critical consideration are attitudes to the use of condoms – certainly miners view them with great suspicion' (Sociology of Work Programme 1988: 15).

Employee assistance programmes and human resources (HR)

Within the private sector a common organisational response is to outsource human resource counselling functions to an employee assistance programme (EAP). A respondent who runs counselling services for an EAP related that the EAP receives few calls regarding HIV/AIDS. Calls appeared to be about how to access the best health care regarding HIV/AIDS, practical

management issues and what benefits employees are entitled to. He thought that HIV-infected or affected people sought help elsewhere, for example, from NGOs because of the issue of confidentiality. In outsourcing the counselling function of human resources, companies are distancing themselves from being confronted by HIV/AIDS. A few respondents added that companies in effect say to employees, 'Your health care benefits are between you and your medical aid, so you deal with them.' They noted, however, that one advantage of EAPs is that they are physically outside the company and so they can ensure privacy and confidentiality.

A respondent in a private health sector company said that EAPs were often not very appropriate – people can't telephone EAPs from work and have privacy because of the culture of open plan offices. He noted that confidentiality was a big issue as was being culturally appropriate for HIV infected and affected people that they work with. He added that in his company people don't trust the human resources department: 'they will arrange to see us in the parking lot even to ensure confidentiality'. Evidently the physical space of counselling, confidentiality and culturally appropriate counselling are viewed differently and need consideration.

Almost all respondents noted that workplace initiatives and programmes were initiated by the human resources department. The majority of respondents note that this was problematic. As a respondent in the financial services and academic sector said, 'AIDS policy is not in the boardroom – it is with the HR people and thus not a top priority.'

Non-governmental organisations (NGOs)

A trade unionist respondent noted that most of the groundbreaking work in HIV/AIDS is being done by non-governmental organisations (NGOs), which themselves are vulnerable and often don't have the resources to care for HIV/AIDS-infected or affected employees. Interestingly a policy consultant respondent described how Interfund had co-ordinated a programme for NGOs to deal with HIV/AIDS. Because of their autonomy NGOs have tended to lead the HIV/AIDS sector, yet there is little work that has been done on workplace issues within and by NGOs.

Networking and processes

The South African Business Council on HIV and AIDS (SABCOHA) was launched in February 2000. It is a subsidiary of the Global Business Council on HIV/AIDS, which was founded in 1997 and had Nelson Mandela as its honorary president. The aim of SABCOHA is to establish a network of expertise and knowledge and a resource centre to assist the private sector to develop the necessary infrastructure to deal with HIV/AIDS and the workplace. The main vehicle for this is intended to be an HIV/AIDS information and resource centre. The budget for this centre is R3,1 million. It is not evident how long the funding cycle would be (SABCOHA 2000). SABCOHA has had difficulty in getting established. Far from being able to provide leadership business with regard to HIV/AIDS, it is still battling for recognition and funding. A few individual businesses have provided support to this initiative Old Mutual seconded a staff member to SABCOHA to be a facilitator for three months and another organisation is sponsoring its website.

A number of respondents referred to SABCOHA and yet were ignorant about its functions. A respondent who works as a consultant said, 'The business council is there but I don't know

what it does and it doesn't function well.' Another NGO academic consultant noted, 'It has failed or stalled. It has spent three years trying to get off the ground and has had no visible impact.' Another respondent contended that people meet in other traditional business fora where AIDS is put on the agenda, which is why SABCOHA has not been successful.

The South African Chamber of Business (SACOB) is working on the issue of HIV/AIDS, according to a respondent in the private sector. SACOB argues that it is the largest multisectoral group representing business in South Africa. However, it is clear that the concept of business representation in South Africa is volatile and dynamic. During the period when this report was being written there were numerous reports in the press regarding the restructuring and changing nature of business representation. Clearly, whilst this is in process, very little leadership and 'championing' regarding business and HIV/AIDS is taking place. One respondent noted that the overall business body in South Africa, Business South Africa (BSA), of which SACOB is a subsidiary, is believed to have taken a position not to support SABCOHA. He suggested that as a new organisation SABCOHA lacks integrity and legitimacy: 'It did not really have any concrete action plans besides being a clearing house for policy, and has a huge budget. At the same time many people are exploiting the epidemic – and are unethical and using it to great commercial ends which is a travesty'. Nevertheless SACOB has now met with SABCOHA and they have decided to work together. Yet at the same time the respondent reported that SACOB was about to launch a programme costed at R13 billion!

In reviewing processes in this arena, a consultant academic argued that most of the activities have been research based in order to provide information and to put in place workplace projects. For example, he noted research involving the : the Durban Chamber of Commerce, the Centre for International Health (Harvard) and Eskom in developing a cost benefit analyses. In analysing these processes it is evident that most of the work done, whether regarding modelling, prevalence rates or impact assessment, is 'in house'. As such it is not independently verifiable and so one cannot easily review the assumptions or methodologies informing the research. A key question is then the issue of information: who owns it and who can access it in order to lead with good decision-making? Most companies are reluctant to share their information, apart from the conclusions of research.

Fora are ad hoc, informal and lack direction, as indicated in a range of responses. A respondent in an employee assistance programme contended that 'there are no alliances, people are quite possessive of this disease, this is a great tragedy'. Similarly, an academic respondent noted, 'There is still a turf battle, it is a bizarre thing, and people want personal kudos.' One respondent noted that the AIDS Consortium carries out networking and the Treatment Action Campaign has a treatment focus. But no forum exists to provide legal protection to HIV-positive employees and so there is a vacuum. Fora are also generally held within sectors. It appears that the private sector has numerous conferences. An academic respondent commented, 'There is that fancy conference-organising group that trots out workplace conferences. They are, however, all the same and there is little more than prevalence dealt with and certainly not practical implementation issues.'

A respondent in an employee assistance programme added in terms of networking, 'EAP providers see each other at ad hoc conferences and there is informal networking.' One respondent, in answer to a question as to how conflict plays out, said that there was no real conflict, as that would imply dialogue. Another respondent agrees with this sentiment: 'I

don't know if conflict plays out, that is possibly part of the problem. Everything is fragmented. People are too busy working on different levels of knowledge to have open conflict.'

The Policy Project, a subsidiary of the Futures Group in the United States, has systematically worked with business in each province. According to a policy respondent, 'the process has been about getting groups of businesses together for an interactive workshop in different provinces, exploring the impact, updating knowledge on anti-retrovirals, what the current corporate responses are and ways to improve that'. A result of these workshops has been the formation of provincial workplace forums, but it is still too early to evaluate whether or not these have been successful.

Workplace policies and programmes

Responses within the workplace are -- not surprisingly -- variable. An academic respondent added that commonly workplaces responded in one or more of the following ways:

- prevention, health promotion, education and condom distribution;
- human resources/industrial relations – cognisance of AIDS in the workplace by gathering data and working trends, thus enabling benefit and survival support to be provided;
- management of ill-health at clinics; and
- human resource monitoring and planning by investigating absenteeism and productivity.

The 2001 Old Mutual survey notes that some 83% of the companies it surveyed provided education and awareness programmes and some 10% did nothing. It was not evident how sustained the education and awareness programmes were, nor what the content was. A few respondents noted the greater attention paid to human rights issues with the promulgation of the Constitution, and the passing of the Employment Equity Act and Medical Schemes Act.

It appears that one of the first activities that companies can engage in is to develop a workplace policy. Policy is a relatively easy response and it is evident that there are numerous generic policies that have been put in place for companies to adapt, as indicated in the legislation section of Appendix 2. It is difficult to gauge what percentage of workplaces have a workplace programme or policy dealing with HIV/AIDS. While arguably workplace policies have been part of business practice for the past ten years, workplaces are not legally obliged to have them. Many respondents suggested that companies are only now starting to put them in place as a wise business practice. Yet an academic respondent cautioned that the policies are not being made public and companies merely retain them for display in boardrooms. He suggested 'In the preamble they have a statement on non-discrimination and confidentiality, noting that they outlaw pre-employment testing. However pre-benefit testing which happens is not taken care of and during the recruitment procedure, which is done by human resources, the briefing on employee benefits is nebulous.' Employers can therefore argue that they have a workplace policy and that it is adequate. The quality of the policy, how often it is updated and whether employees engage with it is generally not scrutinised.

A respondent in the private health sector reported that one of the ways in which companies are responding to the pandemic is to do anonymous testing of employees to obtain an HIV prevalence rate and then conduct surveillance of how HIV/AIDS is impacting on the workplace.

There has been much protesting by trade unions regarding exactly what is made of the prevalence rate, how confidential test results are and how workers will benefit.

A number of respondents referred to the mining industry as having experience in this area, as it was the first sector to be confronted with HIV/AIDS. 'They have done a fair amount of work in changing attitudes, treatment, death benefits and widow pay-outs' said one respondent. Interestingly in May 2001 the mining giant Anglo American announced it was planning to provide treatment to all its workers with HIV/AIDS. Anglo Gold planned to launch a trial programme offering free AIDS drugs to 1 000 of its miners and their wives. Yet these programmes have been hampered. Pharmaceutical companies were reluctant to provide the company with free drugs and they cited the migrant labour context as an obstacle. The trial was reduced to between 200 and 800 participants (Kaiser Daily HIV/AIDS Report, 26 June 2001). It is still too early to judge how successful this programme will be but there are suggestions that treatment will be restricted to skilled office workers rather than to unskilled mine workers (Cullinan 2001). This action will increase inequality in HIV/AIDS care. In response to business, trade unions are also noting that a number of other issues need to be dealt with, along with anti-retrovirals, such as upgrading nutrition in staff canteens and improving the conditions of single-sex hostels.

Most respondents thought it was still too early in terms of the course of the epidemic to be able to discern real trends in workplace management of HIV/AIDS. Again, it appears that the responsibility for these programmes rests with human resources departments, which don't or can't give them much clout. Employees can often get out of the compulsory HIV training sessions, citing other concerns as more pressing and important. HIV training sessions are also not considered a priority, an employee assistance programme respondent related. 'Corporates don't want to pay for AIDS, but they are willing to pay in other areas. They would rather face a huge legal bill than do the right thing.'

Workplace training programmes have tended to be directed towards unskilled or blue- collar workers. This approach further entrenches the belief that 'it doesn't affect us'. One respondent suggested that middle management is being neglected and that peer educators should be systematised throughout whole companies. One NGO consultant who provides training to companies has a policy in terms of which she only accepts a contract for HIV/AIDS training if she can train the whole company, as opposed to one segment of it. She said that she had lost work in this way, but that it expressed her ideological commitment to ensuring that AIDS is not seen to impact on one section of the population only. Interestingly a few respondents said that they did not have any idea as to what was included in their workplace policy. Neither did they know what a generic workplace policy embraced. This reinforces the perception that AIDS is a concern for blue-collar workers and not for professionals, including the managers responsible for disseminating these workplace policies.

An initiative to increase awareness of HIV/AIDS in the workplace and to strengthen workplace programmes is the Greater Involvement of People Living with HIV/AIDS (GIPA) programme sponsored by the United Nations Development Programme. GIPA has 11 fieldworkers, two of whom have died (one of AIDS and another of heart failure) and another 12 who are being trained. It places workers within organisations; initially it has targeted parastatals. It has had difficulty in placing fieldworkers, as companies have not wanted to house fieldworkers.

Prevention programmes

It appears that HIV/AIDS prevention programming is not sustained throughout the year, and is often just centered on World AIDS Day in December. An employee assistance programme respondent contends that the model used for prevention, the health belief model, is simplistic and doesn't work. Information provision in itself does not change behaviour. It appears that this is the generally accepted model and yet it is unsuccessful. The respondent argues, 'there is seldom enough attention about messaging for different target groups and acknowledgement that people have different ways of hearing messages. The context of people's lives varies, for example, for many people a decision is not an individual action and people consult to make a decision'. Clearly these issues are critical to consider in workplace HIV/AIDS prevention programmes.

A private health sector respondent contended: 'In the 80s the trend was prevention by condoms, videos and posters. The same video was shown in the canteen lunchtime after lunchtime and you can't ask videos questions. There was resistance against this methodology and now it has closed doors. In the 90s we are doing behaviour change as prevention.' One of the approaches to prevention that is viewed as more successful is that of training peer educators. An NGO consultant respondent noted that while this approach makes sense it is often difficult to maintain and to sustain.

Health care

Lodhia (2001) investigated HIV benefits provided by 95 medical aid schemes (39 open and 56 closed), which together provided cover to 84% of medical aid scheme members. His preliminary analysis revealed that 67% of schemes and 66% of beneficiaries had access to disease management programmes. The proportion of beneficiaries who are covered for no more than prescribed minimum benefits is some 8%. Some 55% of beneficiaries have access to anti-retroviral therapy.

As this situational analysis was being conducted a variety of groups announced new schemes and responses. Aid for AIDS has been providing services for a number of years; others that provide similar care for people with HIV/AIDS include Mx Health, Qualsa and Lifeworks. The HIV Clinician's Society has been established, and it is linked to the international body of the same name. It appears that these clinicians advise different schemes. There was some concern expressed that case management is largely focused on drug distribution, as opposed to providing individual clinical management.

A respondent in the private health sector noted a trend that is also a concern of some employee assistance programme respondents. This relates to a transfer of responsibilities for negotiating medical aid benefits from the company to the individual. This trend means employers relinquish responsibility for negotiating group benefits and cover for employees. Individuals find the process of negotiation stressful and moreover, if HIV positive, would rather not be identified as HIV positive or vulnerable in case they risk losing benefits.

From a health care perspective one respondent noted: 'There is grossly insufficient capacity development in terms of health services, health workers hardly know a thing. The business-run occupational health care services are problematic – nurses have a very low level of understanding. The STD drugs aren't readily available and they can't provide the STD-syndromic approach.' There is a need for better regulation and the provision of permits so that nurses

can provide an essential service. Similarly occupational health clinics are not stocked with essential drugs for opportunistic infections related to HIV/AIDS.

In the context of evolving medical insurance schemes, with group schemes changing to open schemes, there has been reluctance to provide chronic illness cover including HIV/AIDS treatment. Some medical aids have taken on providing cover, or are investigating providing cover, by linking to health management groups.

With the sharp fall in the prices of anti-retroviral drugs, this form of treatment is certainly an option, and some companies have come out publicly in announcing treatment programmes for employees. Others have cautioned that it is not so easy to do so. One private health sector respondent argued, 'The Treatment Action Campaign activists has created a public perception that ARVs are like antibiotics. Government is correct – we can't have willy nilly provision. In a group of HIV-positive well-managed people, only 10% of people will need ARVs. Good health can be managed and immune systems boosted and we can delay ARV use by eight years.' Yet for the mining company Anglo American, price reduction has brought treatment 'within the realm of feasibility' (Brink 2001).

Gaps

While it is evident that there are significant processes of restructuring and transformation within the organised business sector, there is still a need for coherent leadership. HIV/AIDS is a serious threat to long-term economic and business success and needs to be managed properly. One suggestion has been that large companies could influence contractors to take the pandemic seriously by making an AIDS programme a criterion for the tender process. This would encourage leadership and responsibility.

Respondents thought that it was important that companies begin to manage care and treatment of HIV/AIDS with VCT, counselling and managed treatment, including ARVs. A respondent said, 'one loses money if one doesn't manage your assets, like machinery. We are talking about the human factor, labour. We must invest in health.'

Many respondents noted the need to work within the community, 'so that we don't land up with a destroyed social fabric and more delinquents'. Many respondents in the academic and NGO sectors would welcome this last remark as many believe that the private sector has moral obligations to provide for society. As a respondent said, 'Business has to take care of workers, the costs shift from business to the state and then to the household, business has to take responsibility as the others can't take it all on.' An academic respondent argued that there is a need for more scenario planning and for businesses to work out how they are going to live through this disease. 'Can we survive it and rethink it? What kind of society do we want to become? Our talk needs to move from less form to real content.'

Many NGO activists noted the difficulties that NGOs and consultants face, with tenders related to HIV/AIDS being given to those who are better known and people scrambling for consulting work. HIV/AIDS has turned into an industry and respondents noted there were 'commercially greedy trainers' who exploit the sector. They also expressed the concern that training was often biased by the experience and background of the trainer, which prejudiced trainees. Clear standards should be established for this work to provide a context of integrity and responsibility.

TRADE UNIONS

Leadership and organisational responses

Many respondents criticised the trade union movement for not really engaging with HIV/AIDS issues: 'it is a conspicuous failure and their involvement is belated and focussed on treatment only, what of other workplace issues?' An NGO consultant added that in his experience when running workshops within trade unions, 'the men withdrew and spoke of their fear and risky behaviour'. A number of respondents spoke about offering to work with different trade unions and being rejected. It would appear that HIV/AIDS has been a background rather than a foreground issue.

However a trade unionist respondent noted that other important issues were currently taking precedence over AIDS. These included the issues of exports, job losses, companies closing, retrenchments and wage negotiations. However, he added that the fact that the impact of HIV on provident fund benefits is included in the South African Clothing and Textile Workers' Union (SACTWU) policy document shows that it is important. While there are competing issues, the reality is that HIV/AIDS is still stigmatised and difficult to deal with in the union context. It is apparent that the movement of information from union structures down to the shop floor is not easy. Another trade unionist respondent notes the nervousness regarding HIV/AIDS amongst workers: 'if you show any absenteeism – you are the first on the retrenchment list!'

A trade unionist respondent related how AIDS has been used to justify increased benefit costs and to change from defined contributions to defined benefits with capping. He suggests that the insurance industry is running away with ideas and policies that are not based on reality and that are not regulated. He notes, 'Companies are now saying we will have defined contributions of 15%, how you sort that out is your baby and outsourcing is popular. Employers then don't take on responsibility.' Most of the work of unions has involved trying to maintain collective agreements for group insurance to spread the risk and to stop individualising the burden of insurance.

A trade unionist respondent discussed the Sactwu process of developing a comprehensive programme on HIV/AIDS and the workplace for workers in KwaZulu-Natal. This trade union is clearly a leader, as in 1999 it had already launched a three-phase programme.

There are conflicting understandings of what constitutes success. The UNAIDS best practice award for work on HIV/AIDS which Eskom received is viewed differently 'depending on where you sit'. While clearly taking action as an employer, Eskom has also been criticised. A trade unionist referred to a Labour Bulletin article which critiques Eskom's approach. A NUM shopsteward, has been quoted as saying the following, 'I have declared a dispute with the company Eskom over the treatment of one of our members who is HIV positive. She was booked off sick by her doctor and stayed at home. Eskom refused to accept the doctor's note and never paid her for three months. She was alone at home, sick, with no food because she wasn't paid. The most shocking part was that she was then asked to take ill-health retirement despite the fact that she never applied for such' (Matsepe in Meeson & Van Meelis 2000: 48). In problematising the approach of early ill-health retirement, a trade unionist argues, 'the best thing for HIV-positive people is to keep them economically active for as long as possible and to create a supportive environment'. Clearly this is a challenge for businesses, as to do so incurs costs and, as Meeson & Van Meelis (2000:49) conclude, 'the lights may be on the AIDS programme at Eskom but not everyone is sitting in the same room'. The

challenge remains how to reconcile these opposing views and how to create a synergy between the efforts of Eskom and the trade unions.

One of the responses to a labour shortage is to mechanise and to replace labour with machines. This will clearly compromise the trade union movement. A consultant respondent noted, however, that he understands that preliminary research findings in a CSIR study indicate that contrary to popular belief, machines are more expensive than people. It is apparent that machines and computers need regular updating every three years. Difficulty arises when it is perhaps cheaper to replace labour with machinery or to outsource labour as discussed earlier. A few respondents argued that this occurs within the unskilled labour category or the Pattinson A and B bands. Economists repeatedly insist for example, 'For a high-skill, labour-intensive industry it will be very costly to train replacement staff, whereas low-skill industries such as commercial cleaning will easily find replacement employees even at the height of the epidemic. Some capital-intensive industries can be more vulnerable to HIV/AIDS than labour-intensive ones, especially those in which employees specialise in operating particular machinery. 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. Coal mining, on the other hand, employs small numbers of machine operators, each performing specialised tasks, and loss of a few operators can lead to a substantial production decline' (ABT Associates 2001:13).

As discussed previously, the notion that the only issue regarding unskilled labour is ease of substitution is cause for concern in terms of South Africa's labour history. This notion is divisive and threatens equity amongst workers. The assumptions of 'replaceable' are also of concern, as the pool of unaffected unemployed is not guaranteed to remain uninfected. Similarly, workers who believe that they are viewed as dispensable will not be loyal employees.

Networking and processes

A trade unionist contended, 'Nothing is happening between government, labour and business. People are still in the process of accepting the disease. For Cosatu the 5 March 2001 campaign in support of the court case was an important mobilisation.' This is when the trade union movement for the first time came out on the streets with demands regarding HIV/AIDS. At this juncture it was petitioning government, and one of the calls was to stop the arms deal and rather, 'reduce military spending build the health system.

Many respondents in referring to HIV/AIDS and the workplace spoke of the traditional conflict between management and trade unions, but could not give examples of this taking place. It appears that it may be too early in the epidemic for conflict, or possibly HIV/AIDS is not a bread-and-butter issue for trade unions. However in July 2001 reports of industrial action by a variety of trade unions included the demand of treatment for HIV/AIDS. I would argue that this will become a serious demand that trade unions will make in subsequent negotiations.

As noted previously, companies have been doing in-house research to ascertain the prevalence of HIV/AIDS in their workforces. A number of respondents noted that trade unions have resisted this as initially blood samples were taken without workers knowing what was being done and workers were not offered anything in return. In the mining sector this work has

usually been carried out in conjunction with outreach programmes to local shebeens and sex workers. Condom distribution and regular treatment of STDs has also taken place. A problem here has been that the focus of these programmes is blue-collar workers exclusively without the targeting of white-collar workers, and as a result further stigmatising of HIV/AIDS has occurred.

The US Solidarity Trade Union Federation, a donor group which is funded by American trade unions, has an extensive HIV/AIDS training programme across the three main trade union federations, Cosatu, Fedusa and Nactu.

Workplace policies and programmes

A trade unionist related that an affiliate union has a 30-minute comprehensive HIV/AIDS educational programme, of which 10 minutes is a slide show. There has been a huge demand for the programme, it has been reviewed and adjusted over time, and trainers have been trained to use the programme. The content of the programme is the same for management and workers, men and women. The union argues that the only way to remove discrimination is to replace misperception and assumptions with facts made known to every single individual within a company/organisation.

A trade unionist respondent who has run numerous workshops within the trade union movement describes how the workers she trains complain that 'people just disappear'. She suggests that this is mainly caused by early ill-health retirement and has resulted in a culture where workers are too scared to test for HIV as they may lose their benefits.

An interesting finding has been the role that the trade union Sactwu has played in developing a generic workplace policy, which has been a worker-driven initiative. From another angle, time to work through the policy has been made as a demand during annual wage negotiations. Concern has been expressed by employers regarding the amount of time working through the policy has demanded, with a result that some workers have waived wage increases in favour of time off work to deal HIV and, in particular, to set up home-based care programmes. Apparently this arrangement took two years to negotiate. A trade unionist respondent related that one of the biggest issues is the issue of negotiating time for training.

Health care

Trade unions are dependent on the private or public sectors for the provision of health care benefits. In some affiliates there are work-based clinic options. The concerns raised in the public and private sectors would also be applicable to the trade union sector. In response to the benefit environment, a trade unionist said, 'We have 20 affiliates that we need to advise regarding packages – the increase in stigma does not help – we need to keep people employed in a positive and supportive environment. This early ill-health retirement is irresponsible. We need to protect minimum benefits, working with the Life Offices Association and Actuarial Association of South Africa.'

Gaps

Evian (2000:164) suggests that 'workers will bear the brunt of this plague'. He notes that within the trade unions, industry issues of wages, safety and jobs have up to now been viewed as more pressing. As a result, he suggests that 20-35% of trade union membership is likely to die prematurely from AIDS. Within the workplace, safety is valued. Deaths and injuries are monitored and become the subjects of enquiry and protest. However, morbidity from HIV/AIDS seems to have been assigned a much lesser value and the lives lost from this disease do not evoke the same sadness and anger. It is therefore crucial that the trade union movement move campaigning about HIV/AIDS from the background to the foreground.

Describing the difficulties of ensuring immediate constructive action a trade unionist said: 'There is a need for the whole issue of HIV/AIDS to be addressed comprehensively immediately. I find that even though I have a detailed step-wise implementation plan that there is a demand to do everything today. Unfortunately due to financial constraints it is impossible to do everything today and there is a need to address the different components in a strategic way. The gap that I wish could be addressed immediately is the issue of making anti-retrovirals accessible to PWAs immediately. This will change the approach to the whole programme in that HIV will then become a chronic manageable disease. Unfortunately for this enormous financial resources are essential immediately, not only for the drugs but also to establish an infrastructure to deliver the anti-retrovirals. For this reason I find it impossible to be able to provide the essential drugs to our workers. However, I do believe that this is achievable if it is approached in a joint manner by the integral stakeholders, viz. government, labour and business, and my plan is to put forward a proposal for this kind of venture to the stakeholders very soon.'

Treatment and systems to provide the treatment are bound to become an item at the negotiating table soon.

CONCLUSION

Leadership

There is the need for strong, bold and coherent leadership in all sectors of society. Most respondents have asked for government to take the lead in this area. While government has provided a good legal and policy framework, this needs to be matched by an implementation strategy, which includes an allocated budget. At the same time the private/business sector and the trade union movement need to ensure that HIV/AIDS is a foregrounded issue and that it is the concern of the most senior leaders in their sectors. Similarly there is a need to view the issue of HIV/AIDS in the workplace within a broader frame of reference and to keep in mind the role of healthy workplaces in society. By sustaining workplaces, which are supportive of individual employees, one sustains households and in turn communities which make up the broader society.

A key issue to investigate is what best practice would be for South Africa. HIV should be part of the strategic plan of every organisation and should be matched with a budget and an action plan. There is the need for a coherent leave strategy to take account of absenteeism and workers' needs. Many respondents were concerned about the small and medium micro-enterprise (SMME) sector of the economy and noted its particular vulnerability.

Data

Many respondents across sectors argued for better data that will be more useful for planning. The data need to be independent, open to scrutiny and separate from private interests. Data need to be presented as part of a strategy and should be presented in a form which is enabling. A trade unionist said, 'We need baseline research on the benefit industry and impact assessment to ensure the viability of existing funds and to plan for the future. Every action is a positive action in itself and one should not be paralysed by the impact of the epidemic but should convert the negative energy into a drive to keep pushing forward. Doing something is always better than doing nothing at all.' And a representative of the business and policy sector related, 'We are still learning while working for a better future. We need to interrogate what makes the most difference, what are the key priorities – what is the effect of each rand spent. We can be discouraged by the big picture and the short-term failures – but we are putting down the foundations for big gains.' A medical consultant commented, 'It is not good enough just doing prevalence [studies]. It has to be done in the context of a programme, on its own it is pretty useless. We have to work with the unions. Most prevalence work shuts people up, they split off and don't do anything.'

Implementation

Currently there is a rights-based framework upon which policies and legal precedents are being established. The rights-based framework needs to be protected and workplace policies need to be implemented within this framework. Most respondents suggested that workplace programmes had not changed over time and that there had not been a body of experience from which to learn. It has been shown through this report that serious implementation of workplace policies and programmes has not taken place. While pre-employment testing has been dealt with, the growing recognition that there is a need to offer treatment still merits consideration, along with issues of implementation of policy.

Human resources

Many respondents noted strategic failures in managing HIV/AIDS in the workplace as there hasn't been centralised responsibility and commitment within organisations. Responsibility for HIV/AIDS programmes has resided within human resources departments and as such, HIV/AIDS has been given limited importance by many organisations. As a result workplace policies and programmes are developed devoid of a management strategy and a context. This situation needs to be remedied and there needs to be clear executive and financial commitment in workplaces.

Collaboration

Respondents in different sectors thought that alliances and networking would be helpful, although many in the NGO sector thought that they wouldn't. As noted in the networking and processes section, funders have targetted different sectors to organise and conduct training: USAID (Policy Project) --business sector; US Solidarity trade unions; and Interfund;NGOs. There appears to be very little co-ordination and sharing between the sectors, or even the setting up of loose networks to enable organisations to support and learn from each other.

Individualising of benefits

This issue was raised by a number of respondents. Individuals often have to negotiate for benefits directly with insurance companies, as opposed to their companies taking responsibility for this. While this move has been part of the trend of moving from defined benefits to defined contributions, it has left employees more vulnerable. Many respondents noted the need for a new generation of benefit models, which are affordable and enabling. It is apparent that many individuals are losing cover through pre-benefit testing. This action disadvantages employees, as their welfare is not being catered for by their employers.

Inequality within benefits

There is a growing realisation that HIV/AIDS treatment is affordable and cost effective in managing the health of employees. At the same time economists are estimating for which categories of employees the benefit would be most cost effective. The possibility of offering treatment to some and not to others arises. This clearly is of concern in terms of equity and discrimination. Businesses could avoid this issue by outsourcing work involving lower levels of staff, yet some entity will still have to care for such employees. While businesses have to be economically viable, treatment of employees needs to be fair and responsible. The provision of benefits could be considered a fiduciary duty of management. Balancing these issues needs careful consideration.

Are we replaceable?

The notion that businesses will be able to cope with the HIV/AIDS pandemic because of 'the ease of substitution' was raised by a few respondents and is also reported in the literature. This rationale is neither positive nor constructive. The possibility is remote that there is an endless pool of workers who are uninfected and who can be used to fill vacancies. Businesses need to work with what they have and to access disease management programmes in order to maintain a healthy workforce.

Appendix one

Interviews were conducted with the following people:

	Name	Affiliation	Sector
1	Adelaide De Broize	Consultant	NGO
2	Peter Busse	Consultant	NGO
3	Mark Heywood	AIDS Law Project, Wits University	NGO/Academic
4	Ruth Van Der Vindt	US Solidarity Centre	Trade union
5	Jan Mlhangu	Cosatu employee benefits	Trade union
6	Theo Steel	Cosatu campaigns	Trade union
7	Firoza Mansoor	Sactwu medical officer	Trade union
8	Ria Schoeman	Department of Health	Government
9	Rose Smart	Department of Health/consultant	Government
10	Frans Moetshe	Department of Labour	Government
11	Clive Evian	Johannesburg Hospital/consultant	Medical
12	Stephen Laverack	MedScheme – AID for AIDS	Private health provider
13	Danie Katz	Discovery Health – actuary	Private health provider
14	Jack Van Niftrik	Lifeworks	Private health provider
15	Melanie Judge	The Policy Project	Consultant/policy
16	Anthony Kinghorn	ABT Associates	Consultant policy
17	Mary Crewe	Centre for the Study of AIDS, University of Pretoria	Academic
18	Alan Whiteside	HEARD, University of Natal/consultant	Academic/consultant
19	Rob Dorrington	Actuarial Association of South Africa/ University of Cape Town	Academic/financial services
20	Pierre Brouard	ICAS	EAP
21	Gillian Gresak	Human Dynamics	EAP
22	Engela Roos	Mx Health	Private health provider
23	Brian Wasnuth	SACOB	Private sector
24	Stephen Kramer	Metropolitan Life	Private sector - insurance
25	Rachan Lachman	Metropolitan Life – employee benefits	Private sector - insurance
26	Desiree Daniels	Old Mutual	Private sector - insurance
27	Julia Hill	GIPA	Donor

Appendix two

Legal codes and policies in relation to HIV/AIDS and the workplace

AIDS Law Project documentation

HIV and Employment Code of Good Practice
http://www.hri.ca/partners/alp/

South African Development Community Code

In September 1997 the Southern African Development Community (SADC) Council of Ministers approved a SADC code on AIDS and employment, which is, however, not legally binding. The code is based on fundamental principles of human rights and patient rights, and aims to ensure that the guiding principles of the code are reflected in the law. With regard to occupational benefits it states that:

> Governments, employers and employee representatives should ensure that occupational benefits are non-discriminatory and sustainable and provide support to all employees, including those with HIV infection. Such occupational benefits schemes should make efforts to protect the rights and benefits of the dependants of deceased and retired employees.
>
> Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.
>
> Medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status.
>
> Counselling and advisory services should be made available to inform all employees on their rights and benefits from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums of these funds. (SADC 1997: Principle 7)

Congress of South African Trade Unions Special Congress

The Congress of South African Trade Unions (Cosatu) is the largest federation of trade unions in South Africa and has been more active in terms of HIV/AIDS than Fedusa and Nactu, the other major trade union federations. Cosatu began to take action about HIV/AIDS in the late 1990s. The first significant advocacy recorded on its website is the Cosatu submission in 1998 to the Parliamentary Portfolio Committee on Health in support of the Medical Schemes Bill. The Medical Schemes Bill made provision for pre-medical aid benefit HIV/AIDS testing to be declared illegal. In its conclusion the submission notes, 'Cosatu remains supportive of the objects of the Bill and the Minister's efforts to transform health care in South Africa so that it is accessible to all.'

In August 1999 Cosatu organised a special congress on HIV/AIDS and released the following declaration on HIV/AIDS:

> This Special Congress of Cosatu notes the relentless advance of HIV and AIDS since the 1997 Congress. 3,5 million people in South Africa are infected with the human immuno-deficiency virus (HIV). Life expectancy in South Africa will reduce to 40-45 over the next ten years and health care costs will be beyond the capacity of survivors to pay for. It is now clear that publicity and condom distribution, though important, are not enough. This requires a new approach and strategy, based on a partnership between government and civil society in which the organised working class should play a leading role.

Against this background, Congress adopts the following:

1. HIV/AIDS to be declared a national emergency by the government.
2. Cosatu will run a systematic education programme both on prevention and to raise awareness amongst Cosatu members of the information about HIV/AIDS treatment and care.
3. Cosatu will develop and distribute information and training packs for shop-stewards and union leaders which include guidance on giving positive assistance to workers living with HIV/AIDS [and who are] affected by discrimination.
4. It will develop, with the assistance of specialist AIDS organisations, counselling and other services to union members and staff.
5. Cosatu will engage bargaining councils on the issue of funds and to ensure that Sector Education and Training Authorities are linking education and the issue of HIV/AIDS.
6. Cosatu will continue to work with the Treatment Action Campaign to campaign:
   - in support of the government's progressive legislation on medicines;
   - against multinational pharmaceutical companies which make huge profits on medicines;
   - for Cosatu's existing policy on accessible primary health care and basic needs such as clean water, critical in prolonging the life of people living with HIV/AIDS.
7. Cosatu will fight to ensure that the minimum benefits under the Medical Schemes Act provide affordable and effective treatment benefits for people with HIV/AIDS.
8. Cosatu will continue to work in the most vulnerable sections of the working class such as transport workers, migrant workers, and workers in the single sex hostels should be intensified.
9. We re-affirm the Exco decision that, as part of fighting the silence of those who are living with HIV/AIDS, Cosatu will encourage its leadership and members to voluntarily take the HIV/AIDS test and break the silence. A new culture of openness will be encouraged, including encouraging parents to talk openly to their children, friends, and relatives about this epidemic and the need to use condoms.
10. Cosatu will campaign for provision of a supportive environment for workers and people living with HIV/AIDS. It will support the rights of people living with HIV/AIDS to confidentiality.

11 Cosatu will continue to fight against discrimination based on any unfair grounds, including HIV/AIDS status. In this regard, Cosatu will make a submission to the equality legislation, and call for the improvement of the Employment Equity Act to protect the rights of people living with HIV/AIDS.

12 A more detailed Cosatu policy must be developed, to be tabled at the next central committee meeting. Such a policy must also relate to the bigger question imposed by the epidemic, given our poor social security net. Cosatu must carry out a study on the socio-economic impact the epidemic will have on the country. This should be linked to the issue of affordability and availability of drugs such as AZT that prolong the life of those carrying the disease.

13 For this programme to succeed, Cosatu must invest both human and material resources. The Health and Safety Unit of the federation must co-ordinate the programme. (www.cosatu.org.za)

UN Platform of Action

In June 2000 a special high-level United Nations meeting on HIV/AIDS was held. As a result a Platform of Action on HIV/AIDS in the Context of the World of Work in Africa was agreed upon. The Platform is a comprehensive document reviewing goals, common values, partnerships and action to be taken. Section IV noted the following:

In order to achieve these goals, actions backed by strong African political, religious, traditional and community leadership and commitment should focus on:

1 Fighting the culture of denial;

2 Raising national awareness of the incidence and impact of the pandemic through, among other things, information, education and communication;

3 Eliminating the stigma and discrimination attached to HIV/AIDS by adopting and applying the International Labor Organisation's international labour standards and national labour legislation;

4 Documenting and disseminating information and statistical data through effective labour market information systems;

5 Strengthening the capacity of the social partners to address the pandemic;

6 Empowering women economically, socially and politically in order to reduce their vulnerability to HIV/AIDS;

7 Promoting the transformation of gender roles, norms and social structures;

8 Integrating HIV/AIDS in existing social security schemes and developing new ones to ensure coverage for all;

9 Building capacity to address the dilemma facing AIDS orphans and children exposed to infection or forced into child labour;

10 Incorporating HIV/AIDS considerations into the national development agenda and budget allocations;

11 Creating a rapid response mechanism to mitigate against the implications of the epidemic;

12 Promoting income and employment opportunities for persons living with HIV/AIDS and their families through, for example, informal sector and small enterprise development;

13 Strengthening occupational safety and health systems to protect groups at risk;

14 Formulating and implementing social and labour policies and programmes that mitigate the effect of AIDS;

15 Effective mobilising resources;

16 Improving availability and affordability of drugs;

17 Incorporating HIV/AIDS in collective bargaining agreements.
(www.ilo.org/public/english/standards/relm/ilc/ilc88/aids.htm)

South African Code of Good Practice

In December 2000 the South African government published a Code of Practice on Key Aspects of HIV/AIDS and Employment to provide guidelines for employers and employees regarding non-discriminatory behaviour. With regard to employee benefits, the following is noted:

10.1 Employees with HIV or AIDS may not be unfairly discriminated against in the allocation of employee benefits.

10.2 Employees who become ill with AIDS should be treated like any other employee with a comparable life-threatening illness with regard to access to employee benefits.

10.3 Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or other party.

10.4 Where an employer offers a medical scheme as part of the employee benefit package it must ensure that the scheme does not unfairly discriminate, directly or indirectly, against any person on the basis of his or her HIV status.(www.gov.za)

International Labor Organisation

The International Labor Organisation (ILO) has produced a code of practice on HIV/AIDS and the world of work in 2001. It is a comprehensive document of some 45 pages. It builds on the work of the UN document and the SADC Code. A number of these issues are pertinent to the South African context and are discussed in this report. Some of these include:

1 With regard to training it is suggested that training be targeted at, and adapted to, the different groups being trained. They include all levels of employees, including management (2001:15).

2 With regard to training for managers, supervisors and personnel officers, the ILO Code argues that in addition to participation in information and education programmes directed at them, they should receive training to enable them:

- to explain and respond to questions about the workplace's HIV/AIDS policy;
- to help other workers overcome misconceptions about the spread of HIV/AIDS in the workplace;
- to explain reasonable accommodation options to workers with HIV/AIDS, so as to enable them to continue to work as long as possible;

- to identify and manage workplace behaviour, conduct or practices which discriminate against or alienate workers with HIV/AIDS;
- to advise about health services and social benefits which are available to them. (2001: 15,16)

3 With regard to training for workers' representatives the Code argues that workers should receive comprehensive training during paid working hours.

4 With regard to testing the Code notes, 'Testing for HIV should not be carried out at the workplace except as specified in this code. It is unnecessary and imperils the human rights and dignity of workers: test results may be revealed and misused, and the informed consent of workers may not always be fully free or based on an appreciation of all the facts and implications of testing. Even outside the workplace, confidentiality testing for HIV should be the consequence of voluntary informed consent and performed by suitably qualified personnel only, in conditions of strictest confidentiality' (2001:19).

5 With regard to employment testing the Code argues, 'HIV testing should not be required at the time of recruitment or as a condition for continued employment. Any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or on a regular basis for workers, should not include mandatory HIV testing' (2001:19).

6 In relation to testing for insurance the Code argues, 'HIV testing should not be required as a condition of eligibility for national social insurance schemes, general insurance policies, occupational schemes and health insurance. Insurance companies should not require HIV testing before agreeing to provide coverage for a given workplace. They may base their cost and revenue estimates and their actuarial calculations on available epidemiological data for the general population. Employers should not facilitate any testing for insurance purposes and all information that they already have should remain confidential' (2001:19).

7 With regard to benefits the Code notes, 'Governments, in consultation with the social partners, should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses. They should also explore the sustainability of new benefits, specifically addressing the progressive and intermittent nature of HIV/AIDS. Employers and employers' and workers' organisations should pursue with governments the adaptation of existing benefit mechanisms to the needs of workers with HIV/AIDS, including wage subsidy schemes' (2001:22).

8 With reference to social security the Code adds, 'Governments, employers and workers' organisations should take all steps necessary to ensure that workers with HIV/AIDS are not excluded from the full protection and benefits of social security programmes and occupational schemes' (2001:23). (www.ilo.org)

REFERENCES

Abt Associates. 2001. *Impending Catastrophe Revisited: an Update on the HIV/AIDS Epidemic in South Africa*. Johannesburg: Kaiser Family Foundation.

Bisseker, C. 2001. First AIDS risk cover for companies. *Financial Mail*. August 2001. www.bdfm.org

Brink, B. 2001. Mining giant to provide treatment for workers. Nairobi: UN Integrated Regional Informational Network. All Africa.Com List.

Broomberg, J., Steinberg, M., Masobe, P. & Behr G. 1991. *AIDS in South Africa: The Demographic and Economic Implications*. Johannesburg: Centre for Health Policy.

Congress of South African Trade Unions. 2001. www.cosatu.org.za

Cornell, J. 1984. Workplace health services and employment in the manufacturing industry in greater Cape Town. *Labour Bulletin*, 9(7), pp. 42-59

Chambers, R. 1989. Editorial introduction: Vulnerability, coping and policy. *IDS Bulletin* 20(2): pp. 1-7.

Clarke, E. & Strachan, K. (eds) 2000. *Everybody's Business: The Enlightening Truth about AIDS*. Cape Town: Metropolitan Life.

Cullinan, K. 2001. 'NUM proposes HIV summit'. Healthe news. 19 October 2001. www.healthe.org.za

Doyle, P. 1997. HIV and employee benefits: Where to from here? In Clarke, E. and Strachan, K. (eds) *Everybody's Business: The Enlightening Truth about AIDS*. Cape Town: Metropolitan Life, pp. 250-252.

Doyle, P. 2000. Aids and insurance. In Clarke, E. and Strachan, K. (eds) *Everybody's Business: The Enlightening Truth about AIDS*. Cape Town: Metropolitan Life, pp. 227-229.

Evian, C. 2000. AIDS in the workplace. In Clarke E. and Strachan K. (eds) Everybody's Business: *The Enlightening Truth about AIDS*. Cape Town: Metropolitan Life, pp. 178-181.

Goudge, J. & Govender, V. 2000. *A Review of Experience Concerning Household Ability to Cope with the Resource Demands of Illhealth and Health Care Utilisation*. Equinet Policy Series No.3. Harare: Training and Research Support Centre (TARSC).

Harvard University. 2001. *Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries*.

Heywood, M. and Cornell, M. 1998. Human rights and AIDS in South Africa: From rights margin to left margin. *Health and Human Rights* 2(4), pp. 61-83.

Heywood, M. 2000a. *HIV/AIDS and the World of Work in South Africa – 'Much Ado about Nothing'*. A Report for the International Labor Office. Johannesburg: AIDS Law Project.

Heywood, M. 2000b. *A Human Rights Approach to AIDS Prevention at Work*: The Southern African Community's Code on HIV/AIDS and Employment. Geneva: UNAIDS.

International Labor Organisation. 2001. *An ILO Code of Practice on HIV/AIDs and the World of Work*. Geneva: International Labor Office.

International Labor Organisation. www.ilo.org

Kaiser Foundation. 2001. Mining company testing efforts hampered by migrant labour system. Daily HIV/AIDS report. 26 June. www.kaisernetwork.org/email

Kinghorn, A. 2000. HIV/AIDS and development. In Clarke E. & Strachan K. (eds) Everybody's Business: *The Enlightening Truth about AIDS. Cape Town*: Metropolitan Life, pp. 87-90.

Kramer, S. 2001. HIV/AIDS: *Disclosing the Impacts in Corporate Financial Statements*. Cape Town: Metropolitan Life.

Lodhia, M. 2001 *An Investigation into the Benefits Offered to HIV/AIDS Members of Medical Schemes*. Cape Town: Actuarial Department, UCT.

Lowenson, R. 2001. *'Activist wants taxes for AIDS fight'. Ed. Margie Inggs. Business Report*. 10 June 2001.

Meeson, A. and Van Meelis, T. 2000. Practising in parallel not the best practice. *SA Labour Bulletin*, 24(2), pp. 44-49.

Myslik, W. 2000. Managing the impact of HIV on businesses. *Occupational Health Southern Africa*, 6(2), pp14-17.

Old Mutual. 1994. *The Old Mutual Health Benefits Survey*. Cape Town.

Old Mutual. 1995. *The Old Mutual Health Benefits Survey*. Cape Town.

Old Mutual. 1997. *The 1997 Health Benefits Survey*. Cape Town.

Old Mutual. 1999. *The Old Mutual Health Care Survey*. Cape Town.

Old Mutual. 2001. *Looking Beyond the Obvious: The Old Mutual Health Care Survey*. Cape Town.

Rosen, S., Simon, J., Thea, D., MacCleod, W. & Vincent, J. 2001. The impact of HIV/AIDS on businesses in Southern Africa. Presentation at HEARD seminar. July 2001.

South African Business Council on HIV/AIDS (SABCOHA) 2000. *A South African Business Response to the HIV and AIDS Epidemic*. Pretoria:Business Plan.

Schneider, H., Blaauw, D., Dartnell, E., Coetzee, D.J & Ballard, R.C. 2001. 'STD Care in the South African Private Health Sector.' S*outh African Medical Journal* 91: pp.151-156.

Simon, J., Rosen, S., Whiteside, A., Vincent, J. and & Thea, M. D. 2000. 'The response of African businesses to HIV/AIDS'. *In HIV/AIDS in the Commonwealth 2000/2001*. pp. 72-78.

Abt Associates. 2001. *Impending Catastrophe Revisited: an Update on the HIV/AIDS Epidemic in South Africa*. Johannesburg: Kaiser Family Foundation.

Bisseker, C. 2001. First AIDS risk cover for companies. *Financial Mail*. August 2001. www.bdfm.org

Brink, B. 2001. Mining giant to provide treatment for workers. Nairobi: UN Integrated Regional Informational Network. All Africa.Com List.

Broomberg, J., Steinberg, M., Masobe, P. & Behr G. 1991. *AIDS in South Africa: The Demographic and Economic Implications*. Johannesburg: Centre for Health Policy.

Congress of South African Trade Unions. 2001. www.cosatu.org.za

Cornell, J. 1984. Workplace health services and employment in the manufacturing industry in greater Cape Town. *Labour Bulletin*, 9(7), pp. 42-59

Chambers, R. 1989. Editorial introduction: Vulnerability, coping and policy. *IDS Bulletin* 20(2): pp. 1-7.

Clarke, E. & Strachan, K. (eds) 2000. *Everybody's Business: The Enlightening Truth about AIDS*. Cape Town: Metropolitan Life.

Cullinan, K. 2001. 'NUM proposes HIV summit'. Healthe news. 19 October 2001. www.healthe.org.za

Doyle, P. 1997. HIV and employee benefits: Where to from here? In Clarke, E. and Strachan, K. (eds) *Everybody's Business: The Enlightening Truth about AIDS*. Cape Town: Metropolitan Life, pp. 250-252.