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The Definition and Utilisation of Best Practice HIV/AIDS Interventions in Large South African Companies

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A research report submitted to the Faculty of Commerce, Law and Management, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Business Administration.

Johannesburg
May, 2007

ABSTRACT

The ubiquitous effect of HIV/AIDS on workplaces in South Africa has increased the pressure on large companies to implement effective responses to the disease. As companies have begun to explore workplace interventions, several theoretical guidelines or codes of practice have come into existence and with this, the concept 'best practice' has been brought into the spotlight.

With limited precedent to establish what 'best practice' really means, contemporary HIV/AIDS literature has yet to establish a clear understanding of the concept. As a result, critical questions have been raised around the value of 'best practice' in the workplace programmes of large South African companies and there has been a call for 'best practice' interventions to be more precisely defined.

The research had two primary objectives. The first was to establish a greater level of understanding regarding the meaning of 'best practice' and of the specific interventions that make-up successful workplace programmes. The second was to determine the value of the 'best practice' in promoting and managing effective workplace programmes.

The research employed an interpretive analysis as part of a qualitative methodology over a period of ten months. An in-depth thematic analysis of fourteen codes and guidelines and several 'best practice' documents formed the basis of interview research instruments. Data was collected during a series of thirty-nine in-depth interviews across twenty-one large companies and fifteen workplace HIV/AIDS experts, consultants and service providers. A focused research questionnaire - based on overlapping content in the codes and guidelines - was used to establish views regarding specific workplace interventions and to verify the existence of nine principal components of successful workplace programmes.

The investigation of a wide range of perceptions and organisational factors found to affect the uptake and continuity of 'best practice' allowed for a greater understanding of the concept 'best practice' within the context of workplace HIV/AIDS programmes and enabled the development of a generic conceptual framework for companies to use in evaluating 'best practice' interventions. Within this, the research identified a specific need for renewed focus on the measurable outcomes and intensified efforts in promoting the continuous improvement of workplace HIV/AIDS interventions.

DECLARATION

I, Ronald Whelan, declare that this research report is my own unaided work. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other institution.

Ronald Whelan
01 May 2007

DEDICATION

To Mel for your enduring love and support.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
DMP	Disease Management Programme
DOH	Department of Health (South Africa)
DOTS	Directly Observed Treatment Short-course
EAP	Employee Assistance Programme
EEA	Employment Equity Act
FHI	Family Health International
GBC	Global Business Coalition on HIV/AIDS
GRI	Global Reporting Initiative
HIV	Human Immunodeficiency Virus
IFC	International Finance Corporation
ILO	International Labour Organisation
KAP	Knowledge, Attitudes and Practices
LRA	Labour Relations Act
MER	Monitoring, Evaluation and Review
MERR	Monitoring, Evaluation, Review and Reporting
NEDLAC	National Economic Development and Labour Council
NGO	Non Government Organisation
OHS	Occupational Health and Safety
PEP	Post-Exposure Prophylaxis
PLWA	Person Living with HIV/AIDS
PWA	Person with AIDS
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern African Development Community
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAG	Department of Labour Technical Assistance Guidelines
TB	Tuberculosis
TMPs	Traditional Medical Practitioners
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

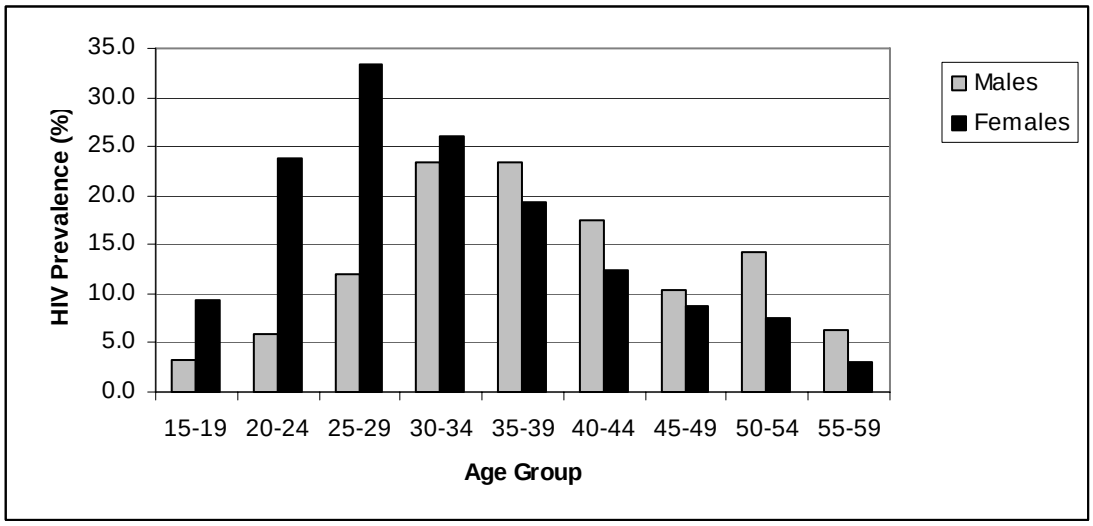
1 INTRODUCTION

1.1 Context of the Research

The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that Sub-Saharan Africa remains: the 'global epicentre' of the AIDS pandemic (UNAIDS, 2006:6). In South Africa, alone, the reported national prevalence rates are as high as 29.5 percent in certain age profiles (Department of Health, 2004); and overall estimates of the number of people living with HIV/AIDS range between 4.9 and 6.1 million (UNAIDS, 2006). Moreover, despite suggestions that the epidemic has reached a stabilisation phase; the prevalence of HIV continues to climb after more than a decade of epidemiological measurement (Department of Health, 2003 and 2004).

Within corporate South Africa, the high level of prevalence amongst persons of working age (Figure 1.1) means that companies can no longer suppose that HIV/AIDS is limited to marginalised populations (GBC, 2006c).

Figure 1.1 HIV Prevalence Working Age Persons (15 years to 59 years), South Africa 2005



Adapted from Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste, and Pillay, 2005

Accordingly, companies have begun to access a variety of HIV/AIDS management programmes (Connelly and Rosen, 2006; DuPreez, 2005; Family Health International (FHI), 2002; Stevens, Apostollelis, Napier, Scott and Gresak, 2006) and are

experimenting with a variety of workplace interventions (Dickinson, 2004; Dickinson and Stevens, 2005; Rosen, Vincent, Macleod, Fox, Thea, and Simon, 2004). This has resulted in companies exploring various information channels.

Unsurprisingly, as the interest in workplace HIV/AIDS strategies has broadened, companies have increasingly begun to look for interventions that deliver favourable outcomes at the lowest possible cost. In an attempt to guide the response of companies to HIV/AIDS in this quest, several codes and guidelines have begun to promote a range of examples of 'best practice'

Despite Vass (2004) suggesting that the principles of what constitutes 'best practice' are broadly recognised, Dickinson (2005) argues that these remain widely open to ideological interpretation. Moreover, despite a range of formal 'best practice' guidelines that have been developed (The Department of Health, 1998; The National Economic Development and Labour Council (NEDLAC), 2002; UNAIDS, 2000e; FHI, 2002; The International Finance Corporation (IFC), 2002; The International Labour Organisation (ILO), 2002; The Global Reporting Initiative (GRI), 2003; Department of Labour, 2003; GBC, 2005), according to Vass (2004), the connection between the guidelines and implemented 'best practice' has remained tenuous.

In view of the relative youthfulness of the field of study and the limited precedent with which to establish what 'best practice' really is, these observations are somewhat unsurprising. Of greater concern is the potential for a greater number of questionable 'best practice' interventions to emerge if 'best practice' workplace interventions are not accurately characterised.

Dickinson (2003) points to the fact that there have been few objective evaluations of programmes to assess the quality of HIV/AIDS programmes in the workplace. The absence of well-known and acceptable standards against which to evaluate interventions, as well as the failure to measure compliance to such standards, is seen by Vass (2004) as an impediment to widespread corporate behavioural change and the uptake of effective workplace HIV/AIDS interventions in South African workplaces.

Toward this end, Vass (2004) asserts that standards need to be developed in terms of key HIV/AIDS interventions commonly practised in the workplace. The Global

Reporting Initiative (GRI) concurs with the view that there is a need for agreed standards so that corporate performance on HIV/AIDS may be benchmarked and compared (GRI, 2003). However, the IFC Good Practice publication cautions against the hurried establishment of rigid standards of practice; it acknowledges that the discernment of 'best practice' remains a learning process and, suggests that it may be too soon to judge the success of various programmes and initiatives (IFC, 2002).

However, as corporate reporting on HIV/AIDS becomes more integral to listed companies (GRI, 2003; Fakier, 2004) and as the drive continues toward good corporate governance in large South African companies (King, 2002; Dickinson and Stevens, 2005), the researcher expected that there would be a greater demand for ways in which to objectively evaluate workplace HIV/AIDS interventions against specific 'best practice' benchmarks and recognised standards of practice.

An evaluation of the current status of 'best practice' interventions, therefore, represented an important step in developing a greater understanding of the concept, 'best practice' and value of 'best practice' interventions in the management of workplace HIV/AIDS programmes in large South African companies.

1.2 Purpose of the Research

The purpose of the research was to evaluate 'best practice' HIV/AIDS interventions in large South African companies. More specifically, the research aimed to explore the overall value of 'best practice' in managing HIV/AIDS in the workplace and to establish a greater shared-understanding of the concept 'best practice' within the context of workplace HIV/AIDS programmes.

The research also sought to establish what the level of agreement was among company managers, consultants, experts and service providers regarding the principal components of comprehensive workplace HIV/AIDS programmes. Together with the development of a conceptual framework for objectively evaluating various examples 'best practice', the findings in this area facilitated an investigation of the factors that were found to affect the uptake and continuity of 'best practice' interventions in large South African companies.

The report was, therefore, structured in accordance with achieving four main objectives:

- determining the value of ‘best practice’;
- defining ‘best practice’;
- establishing what the principal components of successful workplace HIV/AIDS programmes are; and
- determining the factors that affect the uptake and continuity of ‘best practice’

1.3 Research Problem

The research problem was to determine what value, the concept ‘best practice’ had in the management of HIV/AIDS workplace programmes in large South African companies. As part of this investigation, the research also aimed to develop an in-depth conceptual understanding of ‘best practice’, to determine the principal components of successful workplace HIV/AIDS programmes and to investigate the factors that affect the uptake and continuity of ‘best practice’ interventions.

1.4 Research Questions

The first question

What were the perceptions, both positive and negative, of company managers, consultants, experts and service providers with regards to the concept, ‘best practice’, and the use thereof in the management of workplace HIV/AIDS programmes in large South African companies?

The second question

Where did large South African companies acquire information on ‘best practices’ for workplace HIV/AIDS programmes?

The third question

Was there agreement between the content included in codes and guidelines and the perception of HIV/AIDS managers regarding the principal components of comprehensive workplace HIV/AIDS programmes and, if so; what were these components?

The fourth question

What were the factors that influenced the uptake of ‘best practice’ interventions in the workplace HIV/AIDS programmes of large South African companies?

1.5 Significance of the Study

The research explored the value of ‘best practice’ in the management of workplace HIVAIDS programmes in large South African companies. More specifically, the research determined the usefulness of ‘best practice’ for HIV/AIDS managers and company decision-makers in designing and implementing various workplace interventions. In doing this, the research was also able to establish whether examples of ‘best practice’ promoted the uptake and implementation of successful workplace interventions.

By exploring a wide range of opinions regarding the concept ‘best practice’, the researcher was able to develop a fundamental understanding of the concept and principles of ‘best practice’. This allowed for the development of a conceptual representation of ‘best practice’ and a framework within which HIV/AIDS managers and decision-makers could objectively question and evaluate various examples of ‘best practice’ when implementing and/or modifying aspects of their programmes.

Furthermore, the research established what the level of consensus was for the principal components of successful workplace programmes. The juxtaposition of the outcomes from an in-depth analysis of the codes and guidelines with the outcomes from research content analysis allowed for agreement to be reached regarding certain ‘best practice’ interventions.

George and Whiteside (2002) suggest that practice benchmarks provide an outline within which companies can develop their responses to the epidemic. Toward this end, a greater understanding of the factors affecting the uptake of ‘best practice’ as a benchmark, was hoped to promote the success of future efforts at distributing apposite information to companies regarding accepted standards of practice and regarding specific HIV/AIDS interventions.

1.6 Limitations and Delimitations of the Study

The study was confined to twenty-one large businesses and fifteen consultants, experts and service providers in the Republic of South Africa. As activities may be varied both within and between countries, the results of the research may, therefore, not be applicable to other countries or regions.

The study was also limited to companies which had already implemented workplace HIV/AIDS programmes and to individuals with an in-depth knowledge of HIV/AIDS in the workplace. As a result, the findings may have been weighted in favour of the cognitive biases of experienced HIV/AIDS practitioners and researchers.

A number of reports (Boldrini and Trimble, 2006; Connelly and Rosen, 2004; Dickinson, 2004; Ellis, 2006; Ellis and Terwin, 2004; Ellis and Terwin, 2005; FHI, 2002; Fraser, Grant, Mwanza and Naidoo, 2003; SABCOHA, 2002; Ellis and Terwin, 2004; Ellis and Terwin, 2005; Stevens, Weiner, Mapolisa and Dickinson, 2005) indicate that, because medium-sized and smaller companies are unlikely to have the resources to sustain comprehensive HIV/AIDS programmes, the response of smaller companies continues to lag behind that of larger corporations. Therefore, in establishing benchmarks of 'best practice', the research findings may be more applicable – but not entirely limited - to large private and public-listed companies in South Africa.

The researcher also recognised that government is, not only a vehicle for the provision of policy (Fakier, 2004), but also one of the largest employers in South Africa. However, because government operates differently from the private sector with regards to employment practices and labour capacity (Majors, 2004), the researcher elected not to explore the perception of the workplace HIV/AIDS programme managers within state enterprises.

The study was not, in principle, concerned with HIV/AIDS strategies founded outside the realms of the workplace including: HIV/AIDS education in schools, mother-to-child/vertical transmission, intravenous drug users, commercial sex workers and employee dependants. Some of these aspects may, however, have been dealt with along the dimension of workplace interventions that extended into the community or included employee dependants.

Despite vaccines for HIV/AIDS in the phase of clinical trials, a vaccine or cure could not be planned for (Doyle, 2006). Because of this uncertainty, the study did not consider the implications of vaccine research and development.

Furthermore, the research did not explore the matter of conformance or accreditation; rather, it aimed to assist managers and researchers in the self-evaluation of 'best practice' workplace HIV/AIDS interventions.

1.7 Structure of the Report

Chapter 2 provides a review of the literature connected to the research problem. The chapter begins with an examination of the effects of HIV/AIDS on South African businesses and of the high-level strategies that have been applied to counter these effects. In addition, the various codes and guidelines relating to workplace HIV/AIDS programmes are introduced along with notes on the regulatory and corporate governance landscape of HIV/AIDS in large South African companies.

In Chapter 3, the critical components of the codes and guidelines are unpacked and analysed. Together with several 'best practice' publications, the codes and guidelines are used to extract the key components of a comprehensive workplace HIV//AIDS programme. The content and themes from this analysis, laid important groundwork for the establishment of the research instrument structure and content.

Chapter 4 explains the research design and methodology. Included in this chapter is a discussion about the specific methods of data collection, the compilation of the research instruments and the data analysis employed. The main aim of the chapter is to translate the objectives of the report into the questions for the interviews and the research questionnaire.

In Chapter 5 the results of the research are interpreted, presented and discussed. This chapter answers the research questions and considers pertinent findings that emerged beyond the parameters of the study.

Chapter 6 concludes with a summary of the future of 'best practice'. The chapter considers the value of 'best practice'; and offers broad recommendations for the

future utilisation of ‘best practice’ in managing workplace HIV/AIDS interventions in large South African companies.

2 LITERATURE REVIEW

2.1 Introduction to the Effect of HIV/AIDS on South African Companies

The ILO suggests that the effect of HIV/AIDS cuts across all sectors of economic activity and all areas of social life and that it knows no racial, gender, age or social boundaries (ILO, 2003). With this in mind, HIV/AIDS has the potential to become a factor that affects organisations of all sizes and workers at all levels (FHI. 2002). In this section the author explores the broad range of effects that HIV/AIDS has on companies in South Africa.

2.1.1 Effect of HIV/AIDS on the Workplace

The effect of HIV/AIDS on business is classified into two broad areas: internal or micro impacts and external or macro impacts (Reed, 2004). Both these areas refer to structural, cultural, political and economic issues outside and within companies.

The internal impacts are discernible through the effects of increased morbidity and mortality (Rosen et al., 2004). Death and illness within companies have begun to create disorganisation; obvious in staff turnover, loss of skills and declining morale (GBC, 2006c). Indirect costs have increased because of rising absenteeism and falling performance (Reed, 2004) and direct costs have increased as a result of healthcare expenditure, benefit claims and the recruitment and training of replacement labour (ILO, 2004).

A number of studies confirm that increased benefit claims, absenteeism and expenditure on recruitment and training are among the largest HIV-related costs faced by companies (Ellis and Terwin, 2005; Jones, 1996; Morris and Cheevers, 2000; Ellis and Terwin, 2004).

The external impact of HIV/AIDS is a result of the effect that HIV/AIDS has had on labour and consumer markets; aspects that are more closely explored in the following section.

2.1.2 Effect on the Labour Market

At the 1997 World Economic Forum session on AIDS, President Nelson Mandela said:

> The severity of the economic impact of the disease is directly related to the fact that most infected persons are in the peak productive and reproductive age groups. AIDS kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern nations and countries (Mandela, 1997).

The primary impact of the epidemic on the working age population means that those with important economic roles are prevented from making their full contribution to economic development (ILO, 2003). This observation is supported by suggestions that the effect of HIV/AIDS on people of working age continues to undermine the size and quality of the labour base of the South African economy (Reed, 2004; Dickinson, 2005).

Reports indicate that HIV/AIDS has the potential to reduce the labour force by as much as thirty-five percent (ILO, 2003; Walker, Ballnce, Chiloflischi, McCaffrey and Squires, 2005). In numerous South African companies where the primary economic asset is human capital, these labour constraints could seriously impede business operations.

The effect of HIV/AIDS on labour has, according to Hussey (2002), caused per capita growth in half of sub-Saharan African countries to fall by one percent every year. In South Africa, Bruggemans (2005:1) counters this assertion by arguing that there is little indication that HIV/AIDS has affected economic growth and measured Gross Domestic Product (GDP) in a major way. This is attributed to; “the structural realities of the South African labour force”, where high unemployment allows for the replenishment of the formal labour force, through recruitment and training that costs very little; a view that is supported in research by Connelly and Rosen (2004) and Fraser, Grant, Mwanza and Naidoo (2003).

The ILO, however, asserts that it is a mistake to believe that labour is in unlimited supply in developing countries, or that it can be replaced without cost (ILO, 2004). Rosen et al. (2004) supports this argument by suggesting that, although the cost per

infection for unskilled workers is relatively low, the total cost to firms is primarily driven by the large numbers of these workers in most workforces and the high prevalence of HIV/AIDS at these job-levels.

Furthermore, the recruiting and training of new employees may, on the surface, appear to be relatively inexpensive, but when one considers that the overall national prevalence of HIV/AIDS, there is a very real chance that newly recruited employees may also be HIV-positive. This rapid turnover of labour compounds recruiting and training costs and increases the overall cost of labour in South Africa (Dickinson, 2005).

By making labour more expensive, HIV/AIDS is eroding corporate profits and limiting the ability of Africa to attract industries that are reliant on low-cost labour. Rosen et al. (2004) suggests that there is growing concern that the very foundations of economic development in Africa are being threatened by HIV/AIDS. The danger also exists for HIV/AIDS to decrease the number employment opportunities as companies mitigate their dependence on labour by increasing capital intensity, (Barnett and Whiteside, 2002).

For these reasons, effective workplace HIV/AIDS programmes are considered to be central to sustaining the profitability of large South African businesses and the macroeconomic growth objectives of the government (GBC, 2006c; ILO, 2003).

2.1.3 Effect on the Consumer Market

Markets are affected by the number of consumers and the capacity of those consumers to purchase products. By altering the demographics of society, HIV/AIDS erodes the disposable income of households and reduces the number of potential customers for businesses.

As households are deprived of their bread-winners and begin to allocate more income to burial costs and healthcare (ILO, 2003), the potential exists for disposable household income to be reduced by as much as sixty percent (FHI, 2002)

Stanecki (2000) suggests that for the first time ever, negative population growth has been projected for some developing countries. This will affect the margins of those

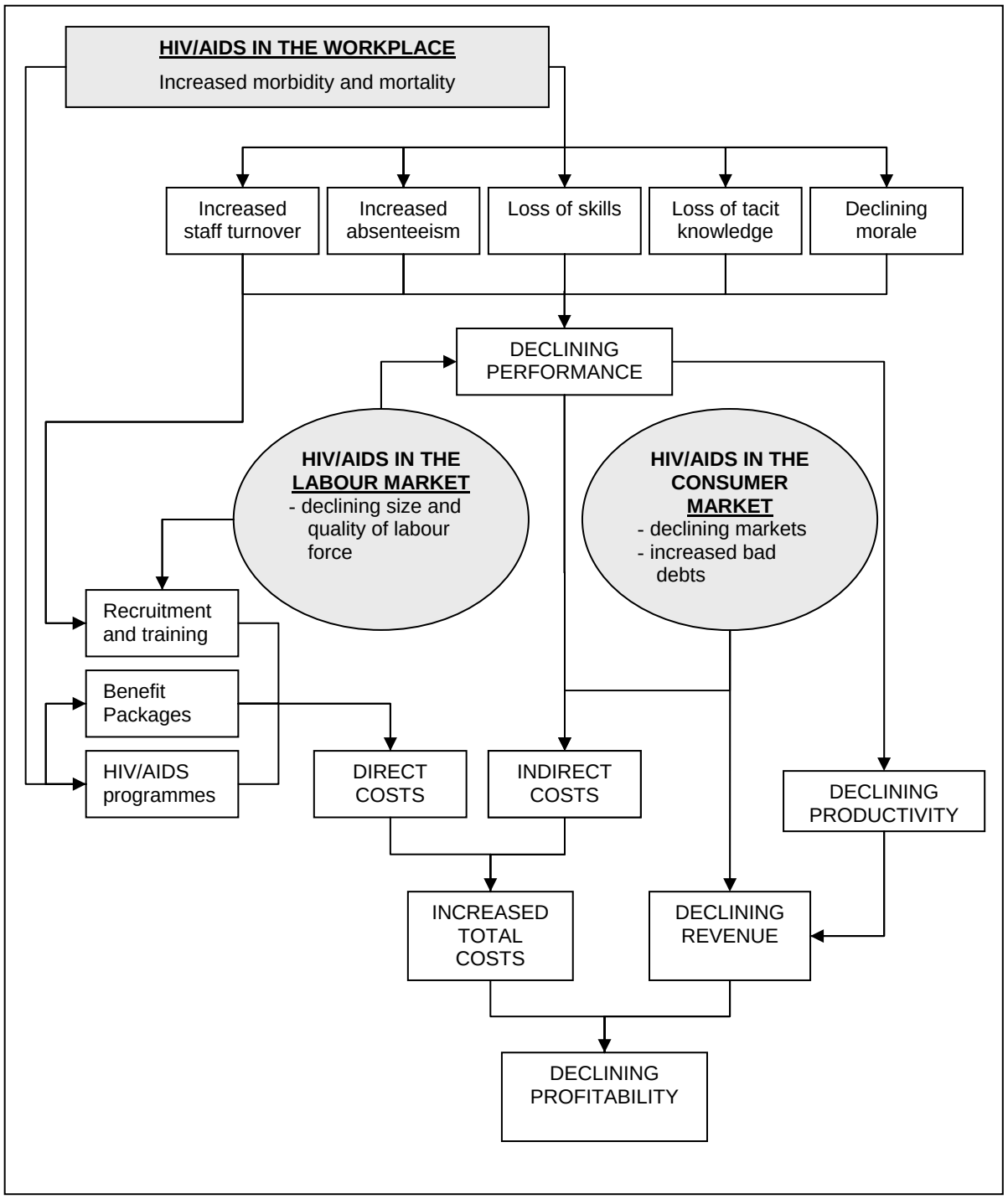
companies which rely on increased population growth and increased consumer disposable incomes to generate future revenues.

Already, the implications of changing markets are compelling companies to strategically reposition their product offering into markets that are not as adversely affected by HIV/AIDS. Whiteside and Sunter (2000) describe how the JD Group, a South African furniture and household appliance retailer, expanded operations to Poland and the Czech Republic; this after projecting an eighteen percent reduction in their customer base by the year 2010, as a result of HIV/AIDS (FHI, 2002).

Another factor to consider is the direct loss incurred by companies that offer credit to customers, such as clothing and furniture retailers. As HIV/AIDS mortality climbs, the costs of bad debt associated with HIV/AIDS will begin to affect several more credit-based retailers and the associated pricing effects will not only be felt in present consumer markets but also in future markets (George and Whiteside, 2002; ILO, 2003).

Figure 2.1 illustrates the potential internal and external effects of HIV/AIDS on businesses and demonstrates how these effects ultimately translate into declining business profitability.

Figure 2.1 Effects of HIV/AIDS on a Company



Source: Adapted from UNAIDS 2000a:15

2.2 Managing HIV/AIDS in the Workplace

Rosen, Simon, MacLeod, Fox, Thea and Vincent (2003) suggest that the only way to respond to the effects of HIV/AIDS on business is to fight the epidemic. Two primary strategies have been put forward in this regard:

- prevent new infections and;
- provide treatment and support for infected employees.

These two strategies cannot stand independently and there is a growing recognition that a comprehensive response to HIV/AIDS is required whereby prevention efforts are simultaneously intensified with expanded access to treatment and care (UNAIDS/WHO, 2005). Mathematical modelling shows that the benefits, in terms of new infections and deaths averted, are greatest when prevention and treatment are jointly scaled up (Salomon, Hogan, Stover, Stanecki, Walker, Ghys and Schwartlander, 2005).

Prevention programmes have four elements: awareness and education; condom promotion and distribution; diagnosis and treatment of sexually transmitted infections (STIs); and voluntary counselling and testing (Harrison, Smit and Myer, 2000; Rosen et al, 2003). These efforts are most effective when they are comprehensive and long term (Salomon, Hogan, Stover, Stanecki, Walker, Ghys and Schwartlander, 2005).

In South Africa there are four models in which companies provide treatment and support for infected employees: a third party health insurance plan or medical aid, an outsourced stand alone HIV/AIDS disease management programmes (DMP), a full service in-house programme and a clinic contracted to provide care for employees (Rosen et al, 2003; Connelly and Rosen, 2006).

Another evolving model is the approach to extend access to care through public-private partnerships. Connelly and Rosen (2006:133) report that this approach, in light of the expanded national coverage, “may prove more feasible and affordable for some employers”.

Each of the models has limitations: in-house programmes require sizeable resources and significant expertise to run efficiently; medical aids struggle to promote the uptake of services (Broomberg, 2006); the availability of tenured, quality, and independent DMPs is limited (Reed, 2004); the clinic provider model remains

untested and public private partnerships greatly rely on the state of the nearest government facility (Connelly and Rosen, 2006).

Although various combinations of treatment and prevention programmes have been tried and tested, the overall objective of managing HIV/AIDS in the workplace must be to ensure that infected workers continue to contribute productively to the business and society (GBC, 2006c).

2.3 Government's Role in the Management of HIV/AIDS in the Workplace

The extent to which companies should fund the healthcare of their workers and the extent to which the state can provide such services is an important consideration. Dickinson (2005) asserts that this issue is not new, but it does takes on new urgency given the scale of HIV prevalence in South Africa.

Although HIV/AIDS afflicts several employees across South Africa; in the eyes of many managers, it remains a public health challenge and the responsibility for its management has been largely assigned to the public health system (Connelly, 2002; Gupta & Taliento, 2003). The ILO reaffirms the responsibility of government by suggesting that, in order to guarantee widespread access to healthcare, "the government's role remains a necessary constant in the total equation" (ILO, 2003:38). The United Nations *2001 Declaration of Commitment on HIV/AIDS* calls for the active participation of the private sector in developing and implementing sound HIV/AIDS strategies, but these strategies should integrate into the mainstream of the national response (OHCR, 2001).

In South Africa, the government has in the past been criticised for its unsettled response to the HIV/AIDS pandemic (Connelly, 2002). However, a renewed commitment to the *HIV/AIDS and the Sexually Transmitted Infection (STI) Strategic Plan in 2004*, has led to the widespread rollout of ART treatment through public hospitals and clinics throughout South Africa. Although universal access to ART treatment is the long-term goal of the national programme, scaling up of services will take some time (Connelly and Rosen, 2006).

The government also plays a key role, notwithstanding regulation and legislation, in providing information and guiding company responses to HIV/AIDS. Connelly and Rosen (2004) point out that most managers will turn to government sources if information or services are needed. Lasting solutions to HIV/AIDS in the workplace are, therefore, unlikely without partnerships between government and private enterprise (Gupta & Taliento, 2003).

2.4 Definition of 'Best Practice'

The use of 'best practice' as a tool by a variety of organisations internationally, including UNAIDS and the ILO, is testimony to its global appeal. The concept has, through the recent adoption of the 'best practice' as strategic concept by delegates at the *Second Annual Regional Meeting of National AIDS Authorities in the SADC Region* in November 2005 (SADC, 2006), been brought to the fore in South African HIV/AIDS thinking too.

Delegates at the SADC Meeting submitted that the concept 'best practice' should be promoted in the SADC region by way of a catalogue of 'best practices' akin to the *UNAIDS Best Practice Collection*; a move that is likely to result in the term 'best practice' becoming more commonplace in South African HIV/AIDS forums, workplaces and literature.

SADC (2006) suggests that HIV/AIDS managers have recognised that the concept of 'best practice' is a useful instrument to gather and share information as well as to replicate and enhance prior experiences. However, for companies to derive full value from the 'best practice' literature and to be able to objectively evaluate various examples 'best practices', the researcher recognised a definite need for the concept to be more accurately characterised.

The notion of 'best practice' is not new; in a book entitled, '*The Principles of Scientific Management*' published in 1911; Frederick W. Taylor made the following assertion:

> Among the various methods and implements used in each element of each trade there is always one method and one implement which is quicker and better than any of the rest (Taylor, 1911:25).

Frederick Taylor's viewpoint became known as 'the one best way' - in modern parlance, 'best practice'.

More recently, the ILO (2003:15) defined 'best practice' as:

> A means of systemically building on effective approaches to any given issue by examining existing experiences and processes that work, understanding them in the light of agreed values, expert opinion and best available evidence and extracting from them lessons learnt that can be applied in the context of different social, economic and cultural settings.

UNAIDS (2000b) puts forward a similar definition which suggests that 'best practice' is about accumulating and applying knowledge regarding the practices as applied in different situations and contexts.

However, as Dickinson (2005) argues; there is no extended precedent of company responses to HIV/AIDS that may firmly establish what 'best practice' really is. UNAIDS (2000b) counters this assertion by pointing out that, although the sources of 'best practice' are relatively recent, a multitude of reports, studies and examples do exist from which to extract current 'best practice'.

The challenge is, therefore, to accurately identify current 'best practice' within the broad range of 'best practice' examples and to be able to objectively evaluate each example. The ILO and UNAIDS propose that 'best practice' be considered along a number of dimensions before arriving at such judgements (Table 2.1). The 'Best Practice Checklist' put forward in the SADC Framework outlines a similar working definition for evaluating examples of 'best practice' (SADC, 2006)

The appraisal parameters for 'best practice', as laid out by the ILO, UNAIDS and SADC, are included in Table 2.1.

Table 2.1 Criteria for Appraising 'Best Practice'

	ILO (2003)	UNAIDS (2000b)	SADC (2006)
Effectiveness		The practice is effective	The practice is effective
Evidence-based	The practice reflects guidelines and best available evidence		The practice is proven to be cost-effective
Efficiency		The practice is efficient	
Alignment with organisational principles	The practice reflects generally accepted values and principles	The practice is contextually relevant	The practice is contextually relevant
Alignment with corporate ethics	The practice is ethically sound	The practice is ethically sound	

Table 2.1 illustrates a clear overlap in the thinking of UNAIDS, the ILO and SADC regarding the concept, 'best practice'. Two broad elements of 'best practice' emerged from the various definitions and synthesis of the data in Table 2.1: firstly; the practice must be effective from a business standpoint and secondly; the practice must be acceptable in terms of the organisation's social responsibility. Although neither element was considered to be a particularly radical notion, these elements did establish a firm foundation upon which the research could begin to probe the dimensions along which 'best practice' could be reliably defined.

A conceptual framework, based on the ILO, UNAIDS and SADC definitions of 'best practice', was constructed by the researcher to illustrate these elements more clearly. Two independent axes form the basis for the two-dimensional chart, namely; *the Axis of Effective Practice* and the *Axis of Accepted Practice*.

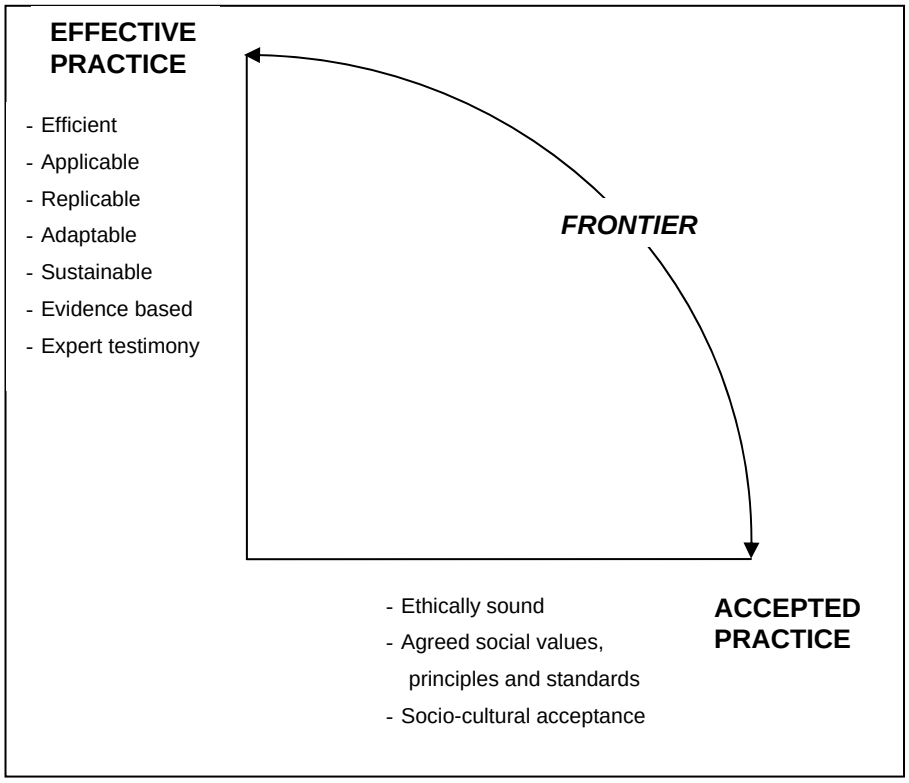
The *Axis of Effective Practice* takes into account, the 'hard' expectations of a business such as efficiency and profitability. It incorporates features such as efficiency, sustainability, expert testimony and quantitative research.

The *Axis of Accepted Practice* incorporates practices that are more attuned to the social expectations incumbent on businesses. This axis, therefore, includes aspects such as corporate ethics, social values and socio-cultural acceptance.

Analysis of the definitions put forward by the ILO, UNAIDS and SADC indicated that 'best practice' HIV/AIDS interventions encompassed elements of both axes. Because of the strong social requirements attached to HIV/AIDS, workplace interventions were unlikely to be successful if they were only built on the efficiency and profitability imperatives of the business. Similarly, interventions that leant heavily toward meeting the achieving socio-cultural acceptance may have proved unsustainable in the longer term.

The *Practice Frontier*, included in this framework, demarcates the range of HIV/AIDS interventions that could result from a combination of the elements of *Effective Practice* and *Accepted practice*.

Figure 2.2 Conceptual Model for HIV/AIDS Interventions



Based on the overlapping parameters for defining 'best practice' put forward by the ILO, UNAIDS, and SADC (ILO, 2003; SADC, 2006; UNAIDS, 2000b) the Conceptual Model for HIV/AIDS Interventions (Figure 2.2), provided a preliminary framework within which the research could begin to examine 'best practices' more closely

2.5 Introduction to the Guidelines and Codes of 'Best Practice'

2.5.1 Introduction

Vass (2004) suggests that larger companies are generally well informed about all the major sources of information on HIV/AIDS. This section presents the wide range of literary resources pertaining to 'best practice' HIV/AIDS interventions that were collated during the course of the research. Analysis of the broad principles and key features of these documents enabled development of a greater level of understanding regarding successful workplace interventions and the construction of a robust research instrument.

The section focuses specifically on the outcomes of an in-depth desktop analysis of fourteen key codes and guidelines relating to workplace HIV/AIDS programmes. In addition to this, the section puts forward important elements that were found to exist in a broad range of related 'best practice' documents.

The compendium of codes and guidelines included in the in-depth analysis are included in Table 2.2.

Table 2.2 Codes and Guidelines Included in the In-Depth Literature Analysis

International agency guidelines	Regional and national guidelines	Business-related guidelines	Corporate reporting guidelines
United Nations (UN): *– International Guidelines on HIV/AIDS and Human Rights, Guideline 5* (UN, 1997) *- HIV/AIDS and Human Rights International Guidelines* (UN, 2002)	**Southern African Development Community (SADC):** *SADC Code on HIV/AIDS and Employment* (SADC, 2006)	**International Organisation of Employers (IOE):** *Employer's Handbook on HIV/AIDS: A Guide for Action* (IOE, 2002)	**Global Reporting Initiative (GRI):** *- The 2002 Sustainability Reporting Guidelines* (GRI, 2002) *- Reporting Guidance on HIV/AIDS: A GRI Resource Document* (GRI, 2003)
Joint United Nations Programme on HIV/AIDS (UNAIDS): *Best Practice Collection and various guidelines* (UNAIDS, 1998, 1999 2000, 2000b, 2000c, 2000d, 2000e, 2002 2005)	**National Economic Development and Labour Council (NEDLAC):** *Code of Practice on Key Aspects of HIV/AIDS and Employment* (NEDLAC, 2003)	**Global Business Coalition on HIV/AIDS (GBC):** *- Outstanding Business Action on HIV/AIDS* (GBC, 2005) *- Best Practice AIDS Standard (BPAS)* (GBC, 2006a)	**2002 King Report:** *King Report on Corporate Governance (incorporates HIV/AIDS reporting)* (King, 2002)
International Labour Organisation (ILO)*: *HIV/AIDS and the World of Work: ILO Code of Practice* (ILO, 2002)	**Department of Labour:** *HIV/AIDS Technical Assistance Guidelines (TAG)* (Department of Labour, 2003)	**South African Business Coalition on HIV/AIDS (SABCOHA)**: *various guidelines*	**JSE Securities Exchange:** *JSE Securities Exchange Social Responsibility Index*
International Finance Corporation (IFC)*: *Good Practice Note: HIV/AIDS in the Workplace* (IFC, 2002)		**National Occupational Safety Association (NOSA)**: *Standard for HIV/AIDS Management System* (NOSA, 2003)	
World Economic Forum (WEF) Global Health Initiative (GHI): *Guidelines for HIV/AIDS and STD Policies and Programmes in the Workplace* (WEF, undated)		**International Finance Corporation (IFC):** *HIV/AIDS Guide for the Mining Sector* (Smart 2004)	
Family Health International (FHI): *Workplace HIV/AIDS Programmes, An Action Guide for Managers* (FHI, 2002)		**Tourism, Hospitality and Sport, Education and Training Authority (THETA)**: *HIV/AIDS Handbook for Tourism and Hospitality Companies* (THETA, 2005)	

* United Nations system organisation

The following section outlines each of the four categories of codes and guidelines with a view to developing a greater understanding of the recommendations included for successful workplace programmes. Chapter 3 explores the degree of content overlap between the various codes and guidelines in an attempt to determine the level of consensus regarding the principal components of successful programmes.

2.5.2 International Agency Guidelines

2.5.2.1 United Nations (UN)

Ten UN system organisations have been brought together to form the Joint United Nations Programme on HIV/AIDS (UNAIDS); these include: the International Labour Organisation (ILO), the World Health Organisation (WHO), the World Bank and a further seven UN agencies. As part of the UN General Assembly resolution in December 2005, UNAIDS has been tasked with facilitating a collaborative response with the goal of achieving universal access to HIV treatment by 2010 (UNAIDS, 2006b). As a part of its strategic agenda, UNAIDS has become a driving influence in the promotion of 'best practice'.

The *UNAIDS Best Practice Collection* comprises a range of publications dedicated to informing countries and organisations about various 'best practice' responses to the HIV/AIDS epidemic. A *UNAIDS Best Practice Collection* document on any one subject typically includes a point of view, 'best practice' case studies, technical updates and a list of key materials (UNAIDS, 2000b)

The United Nations' International Guidelines on HIV/AIDS and Human Rights, contains a series of human rights recommendations specifically relating to HIV/AIDS in the workplace (UN, 1997; UN, 2002). Accordingly, these recommendations have strong human rights dimension for use in the development of workplace HIV/AIDS strategies and plans. The content included in these recommendations was, therefore, used as a basis for establishing the rights framework as laid out in Table 2.3.

Furthermore, in an attempt to ensure transparency in the measurement of national response, to HIV/AIDS, UNAIDS has published 'core indicators' that are designed to measure the constituents of the national response. One of the indicators in the

national response is the percentage of large enterprises or companies which have HIV/AIDS workplace policies or programmes (UNAIDS, 2005). To qualify as having an HIV/AIDS workplace policy, companies need to be seen to be implementing personnel policies and programmes that cover, as a minimum, all of the aspects as listed in Table 2.3 (UNAIDS, 2005).

Despite the UNAIDS' requirements for workplace HIV/AIDS programmes being widely open to interpretation and offering little assistance in the definition of 'best practice', they were useful in establishing a set of minimum criteria against which to evaluate workplace HIV/AIDS interventions. Together with the ILO Code of Practice (ILO, 2002), these UNAIDS guidelines were used to construct an overview of important human rights elements to consider in the planning and development of comprehensive workplace HIV/AIDS programmes.

Table 2.3 Rights Framework for Workplace HIV/AIDS Programmes

Principal Components	United Nations International Guidelines on HIV/AIDS and Human Rights(UN, 1997:14)		ILO Code of Practice: HIV/AIDS and the world of work (ILO, 2002:6-8)		Workplace Programme Criteria (UNAIDS,2005)
Strategy					
Recognition of HIV/AIDS			Recognition of HIV/AIDS as a workplace issue		
Benefit strategy	Protection for social security and other benefits for workers living with HIV/AIDS.				
Multi-stakeholder participation	Workers' participation in decision on workplace issues related to HIV/AIDS		Social dialogue - active involvement of workers affected by HIV/AIDS		
Policy and Principles					
Protection from unfair discrimination Protection from stigmatization Gender equality	Protection from stigmatization and discrimination by colleagues, unions, employers and clients	Freedom from HIV screening for employment, promotion, training or benefits.	Non-discrimination on the basis of real or perceived HIV status Gender Equality	Freedom of screening for purposes of exclusion from employment or work processes	Prevention of stigmatization and discrimination on the basis of HIV-status
Confidentiality	Confidentiality regarding all medical information, including HIV/AIDS status.		Confidentiality regarding workers' personal data		
Legislative cohesion	Inclusion in workers' compensation legislation the occupational transmission of HIV				
Awareness, Education and Training (AET)					
Awareness and education	Information and education programmes on HIV/AIDS				Information on HIV/AIDS
Prevention					
Adequate supplies of condoms	Adequate supplies of condoms available free to workers at the workplace		Prevention Programme		Condom promotion
STD Diagnosis and treatment					STD diagnosis and treatment
Occupational health and safety	Defined safe practices for first aid and adequately equipped first-aid kits		Healthy work environment – facilitate optimal physical and mental well-being		HIV-transmission safeguards
Voluntary Counseling and Testing (VCT)					
					VCT
Healthcare					
Adequate Healthcare	Adequate healthcare accessible in or near the workplace	Access to counseling and appropriate referral	Care and support: all workers are entitled to affordable health services.		Provision for HIV/AIDS related medicines
Reasonable accommodation	Employment security and reasonable accommodation.		Continuation of the employment relationship		Reasonable accommodation

2.5.2.1.1 ILO Code of Practice on HIV/AIDS and the World of Work

This is a set of internationally recognised guidelines that promote and support action against HIV/AIDS in the workplace; it forms the cornerstone of the ILO's efforts against HIV/AIDS (IOE, 2002). *The ILO Code of Practice on HIV/AIDS and the World of Work* (ILO Code) contains fundamental principles for policies at enterprise level and practical guidance for workplace programmes (ILO, 2003).

Vass (2004:315) reports that the ILO Code - because of "its comprehensive nature" - is often used as a point of reference. The key principles in the ILO Code provide a comprehensive, commanding outline within which to craft an effective HIV/AIDS workplace programme (ILO, 2002).

Together with the *United Nations Guidelines on HIV/AIDS and Human Rights*, the ILO Code provides a sound foundation on which to construct a programme that meets the human and labour rights of all employees. Table 2.2 was compiled to distil the key human rights elements of each code into a set of categories for workplace HIV/AIDS programmes.

2.5.2.1.2 International Finance Corporation

The *Good Practice Note* published by the International Finance Corporation (IFC), a subsidiary of the World Bank Group, targets the private sector in developing countries. The publication provides companies with practical guidance and a range of options for designing and implementing workplace HIV/AIDS programmes (IFC, 2002).

The IFC document puts forward a list of possible interventions that formulate a useful framework for the practical implementation of an HIV/AIDS workplace programme. The document is consolidated by leveraging 'best practice' case examples (IFC, 2002).

Furthermore, the IFC document is one of the few codes/guidelines that provides for status and rating of the individual components. The ratings are not designed for conformance or accreditation but rather to, "provide companies with a means to set targets and evaluate their progress" (IFC, 2002:23).

2.5.2.2 Global Health Initiative

The World Economic Forum (WEF) is an impartial non-profit organisation that seeks to engage global leaders on projects such as the Global Health Initiative (GHI) (WEF, 2006). The GHI under the WEF has completed several case studies in co-operation with specific businesses; these resources reveal several examples of 'best practice' reflecting regional and industrial differences (Reed, 2004).

2.5.2.3 Family Health International

Family Health International (FHI) is a non-profit organisation active in the area of public health with substantial involvement in workplace HIV/AIDS issues (FHI, 2002).

The HIV/AIDS Action Guide for Managers is a comprehensive instruction manual for managers to use in the design and implementation of a workplace HIV/AIDS programmes (FHI, 2002). The guide is built from real experiences of 'best practice' and is tailored for action-orientated management.

2.5.3 Regional and National Codes

2.5.3.1 Southern African Development Community's Code on HIV/AIDS and Employment

The Southern African Development Community (SADC) instituted a regional code on HIV/AIDS and employment (hereafter known as the SADC Code) in 1997. Although the SADC code is not colloquially known as a 'code of best practice', the intention was to, "create a regional standard on the best ways to manage AIDS in the employment setting" UNAIDS (2000e:3).

The SADC Code is founded on three key principals namely (UNAIDS, 2000e);

- human rights;
- patient rights and;
- business efficiency.

2.5.3.2 South African Department of Labour and the NEDLAC Code of Good Practice on Key Aspects of HIV/AIDS and Employment

The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (NEDLAC Code) is drawn from both national and international law. Nationally, it remains closely aligned to the legislative frameworks of the *Employment Equity Act, No. 55 of 1998* and the *Labour Relations Act, No. 66 of 1995*.

Because compliance with the NEDLAC Code is voluntary, except insofar as it relates to the mandatory provisions contained in the legislative frameworks, Vass (2004) reports that companies only comply with selective provisions, chiefly, those contained in the *Employment Equity Act, No. 55 of 1998* such as non-discrimination, confidentiality, disclosure and testing.

In terms of the implementation and management of HIV/AIDS interventions in the workplace, the NEDLAC Code suggests a broad outline of objectives, principles and guidelines regarding the content, scope and standards of workplace HIV/AIDS programmes (NEDLAC, 2002; Vass, 2004).

Although the legal and legislative framework and broad implementation objectives are laid out for the establishment of workplace HIV/AIDS programmes, the NEDLAC Code lacks information in terms of practical implementation (Dickinson, 2003).

To assist employers and trade unions in the management of HIV/AIDS in the workplace, the Department of Labour and the Commission for Employment Equity, in 2003, released the *HIV/AIDS Technical Assistance Guidelines* (hereafter known as TAG), as complement to the NEDLAC Code (Department of Labour, 2003).

The TAG aims to provide practical strategies for employers, employees and trade unions to implement workplace HIV/AIDS policies and programmes. Despite having been designed to be more user-friendly, Vass (2004) reports that company knowledge and uptake of the TAG has been erratic. The reason for the poor uptake has been attributed to ineffective marketing and communication (Vass, 2004).

2.5.4 Business-related Codes

2.5.4.1 International Organisation of Employers

The International Organisation of Employers represents and defends the interests of business in international forums such as the ILO and United Nations (IOE, 2006). In 2002, the International Organisation of Employers (IOE) together with UNAIDS, compiled a handbook that outlines a framework for action-implementing responses to HIV/AIDS in the workplace (IOE, 2002).

2.5.4.2 Global Business Coalition on HIV/AIDS

The Global Business Coalition on HIV/AIDS acts as a conduit for communicating and sharing models of good business practice (GBC, 2006b). Although the GBC has no formal business code relating to the management of HIV/AIDS it does collect and publish case studies from its allegiance with a range of local and international companies. In so doing, the GBC promotes programme and policy development through adoption and adaptation of other company approaches. Reed (2004) and Vass (2004) recognise this as a means of developing 'best practice' competence in an environment where resources to develop innovative practices may sometimes be lacking.

In December 2005 the GBC released the *Best Practice AIDS Standard* (BPAS), a quantitative evaluation of the interventions comprising workplace HIV/AIDS programmes. It was specifically designed for member companies to assess themselves and was to be used neither as a rating tool nor as a reporting initiative (GBC, 2006a).

The BPAS is exclusively available to members of the GBC. As a result, the GBC standpoint on 'best practice' is limited to the publicised primary components of the BPAS. The BPAS comprises ten categories for the assessment of corporate engagement; these have been included in Table 2.3.

2.5.4.3 South African Business Coalition on HIV/AIDS

The South African Business Coalition on HIV/AIDS (SABCOHA) provides the forum for co-ordinating the private sector response to HIV/AIDS in South Africa. By

facilitating the assembly of data in the form of case studies and surveys, SABCOHA is able to provide updated feedback on current models of 'best practice'.

South African member-companies such as Eskom, De Beers and Anglo American are highly regarded for their advanced HIV/AIDS programmes and have received recognition as benchmark companies (Fakier, 2004). For this reason, the 'best practice' approaches of these companies were a valuable resource in the overall evaluation of 'best practice' interventions during this research.

2.5.4.4 National Occupational Safety Association HIV/AIDS Management System

In 2003 Debswana, in consultation with the National Occupational Safety Association (NOSA), which is no longer in existence, developed an auditing system standard for the management of HIV/AIDS in the workplace; the *HIV/AIDS Management System* (AMS 16001) .

The AMS 16001 and the accompanying guideline document, AMS 16004, was based on the quality management system standard of ISO 9001:2000, ISO 14001:1996 and OHSAS 18001:1999 (NOSA, 2003) and was designed to allow for the measurement of company conformance to pre-determined HIV/AIDS management standards (Smith, 2004).

2.5.5 Reporting Guidelines and Requirements

Fakier (2004) asserts that one of the main values of reporting on workplace HIV/AIDS programmes is that it puts HIV/AIDS into a business context and leads to the promotion of 'best practice'. There is little doubt that these reasons have added to the pressure that stakeholders, investors in particular, have begun to exert on businesses to disclose detailed information about policies and activities relating to HIV/AIDS (GRI, 2002).

The challenge, however, with business reporting is twofold; firstly, companies need to determine what information should be disclosed and secondly, they have to establish what level of detail will be required to satisfy the various stakeholders. These are difficult questions to answer. Therefore, several companies turn to the conventional reporting guidelines to ensure compliance with corporate governance policies and consistency with the reporting practices of other companies.

This section explores two guidelines that are used most often by South African companies to report on issues pertaining to HIV/AIDS: the King Report and the Global Reporting Initiative (GRI).

2.5.5.1 King Report

The 2002 King Report (King II) on corporate governance is an important document on issues related to good corporate governance, business ethics and compliance in South Africa. The report sought to ensure that the standards of corporate governance remained current and competitive with international norms and 'best practice'.

With regards to HIV/AIDS, King II recommends that the board of directors of an organisation (King, 2002):

- ensures that it understands the social and economic impact of HIV/AIDS on business activities;
- adopts an appropriate strategy, plans and policies to address and manage the impact of the pandemic on business activities; and
- regularly monitors and measures the performance using established indicators.

The report does not delve into the intricate details of workplace HIV/AIDS interventions and does not lay out specific standards of practice. Instead, it provides broad recommendations for companies to assess the potential impact of HIV/AIDS on the business, design and implement strategies to counter theses effects and, continuously monitor the performance of the company's programme against internal objectives. The foremost requirement of the King II is for companies to report on all three aspects of the company's response to HIV/AIDS.

2.5.5.2 Global Reporting Initiative

The Global Reporting Initiative (GRI) is a multi-stakeholder organisation which develops, promotes and disseminates globally applicable reporting guidelines. These guidelines are for voluntary use by organisations for reporting on economic, environmental and social dimensions on their activities, products and services (GRI, 2003).

The GRI's HIV/AIDS reporting project was established following a grant from the Bill and Melinda Gates Foundation in order to develop reporting guidelines for organisations to apply when disclosing information about their HIV/AIDS policies and practices (Fakier, 2004). It offers a practical reporting framework for organisations that want to report on their performance and for stakeholders that require a reputable reporting benchmark.

In the light of the JSE Securities Exchange (JSE) recommendations on financial reporting and the Sustainability Reporting Index; the GRI guidelines have, according to Vass (2004:315), "become a major point of reference for listed corporates." The increased compliance to the GRI guidelines is because the adopted language is believed to be more attuned to that of business (Vass, 2004) and because companies believe it provides an internationally developed benchmark for HIV/AIDS programmes in the workplace (Fakier, 2004).

The GRI has developed performance indicators that seek disclosure on HIV/AIDS workplace programmes across the entire business spectrum from financial to social concerns.

The indicators for GRI reporting are arranged in four categories (GRI, 2003):

- Good Governance:
  - policy formulation,
  - strategic planning,
  - risk management, and
  - stakeholder involvement.
- Workplace Conditions and HIV/AIDS Management
- Depth, Quality and Sustainability of HIV/AIDS Programmes
- Measurement, Monitoring and Evaluation

Furthermore, The GRI framework allows for three levels of reporting (Fakier, 2004):

i. Level 1 Reporting

The first level requires companies to respond to a set of basic level indicators and is aimed at providing a starting point for first time reporters or those in small or low-capacity organisations. It is comprised of nine quantitative questions and one qualitative question.

ii. Level 2 Reporting

Level 2 requires companies to report on eighteen key performance indicators. The second level requires both qualitative and quantitative information regarding the company's policies, procedures and activities relating to each of the indicators.

iii. Level 3 Reporting

The GRI HIV/AIDS framework provides guidance for full and transparent disclosure by companies. Companies who report in accordance with the guidance in Level 3 provide substantially more detail than in Level 2.

2.6 Chapter Conclusion

Several codes and guidelines have come into existence to provide broad recommendations on how 'best' to manage HIV/AIDS in the workplace. Although most guidelines emanate from relatively high-level international, regional and business-related organisations and agencies, guidelines that relate more specifically to certain sectors and industries appear to be emerging. Two examples of this are the *HIV/AIDS Guide for the Mining Sector* (Smart, 2004) and the *HIV/AIDS Handbook for the Tourism and Hospitality Companies* (THETA, 2005).

In order for the research to identify the important elements of successful workplace interventions and construct a robust research instrument to fully evaluate the value of 'best practice', it was necessary for the researcher to conduct an in-depth analysis of the content included in the various codes and guidelines. Chapter 3 lays out the details of this analysis and maps the degree of content overlap between the various codes and guidelines.

3 Key Components of Workplace HIV/AIDS Programmes

3.1 Chapter Introduction

In the Foreword of the 2005 WEF Global Review of the Business Response to HIV/AIDS, Dr. Brian Brink of Anglo American Corporation suggests that there is broad agreement on the fundamentals of workplace programmes:

> Today we know that those firms that respond to HIV/AIDS with strong *leadership* at the CEO level, *impact assessments* based on real data, negotiated *HIV/AIDS policies*, up-to-date *strategic HIV/AIDS responses*, specific HIV/AIDS performance indicators and targets, and ongoing *monitoring and evaluation* also happen to show the greatest productivity, the most effective cost containment and the greatest profitability. These firms are also invariably the safest, the most environmentally responsible and the most harmonious with the communities within which they operate. (WEF, 2005:4)

The purpose of this chapter is to identify the key components of successful workplace HIV/AIDS programmes and to explore specific interventions that make-up these components. The chapter conducts an in-depth analysis of fourteen codes and guidelines to establish the current level of agreement regarding the constituents of successful workplace HIV/AIDS programmes. In addition to this, several more 'best practice' documents are collated and analysed to verify these findings and to identify further important elements.

The aim of this analysis is to provide a consensus-driven view of current practice and the foundation upon which to build a robust research instrument.

3.2 Identifying the Key Components of Workplace Programmes

The fourteen codes and guidelines provided a good starting-point for identifying the components. This was because they ordinarily emanate from credible sources and contain a relatively compact collection of data that has ordinarily been sourced and synthesised from relevant company case studies and evidence-based literature.

Table 3.1 provides a comparison of content included in the fourteen codes and guidelines that were analysed in-depth. Although the research has made every effort

to include as many codes and guidelines as possible in the analysis, it does not prescribe that the list included in Table 3.1 is exhaustive.

The fourteen codes and guidelines included in Table 3.1 do, however, represent the resources most commonly referenced in HIV/AIDS literature and were, therefore, considered to be a good representation of the current level of knowledge regarding key HIV/AIDS interventions.

The table was an important part of the research. Two specific reasons existed for this; firstly, it provided a picture of the overlap in content between the various codes and guidelines. This allowed for a 'snap-shot' assessment of the current level of agreement regarding the foremost strategies for dealing with HIV/AIDS in the workplace.

Secondly, the table enabled the categorisation of HIV/AIDS interventions into the primary components for successful workplace HIV/AIDS programmes. This was achieved by determining the relative frequency at which different interventions emerged during the in-depth content analysis of the fourteen codes and guidelines.

The following nine components were distilled from themes that recurred most frequently:

1. Leadership commitment and strategic planning
2. Policy development and review
3. Integrated risk management
4. Awareness, education and training (AET)
5. Voluntary counselling and testing (VCT)
6. Prevention
7. Treatment and wellness
8. Programme extension
9. Programme performance monitoring and reporting

Table 3.1, therefore, provides an overview of the outcomes of the desktop analysis. The table details the various themes and the relative frequency with which they emerged during the analysis. In addition to this, the table provides a perspective on the content included in the various codes and guidelines and the dominant areas of content overlap.

Table 3.1 Content Comparison of Workplace HIV/AIDS Codes and Guidelines

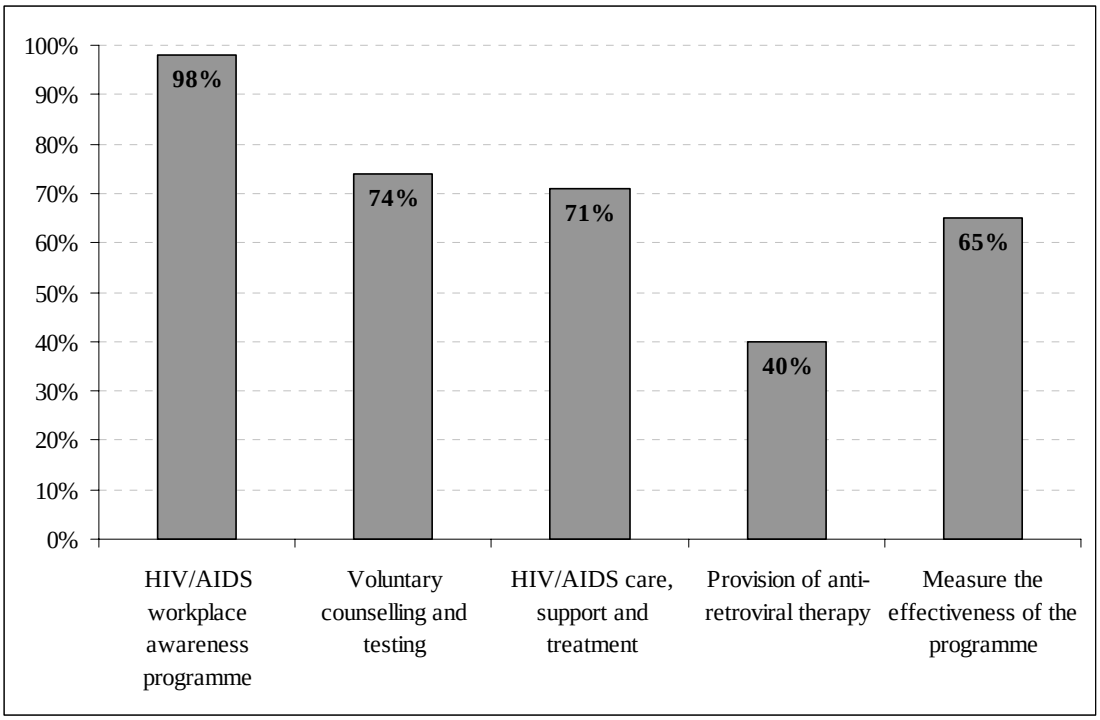
	International guidelines					Regio-nal guideli nes		Business-related guidelines					Repor-ting guideli -nes	
	UNAIDS (2005)	ILO (2002)	IFC (2002)	WEF (undated)	FHI (2002)	SADC (2006)	NEDLAC (2003)	IOE (2002)	GBC (2005, 2006a)	NOSA (2003)	Smart (2004)	THETA (2005)	GRI (2002, 2003)	King (2002)
1. Leadership commitment and strategic planning														
Leadership and commitment					X		X		X	X	X	X		
Strategic planning	X		X	X	X	X	X		X	X	X	X	X	X
Strategic partnerships	X			X	X	X	X		X					
2. Policy development and review														
Policy	X	X	X	X	X	X	X	X		X	X	X	X	
Multi-stakeholder committee			X	X	X		X	X	X		X	X	X	
Policy communication				X				X		X	X	X		
Policy review and improvement				X				X		X				
3. Integrated risk management														
Impact assessment	X			X	X		X	X		X	X	X	X	X
Benefit strategy	X	X		X		X	X	X		X	X		X	
4. Awareness, education and training (AET)														
AET	X	X	X	X	X	X	X	X	X	X	X	X	X	
Peer education		X	X	X	X		X			X		X	X	
5. Voluntary counselling and testing (VCT)														
VCT	X	X	X	X	X	X	X		X		X	X	X	
Support and Care		X	X	X	X	X	X	X	X		X	X	X	
6. Prevention														
Condom promotion and	X		X	X		X	X	X			X	X	X	
STI management	X		X	X		X	X	X			X	X		
OHS	X		X	X		X	X	X		X	X	X		
PMTCT			X								X			
7. Treatment and wellness														
Treatment programme	X	X	X	X	X	X		X	X		X	X	X	
Wellness programme							X				X	X	X	
Reasonable accommodation	X					X								
8. Programme performance monitoring and reporting														
Monitoring, evaluation and review	X		X	X	X	X	X	X	X	X	X	X	X	X
Reporting										X				X
9. Programme extension														
Employee families		X			X	X				X	X	X		
Suppliers, distributors, contractors					X					X				

The findings of a recent SABCOHA/BER survey appeared to suggest that there was agreement regarding - at least – five components of workplace HIV/AIDS programmes from Table 3.1 (Ellis and Terwin, 2005). These components included the following:

- Awareness programmes
- VCT
- HIV/AIDS treatment
- Care and support for infected employees
- HIV/AIDS workplace programme monitoring

A promising aspect of this survey was that a large proportion of the companies surveyed had taken steps to implement the components (Figure 3.1).

Figure 3.1 Uptake of Key Components of Workplace HIV/AIDS Programmes



Source: Adapted from Ellis and Terwin (2005)

A notable limitation of the survey, however, was that the categories appeared to be relatively broad. Although voluntary counselling and testing was considered by the researcher to be a fairly well-defined concept within the context of workplace HIV/AIDS programmes, awareness programmes and HIV/AIDS care and support were considered somewhat more nebulous concepts. As a result the outcomes of the

survey may have been affected by favourable interpretation of respondents regarding the relatively open-ended questions.

The aim of the following section was to ensure that content for the research instrument in this study was rigorous and the questions were well-defined. To achieve this, the researcher undertook an in-depth analysis of the nine identified components of workplace HIV/AIDS programmes.

3.3 Analysis of the Components of Workplace HIV/AIDS Programmes

The objective of this section was to analyse each of the nine components of workplace HIV/AIDS programmes in greater detail. This was important because it collated content for the research instrument and built a robust fact-base for the overall research analysis.

3.3.1 Leadership Commitment and Strategic Planning

3.3.1.1 HIV/AIDS Champion

Vass (2004:317) reports that the presence of one motivated individual with a measure of authority is a "fundamental driver of organisational HIV/AIDS policy". Moreover, the appointment of a person to handle all company HIV/AIDS related activities, brings both accountability and focus to the process (FHI, 2002; Department of Labour, 2003; NOSA, 2003). The importance of appointing an authoritative member of senior management to drive HIV/AIDS policy is echoed by Dickinson (2003:34) describing it as, "the formal prioritisation of HIV/AIDS at the highest levels of the company."

Furthermore, the GRI reporting framework requires that the level of authority of the person in charge of the implementation of the HIV/AIDS policy be recorded and reported on (GRI, 2003); suggesting that the 'HIV/AIDS champion' has become a central actor in good corporate governance (Roberts, 1999).

3.3.1.2 Strategic Planning

The King II Report requires that companies prepare strategic plans to manage the risks and potential impact of HIV/AIDS on the organisation (Fakier, 2004). This issue

is also entrenched in most codes and guidelines (FHI, 2002; GRI, 2003; GBC, 2005; IFC, 2002; NEDLAC, 2002; UNAIDS, 2000e and UNAIDS, 2005).

Four primary strategies are outlined by the Department of Labour to limit the potential impact of HIV/AIDS on an enterprise (Department of Labour, 2003):

- a strategy to deal with the cost implications
- a prevention strategy;
- a wellness strategy; and
- a partnership strategy.

Although Rosen et al (2004) agrees with the need for companies to develop strategies to counter the costs implications of HIV/AIDS, FHI (2002) points out that strategies that seek to minimise increases in costs - benefit costs in particular - often run counter to efforts to sustain employee morale and productivity.

Therefore, successful HIV/AIDS strategic planning was seen to require a thorough assessment of the potential impact of HIV/AIDS on the organisation and carefully designed strategies and plans that met the financial constraints of the business, on the one hand, and the implicit needs of the employees on the other.

3.3.2 Policy Development and Review

A workplace policy defines an organisation's position on HIV/AIDS and spells out the way in which an organisation will deal with the epidemic (Smart, 2004). The policy should be agreed at board level and it should be seen as a part of the Chief Executive Officer's responsibility to turn the policy into action (Sunter, 2004).

The World Economic Forum (WEF) reports that the presence of workplace HIV/AIDS policies varies with national prevalence and the size of the company (WEF, 2006): in countries where prevalence exceeds twenty percent, the majority of companies have a HIV/AIDS policy and larger companies are more likely to have specific HIV/AIDS policies than small or medium size enterprises.

3.3.2.1 Multi-stakeholder Committees

The IOE asserts that policy is more likely to be implemented if it has been developed with full participation of all concerned parties (IOE, 2002). This position is supported

by the suggestion that successful HIV/AIDS workplace policies and programmes require co-operation and trust between employers, workers and their representatives, (GBC, 2006c; Dickinson, 2003; Fakier, 2004; Vass, 2004) and government (ILO, 2003)

Toward this end, a company HIV/AIDS committee, representing all constituents of the company (Department of Labour, 2003), is required to coordinate and implement the policy and programme (ILO, 2003). The GRI presents a similar perspective on the involvement of all relevant stakeholders and requires that companies record the specific stakeholders, describe the way they relate and comment on their individual degrees of involvement (GRI, 2003).

3.3.2.2 Policy Formulation

George and Whiteside (2002) suggest that policies serve to inform and sustain workplace HIV/AIDS programmes. Toward this end, a HIV/AIDS policy should establish compliance with laws; and consistent action within a company; provide clarity and certainty about issues surrounding HIV/AIDS; and inform employees about their responsibilities, rights and expected behaviour (FHI, 2002; IOE, 2002).

3.3.2.2.1 Policy content

Table 3.2 lays out the policy content as recorded in the guidelines from *NEDLAC Code* (NEDLAC, 2003), *NOSA's Standard for HIV/AIDS Management System* (NOSA, 2003), the *HIV/AIDS Guide for the Mining Sector Smart* (2004), the IOE's *Employers Handbook on HIV/AIDS* (IOE, 2002) and FHI's *Action Guide for Managers* (FHI, 2002). These specific guidelines were found to have comprehensive sections covering HIV/AIDS policy and were, therefore, well suited for the analysis of policy content.

Table 3.2 Prescribed Content for Workplace HIV/AIDS Policies

	NEDLAC Code (NEDLAC, 2003)	NOSA Guidelines (NOSA, 2003)	FHI Mining Sector Guidelines (Smart, 2004)	IOE Employer's Handbook (IOE, 2002)	FHI Guidelines (FHI, 2002)
Organisation position statement	The organisation's position on HIV/AIDS	Contextual relevance	Management response to the epidemic		
Legal and ethical compliance	Details on employment policy	Compliance with applicable legislation	Compliance with national and international law.	Legal and cultural compliance	Compliance with local and national laws
Non-discrimination			Elimination of stigma and discrimination	Non-discrimination	Non-discrimination
Confidentiality		Confidentiality and disclosure	Confidentiality	Confidentiality	Privacy
Employee benefits and assistance	Employee assistance programmes	Employee assistance	Employee benefits	Provision of benefits	Provision of benefits
Reasonable accommodation			Reasonable accommodation	Reasonable accommodation	Reasonable accommodation
Programme performance management procedures	Monitoring and evaluation mechanisms	Performance evaluation	Performance management		
Programme outline and scope	Outline the company programme	Prevention	Workplace programme outline		Prevention
Programme implementation responsibilities	Programme implementation responsibilities	Implementation responsibility	Implementation roles and responsibilities		
Communication strategies	Communication strategies	Communication to all interested parties	Communication strategies		

3.3.2.2.2 Policy Principles

3.3.2.2.2.1 Stigmatisation and Non-Discrimination

Unfair discrimination is contrary to the principles of the *Universal Declaration of Human Rights* (UNAIDS, 2000e), the World Health Organisation (UNAIDS, 2000e) and the United Nations (ILO, 2002; UN, 1997; UN, 2002); it entrenches the cycle of poverty, slows economic development, adds to business costs and, according to UNAIDS, has the potential to increase the prevalence of HIV/AIDS in the workplace (UNAIDS, 2000e).

The theme of non-discrimination is presented as a central tenet in most guidelines and codes (FHI, 2002; IFC, 2002; Lau and Wong, 2001; NEDLAC, 2002; UNAIDS, 2000a; UNAIDS, 2000e). The GRI, too, requires that companies report on how non-discrimination is ensured in workplace HIV/AIDS programmes (GRI, 2003).

Successful interventions are part of a wider approach that includes: establishing an atmosphere of openness and trust (ILO, 2002; NEDLAC, 2002; UNAIDS, 2000a). Stigmatisation compromises the attempt to create this atmosphere and with it the prevention efforts which depend so heavily upon openness, trust and the respect of basic rights (ILO, 2003).

The WEF considers companies well placed to tackle these issues. By providing accurate information and promoting non-discriminatory practices, companies can help instil more tolerant perceptions of the disease (WEF, 2006).

3.3.2.2.2.2 Confidentiality

This ethical and human rights principle recognises that all people have rights to privacy about personal medical conditions (UNAIDS, 2000e). In an employment setting, this means that a person infected with HIV should have full control over decisions about who is informed (ILO, 2003; GRI, 2003; UNAIDS, 2003).

3.3.2.2.2.3 Gender Equality

For biological, socio-cultural and economic reasons; women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men (Harrison et al., 2000; ILO, 2002; Wingwood and DiClemente, 1996). This imposes the need for an increased focus on gender as a dimension in workplace programmes from both the policy and implementation standpoints (NEDLAC, 2002; IOE, 2002; ILO, 2003; Smart, 2003).

3.3.2.3 Policy Communication

A HIV/AIDS policy must be accessible to employees in a variety of ways (Reed, 2004). The policy and related information on HIV/AIDS should be communicated to all company employees at all levels; to associated businesses and to the wider public (NEDLAC, 2002). The full range of communication methods available to the company

should be used in the dissemination of the policy (FHI, 2002; IFC, 2002; ILO, 2003). Indicator Two of the *GRI Reporting Guidance Document* covers the detailed strategy for communicating the organisation's HIV/AIDS policy (GRI, 2003).

3.3.2.4 Monitoring and Review of the policy

The field of HIV/AIDS in the workplace is rapidly transforming and requires regular adaptation of policies to meet the requirements of new developments. Reed (2004:240) calls for the HIV/AIDS policy to be a 'living' document; a document subjected to regular review and revision in the light of changing conditions (NEDLAC, 2002; UNAIDS, 2000e; FHI, 2002; ILO, 2003, Vass, 2004).

3.3.3 Integrated Risk Management

Vass (2004) asserts that the perceptions of the possible impact of HIV/AIDS on a company are largely mitigated by the level of information available regarding the particular risks faced by the company.

Several guidelines and 'best practice' commentaries (Brink, 2005; FHI, 2002; GRI, 2003; IFC, 2002; King, 2002; NEDLAC, 2002; UNAIDS, 2000e) identify risk assessment and risk management as a key component of HIV/AIDS workplace programmes. Toward this end, economic impact assessments and institutional audits play an important role in the development of contemporary HIV/AIDS workplace programmes.

The NEDLAC Code reports that impact assessments should include: risk profiling, an assessment of the direct and indirect costs associated with HIV/AIDS and the measurement of the cost effectiveness of HIV/AIDS interventions in the workplace (NEDLAC, 2002).

As a starting point for risk assessment, FHI sets out three general methods that can be used to measure the primary exposure of a company to HIV/AIDS (FHI, 2002):

- conduct a HIV prevalence survey within the confines of VCT;
- extract the expected prevalence rates for the company from the public statistics for the region; and
- track company indicators including human resources and medical records.

VCT surveys reduce reliance on the broad assumptions in actuarial modelling required by the other two methods (ASSA, 2002) and offer the added incentive of increasing awareness among employees (UNAIDS, 2000d; Stevens et. al., 2006). However, application is limited by the relatively high costs of its various components and the continued spurious uptake by employees (UNAIDS, 2000d; Stevens, Apostolellis, Napier, Scott and Gresak (2006).

Despite theses complexities in calculating prevalance, sixty-five percent of companies surveyed were found to have estimated the prevalence of HIV/AIDS in a recent study by Connelly and Rosen (2006).

As the impact of HIV/AIDS in the workplace is too complex to be considered in accountancy terms alone, a broader method, such as the institutional audit is advocated by UNAIDS. The framework for this is formed by a series of six linked steps (UNAIDS, 2002):

1. personnel profiling
2. critical post analysis
3. assessment of organisational characteristics
4. estimation of organisational liabilities
5. productivity
6. organisational context

The loss of critical personnel has an effect, not only on the immediate running of an operation, but also the ongoing risk of not being able to replace critical personnel with employees of equal competency. This is supported by Dickinson's view that the future effect of HIV/AIDS on key personnel and company specific skills poses great risk to companies (Dickinson, 2005). UNAIDS concurrently argues that the identification of critical posts places companies in a better position to develop and adopt appropriate risk reduction strategies (UNAIDS, 2002).

3.3.4 Awareness, Education and Training

Concordant with the UNAIDS call for intensified efforts to avert new infections (UNAIDS/WHO, 2005) prevention remains the main focus for workplace HIV/AIDS programmes (GBC, 2006c). Although the development of education programmes that

provide information on HIV/AIDS is clearly beneficial, education initiatives have to focus on behaviour change to have a significant prevention impact (GBC, 2006c).

Dickinson (2003:35) suggests that the first tier of an HIV/AIDS programme namely; 'awareness, condoms and counselling'; represents interventions that can be easily achieved. However, the second tier, which includes: 'education and training, STI treatment and prevention of occupational infections'; requires a greater level of resources and tends to lag behind the first tier.

3.3.4.1 Awareness Programmes

As an increasing perception of risk has been shown to significantly increase HIV protective behaviour (Stevens and Hall, 1998); awareness programmes should be conducted to inform employees about HIV/AIDS, and to help them to protect themselves and others against infection (IFC, 2002, ILO, 2003).

The ILO emphasises the need for gender and age-specific awareness initiatives that will take into account the different needs of male and female employees, and will include the families of employees and the local community (ILO, 2002). Furthermore, the prescribed programme should address language differences (GRI, 2003; GBC, 2006c) and non-written communication (IFC, 2002).

The subject matter to be addressed in awareness programmes is listed in Table 3.3. The two codes and guidelines that were found to provide detailed information on what topics should be covered in awareness programmes are the ILO Code and the IFC's *Good Practice Note.* For this reason Table 3.3 includes content from these two sources.

Table 3.3 Subjects to be Covered by Awareness Programmes

Subject/ topic	ILO Code of Practice (ILO, 2002)	IFC Guidelines (IFC, 2002)
Modes and risks of HIV transmission	X	X
Methods of HIV prevention	X	
Social costs of HIV/AID infection	X	X
Possibilities for care, support and treatment	X	

Further important features of awareness programmes are that all information should be current (ILO, 2002) and the programmes should be regularly repeated (NEDLAC, 2002; ILO, 2002).

3.3.4.2 Education and Training Programmes

Education programmes are an essential component of workplace HIV/AIDS programme (ILO, 2002). The GRI, NEDLAC and FHI guidelines identify a range of key issues to be covered in the HIV/AIDS education programme. The components have been included in Table 3.4.

Table 3.4 Subjects to be Included in Workplace HIV/AIDS Education Programmes

	TAG (Department of Labour, 2003:59)	**FHI Guidelines (FHI, 2002)**	**GRI Guidelines (GRI, 2003)**
Company HIV/AIDS policy and position	Company policy	Details of company policy and position on HIV/AIDS	Communication of HIV/AIDS policy
Legal rights and grievance procedures	Legal, ethical and rights issues	Procedure for handling HIV/AIDS related grievances	
Working alongside co-workers who are HIV-positive	Working alongside PLWA		Working alongside HIV positive employees
HIV modes of transmission	Modes of transmission of HIV	Modes of transmission of HIV	Methods of HIV transmission
Methods of preventing HIV infection	Methods to prevent the spread of HIV/AIDS	Methods to prevent the spread of HIV/AIDS	Condom and femidom use
Prevention and treatment of STIs	HIV association with STIs	Prevention and treatment of STIs	HIV association with STIs
Safe sexual behaviours	Safer sex	Responsible sexual behaviour	Behavioural change to safer sex
VCT facilities	Testing facilities and processes		
Access to treatment	Availability of treatment care and support		Access to healthcare
Additional programme information	Available resources, referrals and support	Access to additional information and available resources	Awareness

These programmes are particularly important in attempts to reduce stigma (GBC, 2006c). As such, they are an investment that will benefit every workplace (UNAIDS, 2000e).

3.3.4.2.1 Induction Programmes

The introduction of HIV/AIDS induction training for new employees has become an increasingly important facet of workplace HIV/AIDS programmes. These programmes have gained support from the ILO and UNAIDS (UNAIDS, 2002; ILO, 2003) and should form part of all contemporary workplace programmes.

3.3.4.2.2 Peer Education

Reed (2004:242) describes peer education as; “the most powerful component” of workplace HIV/AIDS programmes. This view is supported by the suggestion that peer education has become central to an effective response to HIV/AIDS (UNAIDS, 2000a). George and Whiteside (2002) believe that this is because peer educators usually share a common cultural and communal background they are better equipped to understand HIV/AIDS issues and provide more effective counsel to employees.

The advantages of peer education are (Dickinson, 2005):

- understanding through shared experience;
- understanding of the language and patterns of communication;
- ability to access infected people and people at risk; and
- third channel of communication.

Successful peer education initiatives consist of a cross section of a company’s employees in terms of occupational level as well as demographic characteristics such as race, age and gender (Dickinson, 2003; Reed, 2004).

A project coordinated by UNAIDS in Jamaica identified principles and components that affect HIV/AIDS peer education programme quality and effectiveness. These include:

- providing training for peer educators (GRI, 2003; IFC, 2002 Reed, 2004; UNAIDS, 1999)
- compensating peer educators in some way (IFC, 2002, Reed, 2004; UNAIDS, 1999)
- involving them in the design of training curricula and materials (UNAIDS, 1999)
- linking the education programme to other components of the HIV/AIDS workplace programme (IFC, 2002; UNAIDS, 1999)

NEDLAC (2002) and GRI (2003) suggest that peer educator programmes can be measured by calculating the ratio of the number of peer educators to the number of employees. Reed (2004) counters this assertion by arguing that companies should rather focus on the quality of peer educators rather than the quantity of peer educators.

3.3.5 Prevention

The starting point for many companies establishing a workplace programme is to implement prevention interventions (Simon, Rosen, Whiteside, Vincent and Thea, 2000). Merson, Dayton and O'Reilly (2000) suggest that this is probably because so many prevention activities have been shown to be effective.

As a result, workplace prevention programmes have become one of the cornerstones of a comprehensive workplace response to HIV/AIDS (Department of Labour, 2003).

Four components ordinarily make-up prevention programmes:

- distribution of condoms (ILO, 2002);
- provisions of treatment for STIs (ILO, 2002);
- provision of post exposure prophylaxis (PEP) and;
- prevention of mother to child transmission.

3.3.5.1 Condom Promotion and Distribution Programme

An important element of any HIV/AIDS prevention programme is a reliable supply of free or affordable, high quality condoms. Toward this end, five components of a condom promotion and distribution programme have been identified as being crucial:

- condom promotion (FHI, 2002; GRI, 2003; IFC, 2002; NEDLAC, 2002)
- education on condom usage (George and Whiteside, 2002; GRI, 2003)
- widespread discrete access (George and Whiteside, 2002; FHI, 2002; GRI, 2003; IFC, 2002)
- condom stock management (GRI, 2003)
- condom quality assurance (GRI, 2003)

The Harmony Gold Mining Company (Harmony Gold) has identified a correlation between the low rate of condom distribution and high numbers STI cases presenting at the medical stations. For this reason, the company has targeted an increased distribution from three condoms per employee per month to ten condoms per employee per month (Harmony Gold, 2005).

Furthermore, condom usage can also be a measure to track responses to awareness, education and employee behavioural change initiatives.

3.3.5.2 STI Diagnosis and Treatment

Sexually Transmitted Infections (STI), particularly those which result in genital ulceration, can facilitate the transmission of HIV/AIDS by increasing the susceptibility of HIV-negative individuals and the infectiousness of HIV-positive individuals (Grosskurth, 1995; UNAIDS, 2006). As a result, interventions that are designed to treat symptomatic STIs promptly and effectively can achieve a substantial reduction in HIV incidence (Orroth, Gavyole, Todd, Mosha, Ross, Mwijarubi, Grosskurth and Hayes, 2000).

Treatment of STIs, therefore, offers a primary entry point for HIV/AIDS awareness and education activities (Department of Health, 1998; FHI, 2002; GRI, 2003; IFC, 2002; Department of Labour, 2003; UNAIDS, 2000a).

STI monitoring and surveillance affords companies the opportunity to identify patterns of unsafe sexual behaviour. By monitoring STI diagnosis and treatment

statistics, Harmony Gold identified a rise in STI cases around the time of the traditional Christmas and Easter Holiday periods (Harmony, 2005). This data allowed managers to intensify awareness and education during these periods.

3.3.5.3 Occupational Health and Safety

Although the risk of contracting HIV in the workplace is almost nil (Reed, 2004; UNAIDS, 2000e), blood accidents do occur. The possibility of infection is compounded when businesses are located large distances from facilities that provide access to PEP.

A number of the guidelines point to the issue of occupational health and safety (FHI, 2002; GRI, 2003; IFC, 2002; NEDLAC, 2002; NOSA, 2003; UNAIDS, 2000e). The incorporation of universal precautions and access to post-exposure prophylaxis into occupational safety training and the relevant safety manuals is becoming evermore important, in particular in workplaces with high HIV/AIDS prevalence rates (Department of Health, 2000).

3.3.5.4 Prevention of Mother to Child Transmission

Reed (2004) suggests that employees should be counselled on proper birthing procedures in relation to HIV/AIDS. Nevirapine, the standard agent used in the prevention of mother to child transmission, is available in South African Government clinics as standard therapy for HIV-positive mothers. Accordingly, there is no reason for pregnant employees not to be afforded access to this treatment. The prevention of Mother to Child Transmission (PMTCT) is advocated by GRI (2003), FHI (2002) and IFC (2002).

3.3.6 Voluntary Counselling and Testing

Brink (2005) suggests that one of the main reasons why the HIV/AIDS epidemic continues unabated is that so few people know their HIV status. Toward this end, voluntary counselling and testing (VCT) presents an avenue for the reinforcement of prevention (Department of Labour, 2003).

Regular VCT campaigns should be held to encourage all employees to test. This contrary to the belief that such campaigns are only for people who feel unwell or

suspect they may be HIV-positive. Importantly, employees who are diagnosed negative and know their status are empowered to remain negative (Mzolo, 2006).

Furthermore, VCT promotes early access to treatment, wards off AIDS associated illness and ensures cost effectiveness of ART treatment. As such, VCT supports the prevention strategy and forms the gateway to treatment and care (Harmony Gold, 2005).

VCT campaigns can also help employers determine the actual prevalence in their companies and are an important way for companies to measure the success of prevention initiatives (Mzolo, 2006). Dickinson (2003:38) endorses these positions by asserting that, “voluntary counselling and testing (VCT) is legal, desirable and good for the company and its employees”.

The goal for all companies should be to have a VCT system that is recognisable, acceptable and accessible within the ambit of confidentiality and non-discrimination. In a recent WEF survey fifty-seven percent of companies report that VCT has been included as a part of the workplace HIV/AIDS policy (WEF, 2005).

The success of VCT depends on education, information, and accessible convenient testing sites (Mzolo, 2006). Moreover, all HIV testing, whether it is ‘authorised’ HIV testing or ‘permissible’ HIV testing, should only take place under the following conditions:

- With informed consent (ILO, 2002 NEDLAC, 2002).
- Within a health care worker and employee-patient relationship (NEDLAC, 2002).
- With pre- and post-test counselling (FHI, 2002; IFC, 2002; ILO, 2002; NEDLAC, 2002; UNAIDS, 2000e).
- With strict procedures relating to confidentiality (IFC, 2002; ILO, 2002; NEDLAC, 2002; UNAIDS, 2000e).

Brink (2005:4) suggests that VCT be ‘vigorously’ promoted and that annual targets be set for VCT uptake. The theme of uptake targeting is fortified in the GRI reporting framework for HIV/AIDS whereby companies are required to report on the proportion of staff utilising VCT within specific time frames (GRI, 2003).

3.3.7 Treatment and Wellness

Although the main focus on workplace HIV/AIDS policies and programmes should remain on prevention (Reed, 2004; Whiteside, 2006); the evidence suggests that many businesses are - for both humanitarian and business reasons - beginning to expand their activities in the area of general well being and comprehensive disease management (Connelly, 2002; FHI, 2002; GBC, 2006c; IFC; 2002; UNAIDS, 2005; UNAIDS, 2006; WEF, 2005). In those countries hardest-hit by HIV/AIDS, including South Africa, up to thirty percent of firms offer ART treatment (WEF, 2005).

There are three principal components of healthcare (FHI, 2002; IFC, 2002; ILO, 2003) including a:

- wellness programme
    - advice on healthy living, including nutritional counselling and stress reduction
- treatment programme
    - treatment for the relief of HIV/AIDS-related symptoms
    - treatment of opportunistic infections
    - the provision of ART drugs
- support programme
    - reasonable accommodation
    - provision for the care of terminally-ill HIV/AIDS employees

In the ILO *Brief on Workplace Policy* (ILO, 2003), two alternatives exist, based on company size and available resources, for the provision of healthcare:

- an occupational health service that offers the broadest range of services to manage HIV/AIDS or
- a programme that assists employees living with HIV/AIDS to find appropriate:
    - medical services in the community;
    - counselling services;
    - professional support and;
    - self-help groups, if required.

Connelly and Rosen (2006) suggest that, although very few companies have the resources or the necessary expertise to run in-house programmes, it is unsafe to assume that employees will have ready access to treatment at public clinics for many years to come.

3.3.7.1 Wellness Programme

A wellness programme is advocated by NEDLAC (2002); ILO, (2002); GRI (2003) and Reed (2004). Dickinson (2003:35) defines a wellness programme as; "a proactive programme designed to educate and help people improve their diets, reduce stress and live more balanced lives." The Anglo American wellness programme has expanded on this position and endorsed this standpoint by including a broad range of components in the company wellness programme (Brink, 2005:9):

- understanding of HIV/AIDS through counselling
- encouraging a healthy lifestyle
- offering nutritional supplements
- immune system monitoring through regular CD4 counts
- preventing and treating opportunistic infections, especially TB
- providing access to appropriate, affordable and sustainable anti-retroviral therapy when clinically indicated

Furthermore, the efficiency of wellness programmes should be measured by setting targets of uptake and enrolment (Brink, 2005).

3.3.7.2 Treatment Programme

The *2001 Declaration of Commitment on HIV/AIDS* embraced equitable access to treatment as a fundamental to an effective HIV response (OHCR, 2006). At the 2005 meeting of the G8 Nations and United Nations World Summit, world leaders renewed their commitment to achieving universal access to treatment by 2010. In the interim, several employer programmes have definitively demonstrated the feasibility of delivering HIV treatment in resource-limited settings (UNAIDS, 2006). In a study of seventy-five member-companies, the *GBC Baseline Report* indicates that as many as seventy-percent of member-companies with operations in Africa are now fully subsidising access to HIV treatment for all employees (GBC, 2006c).

3.3.7.2.1 Provision of ART Drugs

In 2002, Anglo American became the first large South African company to announce drug provision for its employees on the grounds of cost effectiveness. Since then,

other large companies have made similar announcements and begun to supply ART drugs to their employees (Dickinson, 2003; Dickinson, 2005).

For Anglo American, access to ART is the most important intervention required to generate a long-term impact sufficient to turn the epidemic around. Moreover, ART therapy prevents illness, contains the cost of rising employee benefits, improves productivity and enhances workforce morale in general (Brink, 2003).

Although the cost and complexity of providing and administering treatment has been a barrier to widespread acceptance of ART in the majority of companies (Connelly, 2002; Dickinson, 2003; Rosen et al., 2000); a growing number of companies have decided to offer free or low cost ART through a sense of corporate social responsibility and an understanding that this approach will ultimately be less costly than not doing so (Naidoo, 2006; Rosen et al. 2003; UNAIDS, 2005).

Rosen et al. (2000) reports that, even for resource-limited companies, the benefits associated with treatment interventions outweigh the costs. Brink (2005) supports this assertion by reporting that over the first twelve months that Anglo American made ART freely available to employees, approximately seventy percent of the cost of the treatment was covered by the reduction in absenteeism; the remainder of the ART cost was covered by declines in healthcare utilisation and associated costs.

An actuarial finding in 2001 pointed out that it would cost Debswana and its subsidiaries almost twelve percent of the total payroll to provide ART to employees and their spouses. Despite the cost of providing the treatment outweighing the cost savings to the company, it was seen as a part of the total strategy and a way of mitigating the human and systemic costs of the disease. For this reason, the Debswana board approved the funding of company-wide ART treatment (UNAIDS, 2002).

Sendi, Palmer, Gafni and Battegay (2001) report that Highly Active Anti-retroviral Therapy (HAART) is the gold standard for treating HIV/AIDS infected patients. In the United States HAART has been the most commonly used treatment regime since 1996 and the effectiveness in reducing mortality and morbidity as a result of HIV/AIDS has been well documented (Barnett and Whiteside, 2002; Brink, 2003; Palella, Delaney, Moorman, Loveless, Furher and Satten, 1998). In the absence of

long term data on the effectiveness of HAART, the conservative assumption that HAART only postpones the occurrence of opportunistic infections still represents a good outcome (Sendi et al, 2001). Moreover, the treatment with HAART reduces viral load, thereby rendering HIV positive patients less infectious.

The implementation of HAART programmes cannot be realised in isolation. Kallings and Vella (2001) estimate that for every dollar spent on HIV/AIDS drugs, three dollars have to be spent on health infrastructure. These are complex treatment regimes and patients need to be monitored in appropriate facilities with specific medical service offerings such as reliable laboratories, training and voluntary counselling centres.

Further key components of a workplace HIV/AIDS treatment programme include:

- Treatment, observation and monitoring (Brink, 2005; IFC, 2002)
- Viral load testing (FHI, 2002)
- CD4 count testing (FHI, 2002)

Connelly and Rosen (2006) suggest that a company can only be considered to have a HIV/AIDS treatment programme if all of its employees have access to ART treatment regardless of which model is used.

3.3.7.2.2 Treatment of HIV/AIDS-related Symptoms and Opportunistic Diseases

HIV/AIDS infection is characterised by a progressive weakening of the immune system, with a result that infected individuals gradually become susceptible to a range of opportunistic infections.

The evidence of interventions that treat and prevent opportunistic infections is well documented: reports have shown that tuberculosis (TB) prophylaxis (Bell, Rose and Sacks, 1999; FHI, 2002; IFC, 2002; Moreno, Miralles, Diaz, Baraia, Padilla, Berenguer, and Alberdi, 1997; UNAIDS 1998) and pneumocystis carinii (co-trimoxazole) prophylaxis (Anglaret, Chene, Attia, Toure, Lafont, Combe, Manlan, N'Dri-Yoman and Salamon, 1999; Badri, Ehrlich, Wood and Maartens, 2001) have led to decreased opportunistic infections and increased survival time of HIV positive adults. By extending the working lives of employees, these interventions push the costs associated with HIV/AIDS further into the future, causing them to be discounted

more heavily and thus allowing for the benefits of the intervention to outweigh the costs incurred (Rosen et al., 2000).

As part of 'best practice', HIV-positive individuals should be evaluated for prophylaxis against opportunistic infections (IFC, 2002; GRI, 2003).

3.3.7.3 Support and Reasonable Accommodation

Companies are increasingly dealing with employees who are HIV-positive or who have become ill with AIDS. To maximise performance, the NEDLAC Code, as part of the wellness strategy, recommends that companies afford affected employees reasonable accommodation (NEDLAC, 2002).

Reasonable accommodation includes the following:

- Flexible working schedules (FHI, 2002; ILO, 2002; ILO, 2003; Department of Labour, 2003)
- Work re-structuring or re-assignment (Department of Labour, 2003)
- Special equipment (ILO, 2002)
- Opportunities for rest breaks (ILO, 2002)
- Time off for medical appointments (ILO, 2002)
- Onsite support groups (FHI, 2002, ILO, 2002)

3.3.7.4 Palliative Care and Home-based Care

Home–based care for employees terminally ill with HIV/AIDS increasingly falls within the ambit of 'best practice' (FHI, 2002; IFC, 2002). Three options currently exist for the provision of care:

- company medical staff administered
- family administered
- institutional caregiver administered (e.g. Hospice)

3.3.8 Programme Extension

HIV/AIDS is a societal issue (IOE, 2002). Infection, prevention and care exist in an environment where social, economic, political and family factors all influence workers' sexual behaviour; companies form one part of that environment (Boldrini and Trimble, 2006; FHI, 2002; ILO, 2003).

Beyond the motivations of financial incentive and risk management; companies are becoming motivated by a sense of corporate social responsibility (Dickinson and Stevens, 2005) to link programmes with interventions that will benefit the families of employees, the wider community and company's supply chain networks (GBC, 2006c; IFC, 2002; IOE, 2002; Boldrini and Trimble, 2006).

Programme extension beyond the formal workplace not only helps to reinforce efforts by companies to protect their staff when interacting with the communities around them (ILO, 2003), it also increases company profile and public respect (FHI, 2002). Moreover, if a company is to fulfil all three requirements of the triple bottom line it must add an outreach component to the workplace programme (Sunter, 2004).

3.3.8.1 Partners and Dependants

Because HIV is transmitted between partners and dependants, there is growing recognition that companies cannot only offer treatment to employees but will, of necessity, have to make key interventions available to dependants and life partners.

3.3.8.2 Suppliers, Distributors and Contractors

As HIV/AIDS has spread within the general population, large companies have begun to report reduced levels of quality and reliability amongst their suppliers and distributors (Boldrini and Trimble, 2006). The argument for extending assistance to these suppliers is significantly bolstered when the supply of materials is critical to the production process and those services that are difficult to substitute. FHI recommends that all sub-contractors be required to implement and maintain HIV/AIDS programmes at least equivalent to those of the company itself (FHI, 2002).

3.3.8.3 Community Extension

The ILO states that, "reaching out to and involving communities is essential for reducing the risks facing workers and their families and, ultimately, for the success of workplace activities" (ILO, 2003:40). Reports by Dickinson and Stevens (2005); Brink (2005) and Noehrenberg (1998) support this assertion by suggesting that company partnerships with communities and non-governmental organisations (NGOs) can

build alliances between workers and communities and in-turn render company efforts more successful.

Furthermore, the private sector can make significant contributions by drawing on its experience and expertise to raise public awareness and meet key public health needs (IOE, 2002; GBC, 2005). The support of community HIV/AIDS awareness activities not only contributes to corporate social responsibility and credibility but also adds to other initiatives to change social norms and beliefs (FHI, 2002; ILO, 2003). The most effective outreach programmes involve employees who have; “promoted HIV/AIDS prevention in the community where they live, worship and socialise” (FHI, 2002:12).

3.3.9 Monitoring, Evaluation, Review and Reporting

An examination of various definitions for ‘best practice’ (Table 2.1) established the need for ‘best practice’ to be evidence-based. Within companies, this manifests in the need for evidence and/or data that would allow for greater understanding of which programmes are working and which are not (Brink, 2003; Department of Labour, 2003; ILO, 2003). Data collation has, however, been hampered by the limited degree to which the outcomes of workplace HIV/AIDS programmes has been measured (Brink, 2003).

The NEDLAC Code, AMS 16001 and the GRI attach a great deal of importance to the monitoring, evaluation and review (MER) of company HIV/AIDS programmes (GRI, 2003; NEDLAC, 2002; NOSA, 2003); a position that is supported by a statement in Dickinson (2003:38) that alludes to the absence of monitoring, evaluation and review as; “a sign of weakness in implementation”. Moreover, monitoring of a corporate HIV/AIDS programme enables companies to measure their progress against stated goals and to make informed decisions about the effectiveness of the implemented interventions relative to the costs incurred (IFC, 2002; NOSA, 2003).

There are three essential functions in MER (ILO, 2003):

- Data collation
- Financial and situational analysis
- Trend monitoring and feedback

3.3.9.1 Data Collation

Connelly (2002) suggests that the lack of data has, in the past, contributed to poor decision making. Without both quantitative and qualitative data, the efficacy of workplace programmes cannot be reliably calculated (IFC, 2002) and without sufficient data, companies are not able to facilitate corrective and preventative action (NOSA, 2003).

To plan and evaluate the HIV/AIDS policy and programme effectively, regular surveys should be conducted to establish baseline data (ILO, 2003). Dickinson (2005) suggests that business costs rise disproportionately with the level of infection, thereby advocating regular HIV/AIDS prevalence surveys (ILO, 2003 and UNAIDS, 2002). This claim is supported by the GRI reporting guidelines that require companies to reports on the current and projected prevalence and incidence among relevant populations (GRI, 2003). Mortality data is the third indicator of disease progression (Berry and Noble, 2006) in addition to prevalence and incidence.

Data collection is, however, impeded by a number of business factors and an array of issues surrounding HIV/AIDS. Firstly; the stigma attached to HIV/AIDS makes it difficult to collect data on employees who have HIV/AIDS or have died as a result of HIV/AIDS (Berry and Noble, 2006; UNAIDS, 2002). Secondly; there is a timing dilemma because of the long latency period between HIV infection and the onset of symptoms (Berry and Noble, 2006; Rosen et al., 2000). Thirdly; the cost of data collection and contemporary management information systems means that few organisations are adequately equipped for the task of evaluating effects of HIV/AIDS on the workplace (Barnett and Whiteside, 2002; Dickinson, 2005).

Furthermore, HIV/AIDS data collection requires that the medical database interfaces with both the financial and human resource databases. One of the problems in larger corporations and companies with widespread operations is that the management information systems are not uniform across the operation. Often definitions of absenteeism and productivity differ widely. The systems are, therefore, not always well-adapted to collecting relevant HIV/AIDS data (UNAIDS, 2002). In response, management information systems often need to be elaborated and refined along the lines of integrated Group Information Systems.

The following data is required for an institutional audit (UNAIDS, 2002) and would thus form the basis for collection by the management information system:

- Personal Impact Data
    - Sick leave absenteeism
    - Compassionate leave
    - Ill-health, retirement and death data
    - Recruitment, training and payroll costs
- Health Impact Data
    - Healthcare costs
    - Bed Utilisation rates
    - Disease profiles

3.3.9.2 Financial and Situational analysis

Cost and cost-effectiveness analyses serve to provide basic evidence for on-going policy questions and debates (UNAIDS, 2000c). The direct and indirect costs of activities, and of their benefits, need to be evident and analysed (GRI, 2003; ILO, 2003).

3.3.9.3 Trend Monitoring

The dynamic nature of HIV/AIDS in terms of knowledge, impact and 'best practice' necessitates the monitoring of programme and medical trends (UNAIDS, 2000c). Few situations remain static over time and no interventions are without room for improvement. For these reasons trend monitoring and critical feedback loops are crucial for companies to continuously adapt interventions to environmental trends (ILO, 2003; Department of Labour, 2003).

3.4 Chapter Conclusion

The response of businesses to HIV/AIDS appears to be driven by strong socioeconomic forces. Firstly; growing expectations from government and a broad range of stakeholders that include; investors, employees and community groups, appear to have forced companies into careful consideration of the effect that social pressures would have on the response to HIV/AIDS in the workplace. Secondly; the impact that an increased level of HIV prevalence has in terms of increased costs,

declining employee moral and strained productivity, appears to be defining - in theory at least - a business case that could potentially drive the response of businesses to HIV/AIDS. As a result of these forces, it is likely that many large South African companies have been forced to explore strategies to combat the adverse effect of HIV/AIDS on business.

With the increasing demand for HIV/AIDS-related information, several agencies and business fora have come into existence and a range of guidelines have been published to shape the business response to HIV/AIDS. Reassuringly, the in-depth analysis of fourteen of these codes and guidelines and several 'best practice' publications in this chapter demonstrated broad overlap in the content included in these publications. Moreover, there appeared to be significant degree of content congruence in nine principal components for comprehensive workplace HIV/AIDS programmes.

The concept 'best practice' was, however, found to be widely used in most of the codes and guidelines in an attempt to promote specific workplace interventions. On a theoretical level this appeared to make sense. However, as more organisations have gone on to implement examples of 'best practice' - with varying levels of success - the validity of 'best practice' has been brought into question.

Two reasons are likely to exist for the disconnection between 'best practice' theory and practice. Firstly; examples of 'best practice' do not always include all the variables that are required to ensure that the intervention is a success (analysis of the codes and guidelines in this chapter provided several examples of 'best practice' interventions that appeared to be very generic). Secondly; because of the nebulous nature of 'best practice' as a management concept, many HIV/AIDS practitioners are unlikely to have an in-depth understanding of what the concept really means and how to objectively evaluate various examples of 'best practice'.

The aim of this research was, therefore, to reaffirm the value of 'best practice' within the context of workplace HIV/AIDS programmes and to establish a greater level of understanding regarding the specific meaning of the 'best practice' and of the interventions required to make-up a successful workplace programme.

In order to achieve these objectives, a robust research instrument - based on data collated during the literature analysis - would need to be constructed; and a shared understanding of the value and meaning of ‘best practice’ would need to be established through in-depth analysis of the viewpoints of a wide-range of HIV/AIDS practitioners and researchers.

4 RESEARCH METHODOLOGY

4.1 Chapter Introduction

This chapter reports on the methodology employed in the research; it describes the survey population, sample selection, data collection and data analysis that were applied by the researcher to resolve the research questions.

4.2 Nature of the Research

The study examined the concept of 'best practice' within the domain of HIV/AIDS workplace programmes in large South African companies. The researcher conducted an in-depth analysis of original resources of 'best practice' and carefully considered the perceptions of thirty-nine HIV/AIDS practitioners, experts and service providers regarding the notion of 'best practice'.

The study also sought to identify the factors that affected the uptake and continuity of 'best practice' in workplace HIV/AIDS programmes and in so doing, allowed for the development of a greater level of understanding regarding the meaning and value of 'best practice' within the HIV/AIDS programmes of large South African companies.

The data was captured from two principal resources: a desktop investigation of current literature regarding workplace HIV/AIDS practices and a content analysis of transcripts made during a series of semi-structured interviews.

An extensive desktop analysis of fourteen codes and guidelines and several more 'best practice' documents was conducted as part of the literature review (Chapter 2 and Chapter 3). This allowed for the researcher to further develop his understanding of workplace HIV/AIDS interventions and for the research to identify the degree of content overlap between various 'best practice' documents.

The field investigation comprised thirty-nine semi-structured interviews with a range of decision-makers in the field of workplace HIV/AIDS programmes. Twenty-four interviews were conducted with company respondents and a further fifteen interviews with a range of HIV/AIDS experts, consultants and service providers. The research sample was carefully designed and interviewees were selected based on extent of knowledge and experience in the field of study.

During the course of the interviews, the evidence presented in the literature was substantiated and additional factors were identified. Leedy and Ormrod (2005) point out that the additional data collected earlier on in a qualitative investigation often influences the type of data subsequently collected. This allowed for the limited use of emergent design during the first three interviews for the study.

To inform the outcome of the study, the researcher employed an interpretive analysis as part of a qualitative methodology. Leedy and Ormrod (2001) suggest that qualitative research allows for the interpretation of data so as to enable the researcher to gain insights about a particular phenomenon. In this report the use of a qualitative research paradigm allowed for the data analysis to inform the further understanding of the concept of 'best practice'; its origins, usefulness and the factors that affected its uptake.

4.3 Research Population

4.3.1 Large Companies

The researcher sought to extract a cross-section of opinion regarding the concept of 'best practice' for workplace HIV/AIDS programmes. For this reason, the research population comprised all relevant representatives from large private sector companies - both public-listed and private - to whom the standard of the organisation's HIV/AIDS programme was considered to be important.

The definition of 'large' companies was deduced from the schedule in the National Small Business Amendment Act of 2003 and the definition for 'large' businesses used in the 2005 SABCOHA/BER survey (Ellis and Terwin, 2005). Based on these writings, 'large' companies were classified as those which had greater than five-hundred permanent employees. Noteworthy, was the fact that only two of the companies included in the interview schedule, reported employing less than one-thousand permanent employees. The list of company respondents together with the organisation's approximate number of employees is included in Table 4.1.

A further requirement was that all companies included in the research sample had to have a HIV/AIDS programme in place and a designated person for co-ordinating the programme.

4.3.2 Consultants and Service Providers

To enhance and validate the data collated in the area of study, input was sought from a range of experts and consultants involved in workplace HIV/AIDS programmes. The research only considered respondents with greater than five years of experience in workplace programme development, implementation and research as part of this category.

Vass (2004) reports that service providers play an important role in interpreting policy and developing business practice along such lines; they support private business by supplying knowledge and information. For these reasons, the commentary of service providers was deemed to be an important component of this research.

Furthermore, consultants and service providers were considered by the researcher to have had experience that pertained to a variety of organisations and were, therefore, in a good position to make wide-ranging contributions to the body of research.

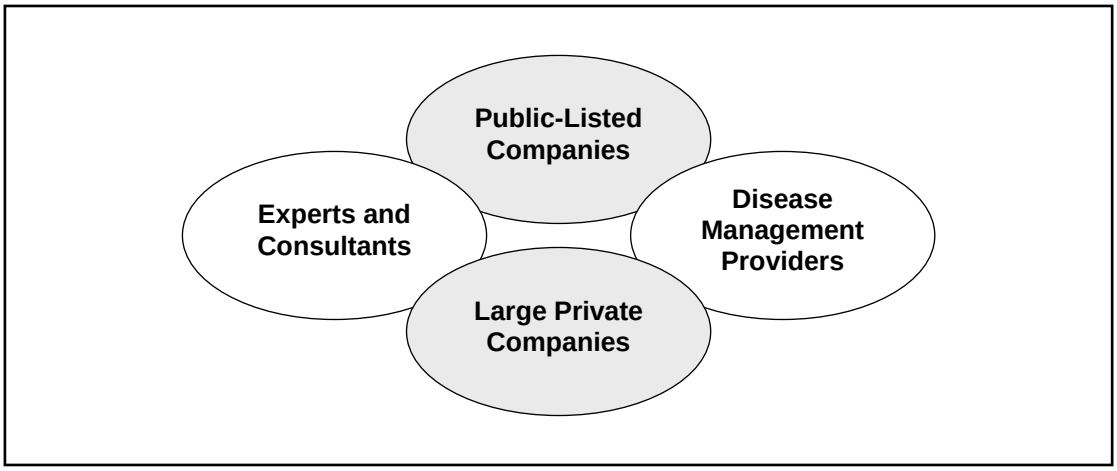
The list of experts, consultants and service providers is included in Table 4.2.

4.4 Research Sample

4.4.1 Sample Design

Leedy and Ormrod (2005) suggest that triangulation can be used as one of the ways to support the validity of the findings. For this reason, the sample was, at first, designed to include representatives from three main categories: public-listed companies, large private companies and field experts and consultants. During the course of the study, however, the author recognised a need to target representatives from specific service provider companies and, more specifically, disease management provider companies. The sample was, therefore, re-structured to incorporate representatives from the four groups as illustrated in Figure 4.1.

Figure 4.1 Sample Design and Respondent Categories



To effectively assess current perceptions of 'best practice' within the workplace HIV/AIDS community, the author conducted thirty-nine in-depth interviews with HIV/AIDS decision-makers in each of the four categories.

Purposive sampling was used to select the interviewees. In order for the research to assimilate a range of knowledgeable perspectives, the interviewee selection was based on the degree of involvement and experience of respondents in the field of workplace HIV/AIDS programmes. Toward this end, the researcher specifically pursued interviews with healthcare executives, human resources executives, company HIV/AIDS practitioners, corporate social investment managers, medical directors and occupational health personnel (Table 4.1).

Table 4.1 Company Respondents

	Organisation	Number of employees*	Designation \ Position
Public Listed Companies			
1.	Multinational Diversified Mining Company	195,000	Healthcare Executive 1
2.	Multinational Gold Mining Company	60,000	Company HIV/AIDS Practitioner 1
3.	International Services Company, Security Subsidiary	93,000	Human Resources Executive 1
	Multinational Diversified Retail Company	22,000	
4.	Diversified Retail Company Subsidiary 1		Human Resources Executive 2
5.	Diversified Retail Company Subsidiary 2		Company Medical Officer
6.	Diversified Retail Company Subsidiary 3		Human Resources Executive 3
7.	Diversified Retail Company Subsidiary 4		Human Resources Executive 4
8.	Multinational Industrial Services Company	6,500	Healthcare Executive 2
9.	Multinational Financial Services Group	33,000	Healthcare Executive 3
10.	Multinational Healthcare Company	18,000	Company HIV/AIDS Practitioner 2
11.	Multinational Food and Beverage Group	140,000	Corporate Social Responsibility Manager
12.	Multinational Food and Beverage Group	140,000	Company Nurse Practitioner 1
13.	Multinational Consumer Products Group	>200,000	Healthcare Executive 4
14.	Multinational Consumer Products Group	>200,000	Company Nurse Practitioner 2
15.	South African Telecommunications Company	>20,000	Occupational Health and Safety Manager 1
Large Private Companies			
16.	Multinational Mining Company	12,000	Human Resources Executive 5
17.	International Health Distribution Company	600	Occupational Health and Safety Manager 2
18.	Large Diversified Industrial Services Company	700	Human Resources Executive 5
19.	Large Food and Beverage Services Company	>5000	Company HIV/AIDS Practitioner 3
20.	Large Diversified Industrial Services Company	>12000	Support Services Manager
21.	Large Utility Company	30000	Company HIV/AIDS Practitioner 4
22.	Large Diversified Transportation Group	>30000	Human Resources Executive 6
23.	Large Security Services Group	>5,000	Human Resources Executive 7
24.	Large Security Services Group	>5,000	Industrial Relations Manager

* Estimated

Table 4.2 Experts/Consultants and Service Provider Respondents

	Organisation	Designation \ Position
Experts and Consultants		
1.	Private Consulting Company	Private HIV/AIDS Consultant 1
2.	Private Consulting Company	Private HIV/AIDS Consultant 2
3.	Private Consulting Company	Private HIV/AIDS Consultant 3
4.	International Business Agency	Private HIV/AIDS Consultant 4
5.	International University	International HIV/AIDS Researcher
6.	HIV/AIDS Business Coalition	HIV/AIDS Agency Director 1
7.	HIV/AIDS Business Coalition	HIV/AIDS Agency Director 2
8.	Private Consulting Company	Private HIV/AIDS Consultant 5
Service Providers		
9.	Disease Management Provider Company	Disease Management Consultant 1
10.	Occupational Health Consultant	Occupational Health Consultant 1
11.	Integrated Disease Management Provider	Disease Management Consultant 2
12.	Disease Management Provider	Disease Management Consultant 3
13.	Disease Management Provider	Disease Management Consultant 4
14.	Disease Management Provider	Disease Management Consultant 5
15.	Occupational Health Provider	Occupational Health Consultant 2

Prospective respondents were assured that - if required - their participation would remain anonymous and confidential. However, for the purposes of consistency, the researcher later elected to assure all participants that their participation, commentary and representation would remain anonymous. For this reason Table 4.1 and Table 4.2 only include generic descriptions of the organisations and the references used for the respondents in the research.

To ensure that the validity of the research has not been compromised, the author has included a separate research addendum that details the names of respondents and the organisation they represented. This table has been included solely for examination purposes with the understanding that details of the table will remain confidential.

4.4.2 Sample Coordination

The researcher initially contacted all the preferred respondents telephonically. This method of communication was chosen on the premise that personal communication would enhance the likelihood of getting respondents to agree to partake in the research.

During the telephonic conversation, the researcher introduced himself as medical doctor with a specific interest in the field of workplace HIV/AIDS programmes. The purpose and importance of the study were outlined together with the detailed the mode of data collection. The credibility of the research was substantiated through mention of the fact that the study would be conducted under the supervision of Professor David Dickinson, an already acclaimed researcher in the field of workplace HIV/AIDS programmes.

The reaction to the research proposal was, surprisingly participative, with all but one prospective respondent agreeing to be interviewed. Whenever possible, appointments were scheduled at the time of the initial contact.

Prior to the appointment, the researcher e-mailed a letter of introduction (Appendix A) outlining the purpose, content and methodology of the research. In addition, the interview questions and questionnaire (Appendices B and C) were forwarded to all respondents no later than twenty-four hours prior to the scheduled appointments.

This correspondence proved invaluable in ensuring that respondents were familiar with the parameters of the enquiry and at ease during the interviews.

4.5 Data Collection

Data was captured from two principal resources: a desktop investigation of current literature and data collected during a series of semi-structured in-depth interviews. Further data was gathered by way of a research questionnaire. The aim of this section is to describe the content and structure of the research interview and questionnaire.

4.5.1 In-Depth Interview

The primary method for data collection in the field was semi-structured in-depth interviews, an approach considered by Dickinson (2004) to be of particular value when attempting to expose and understand the dynamics of the research topic. The interviews elicited the opinions and perspectives of the respondents on 'best practice' in workplace HIV/AIDS programmes.

The advantages of an in-depth interview are:

- It provides access to information that is difficult to obtain through other research methods (Saunders, Lewis and Thornhill, 2000)
- The researcher can take note of non-verbal behaviour (Pirow, 1990)
- Its flexibility allows the researcher to prompt if necessary (Pirow, 1990)
- It allows the researcher to shift the focus if necessary (Leedy and Ormrod, 2001) and probe the person's reasoning (Leedy and Ormrod, 2005).
- The researcher controls the questions asked (Cresswell, 1994)
- It provides for immediate clarification of ambiguous answers (Saunders, Lewis and Thornhill, 2000)

The disadvantages of an in-depth interview are, however:

- People are not equally articulate, communicative or perceptive (Cresswell, 1994)
- The presence of the researcher inevitably affects the content and flow of events (Leedy and Ormrod, 2001:162)
- Data may be misinterpreted by the researcher (Saunders, Lewis and Thornhill, 2000)
- Some issues may remain undiscovered if neither researcher nor informant is aware of a specific issue or its relevance to the research topic (Dickinson, 2005)
- The differing information obtained from different people may result in the researcher not being able to compare the responses (Leedy and Ormrod, 2005).

In a semi-structured interview the researcher may follow a set of core questions, with one or more individually tailored questions to obtain clarification or probe a person's reasoning (Leedy and Ormrod, 2001). Disparately, a structured interview allows for

the researcher to ask nothing more than a standard set of questions (Leedy and Ormrod, 2005).

The questions forming the basis of the semi-structured in-depth interview for this research were divided into four broad categories. This was to elicit responses that would specifically inform the research questions. The interview was structured according to the following themes and core questions:

- Resources used to collate information on 'best practice'.
- Organisational opinion regarding 'best practice' intervention in workplace HIV/AIDS programmes:
    - perceptions of what 'best practice' is
    - importance of 'best practice' in managing HIV/AIDS programmes
- Factors affecting the uptake and implementation of 'best practice':
    - uses of 'best practice'
    - limits of 'best practice'
- Opinions and perceptions regarding benchmarks and standards of practice:
    - transferability of 'best practice' across companies and industries
    - legislation and regulation
    - standards of governance and management

With the open-ended questions, the researcher generated fuller data that allowed for the understanding of the respondents' perceptions regarding 'best practice' in workplace HIV/AIDS programmes.

The thirty-nine semi-structured in-depth interviews were conducted during the period between April 2006 and June 2006. All interviews were conducted by the researcher in person. Permission for audio recordings was granted by all participants, thereby allowing the researcher to concentrate and direct probing questions without the distraction of extensive note taking.

Wherever ambiguous answers arose and the themes did not converge to answer the research questions, the researcher conducted additional interviews. Similarly, where matters remained unclear within certain interviews, the researcher pursued further interviews with alternative respondents within the same organisation.

4.5.2 Research Questionnaire

The research questionnaire had a dual purpose in this study; firstly, it allowed for data collection that would establish whether those involved in the research, design and implementation of workplace HIV/AIDS programmes were in agreement regarding the principal components of workplace HIV/AIDS programmes. Secondly, the questionnaire assisted the researcher in establishing what factors affect the uptake of 'best practice' within large South African companies.

4.5.2.1 Research Questionnaire Structure

The questionnaire included opinion and judgement according to the nine components of comprehensive workplace HIV/AIDS programmes identified in Chapter 3:

- Leadership commitment and strategic planning
- Policy development and review
- Integrated risk management
- Awareness, education and training (AET)
- Voluntary counselling and testing (VCT)
- Prevention
- Treatment and wellness
- Programme extension
- Programme performance monitoring and reporting

The questions in the questionnaire also allowed for respondents to point out which interventions - based on the list of key interventions extracted in Chapters 3 - were included in their company's HIV/AIDS programme. The researcher followed these responses up by probing for information as to the reasons for the respondent's particular response.

4.5.2.2 Research Questionnaire Response

The research questionnaire was sent to all thirty-nine interviewees more than twenty-four hours prior to the scheduled interviews. Despite this, only twenty-nine questionnaires (74%) were eventually retrieved. The reasons for this were mainly related to the reported time constraints of several interviewees.

In view of the limited time available during a number of the interviews, the researcher elected to focus on the in-depth interview component. This approach proved to be helpful in building a level of comfort and trust with interviewees and resulted in most interviews being extended well beyond an hour.

As a result, the researcher was able to cover all aspects of the in-depth interview as well as assist several respondents in completing the questionnaire. By assisting the respondents in completing the questionnaire, the researcher was afforded opportunity to probe and discuss some of the more interesting responses to the questionnaire.

4.6 Data Analysis

Leedy and Ormrod (2005) suggest that human communication is typically analysed using content analysis. The interpretive nature of this research rendered it appropriate for the responses to be examined using content analysis.

The content analysis was in the form of thematic analysis, whereby recurring themes were noted and each response was assessed to identify any patterns or trends that the data reflected. The content analysis allowed for the data to be scanned for differences and similarities between the various companies and their representatives. The outcomes from the content analysis and the thematic frequency analysis were then compared with the theory extracted from the literature review.

4.7 Validity and Reliability

Leedy (1993) suggests that validity is concerned with the soundness and effectiveness of the measuring instrument, and whether the research really measures what we think we are measuring. Whereas validity errors reflect biases in the measuring instrument itself, reliability errors reflect use of the instrument (Leedy and Ormod, 2005). As a result, validity errors are relatively constant sources of errors as opposed to reliability errors which tend to vary unpredictably.

The number of interviews conducted was relatively small in number and, because the representatives were not randomly selected and may not necessarily have been representative of the entire business community; the researcher recognised the potential for research bias. For this reason it was not possible to generalise the

opinions and views and extrapolate the research findings across the research population in its entirety.

The reliability of the research was, however, enhanced by the semi-structured interviews whereby the content of all the interviews was been underpinned by a set of core questions.

4.7.1 Internal Validity

Internal research validity is according to Leedy and Ormrod (2001:103); “the extent to which its design and the data that it yields allow the researcher to draw accurate conclusions about cause-and-effect and other relationships in the data”. Moreover it “tends to minimise alternative explanations for the results obtained” (Leedy and Ormrod, 2001:107).

To confirm internal validity, the researcher verified with interviewees that the conclusions which were drawn were both accurate and reflected the views of the organisation they represented. To limit the natural bias associated with qualitative research, the researcher conducted in-depth interviews and sought to include various perspectives from multiple sources.

4.7.2 External validity

Leedy and Ormrod (2001) assert that external validity is the extent to which results apply to situations beyond the body of research. The researcher recognised that, because many of the key issues and interventions identified were environmentally specific – the findings of the study were potentially limited to the workplace HIV/AIDS programmes in South African. However, the researcher did believe that the broad principles of ‘best practice’ were likely to be transferable to contexts outside South Africa thereby rendering the results valid beyond the South African context. The diversity of expert opinion collated as part the research process was regarded as testimony to the external validity criterion.

5 PRESENTATION AND ANALYSIS OF THE RESULTS

5.1 Chapter Introduction

This chapter analyses the findings of the research and presents the evaluation of the concept, 'best practice' and of 'best practice' HIV/AIDS interventions in large South African companies. The chapter comprises four sections: each section presents findings that specifically relate to one of the four objectives of the study:

- the value of the concept, 'best practice';
- the definition of 'best practice';
- the principal components of comprehensive workplace programmes and;
- the factors that affect the uptake and continuity of 'best practice'.

The first of these four sections considers the opinions of a wide-range of company representatives, consultants, experts and disease management providers regarding the value of 'best practice' in the management of workplace HIV/AIDS programmes. In addition, the section explores the association between what respondents considered to be 'best practice' and the 'best practices' included in the various codes and guidelines.

In the second section, the author considers the research data that related directly to defining the concept 'best practice'. The aim of this section was to develop a shared understanding of what respondents considered 'best practice' to mean, to align this with the findings of the literature review and to synthesise these outcomes into a compact and coherent definition for 'best practice'. The section undertakes an exploration of the conceptual framework developed during the course of the research process and delineates clear dimensions along which decision-makers could objectively analyse various 'best practice' interventions.

The third section presents the analysis of the research questionnaire. This section explores the response to specific workplace interventions and details the level of agreement among respondents regarding the principal components of comprehensive workplace HIV/AIDS programmes.

The fourth and final section deals with the factors that affect the uptake and continuity of 'best practice'. In parallel with this, the section also explores issues

relating to the transferability of ‘best practices’ between different companies and across different industries.

5.2 Value of ‘Best Practice’

5.2.1 Section Introduction

This section explores the value of the concept, ‘best practice’ in the design and on-going management of HIV/AIDS programmes in large South African companies.

The first part of this section explores the reservations surrounding the term ‘best practice’. The purpose of this sub-section is to shed light on the reasons for the loss of faith in the concept and in-so-doing present the specific shortcomings of ‘best practice’ as a management concept.

The second part of this section looks more closely at one of the significant findings of this research: the surprisingly low usage of the codes and guidelines. A more detailed examination of the reasons for the marginal uptake of the codes and guidelines was required when it was observed that respondents often could not separate their thoughts relating to the codes and guidelines from their thoughts regarding ‘best practice’. As an additional outcome, this examination also helped the author in assessing the practical usefulness of the codes and guidelines in the design and implementation of workplace programmes.

In the third sub-section arguments are presented for the persistent interest in and use of the concept, ‘best practice’. This sub-section draws on evidence of the widespread use of the term and its inherent marketing attributes to demonstrate that ‘best practice’ remains a valuable concept in promoting the uptake of workplace HIV/AIDS interventions in certain instances. In view of the limited uptake of the codes and guidelines observed in the first sub-section, this sub-section also provides details regarding the alternative methods which managers were found to be using to establish how ‘best’ to manage HIV/AIDS in the workplace.

5.2.2 Reservations Surrounding 'Best Practice'

To obtain a clearer understanding of workplace programmes and the associated workplace HIV/AIDS community the author attended the 2006 *SABCOHA Private Sector Conference on HIV/AIDS.*

From the outset of the conference it was clear that 'best practice' played a significant role in workplace HIV/AIDS thinking. During the opening address, the Managing Director of Human Resources at Eskom, Mpho Letlape made the assertion that; "*we need to move from the review of best practice to the implementation of best practice*" (Letlape, 2006). Despite the influential appeal, the statement was built on two key assumptions: the first assumption was that the concept, 'best practice' was fully developed and the second assumption was that the workplace HIV/AIDS community knew what 'best practice' really was.

Several delegates at the conference pointed to the relative youthfulness of the knowledge-base surrounding HIV/AIDS. They contested that far more research and general field experience would be required before anyone in the HIV/AIDS community would be able to accurately define the best way to manage the disease in the workplace. In a similar vein, Sydney Rosen, a researcher from Boston argued that;

> For some time now, we've been claiming best practice but, in reality we don't know what it is. The fact is; we don't really know what works. If we really knew what best practice is, I'd feel much more comfortable punting it (Rosen, 2006).

During the course of the thirty-nine in-depth interviews conducted for this study, several respondents confirmed the above-mentioned observations around the relative youthfulness of the field of study and highlighted the point that it may well have been too early to define 'best practice' (Private Consultant Respondent 1, 2006; Private Consultant Respondent 2, 2006; Company HIV/AIDS Practitioner Respondent 3, 2006).

A number of respondents also questioned the way in which certain organisations promoted 'best practice' by way of case studies and achievement awards when; "there are no set benchmarks against which to measure these practices"

(Occupational Health Consultant Respondent 1, 2006). The practices from a small pool of pioneering companies enabled the establishment of informal benchmarks and many so-called ‘best practices’, but without a greater scale of HIV/AIDS workplace programme uptake, these practices were not always considered representative of what ‘best practice’ should be.

Moreover, there was general concern that many organisations had accepted the ‘best practices’ of acclaimed companies without paying due consideration to the apparent lack of supporting evidence. An experienced HIV/AIDS consultant highlighted this point by suggesting that: “the concept has just been taken on by too many people who have not questioned it” (Private Consultant Respondent 1, 2006).

The fact that there had been relatively limited opportunity to benchmark and test HIV/AIDS interventions within a range of different contexts and against a number of similar interventions appeared to have been a root-cause for existence of questions around the validity of ‘best practices’. Interpretation of the literature review raised similar questions around the validity of ‘best practice’ and the extent to which ‘best practices’ could be transferred within and between companies. Similarly, a large number of respondents confirmed uncertainty as to the usefulness of ‘best practice’ in managing HIV/AIDS in the workplace across different companies and industries.

To fully evaluate the usefulness of ‘best practice’ it was important for the researcher to consider the reasons behind this uncertainty. The content analysis of the in-depth interview recordings gave rise to three main reasons for this:

- the inattention to differences in organisational operating environments;
- the inattention to the role of the HIV/AIDS practitioner and;
- the inattention to continuous improvement.

5.2.2.1 Inattention to the Differences in Organisational Operating Environments

The general scepticism around ‘best practice’ appeared to stem from the suggestion that, despite the different environments within which businesses operate, a certain approach could be considered the ‘best way’. A service provider noted that - amongst the many factors that had an affect on HIV/AIDS workplace programmes - “the definition of best practice depended on the industry involved, the maturity of the

company and the demographic composition of the organisation (Disease Management Consultant Respondent 1, 2006).

'Best practice' was, therefore, widely considered to be a function of context. Understanding that businesses were unique in a number of respects and that operating environments were not uniform across companies, resulted in a number of the respondents questioning the oversight of context:

> You can't say it's 'best practice' when in some contexts that practice would be unachievable and in other contexts that practice would barely meet the minimum standard (Private Consultant Respondent 1, 2006).

Interestingly, context differed not only between companies but also within companies. Companies with extensive operations and large global footprints appeared to have similar difficulties in reaching consensus on what 'best practice' was. A respondent from a multinational company with numerous large subsidiaries pointed to the difficulty of achieving the same results within a company where systems and processes were deemed to be almost identical: "the practices within our organisation may have been the same, but I keep seeing outcomes across our companies that remain vastly different" (Multinational Industrial Services Company; Healthcare Executive Respondent, 2006).

This phenomenon was confirmed in reports from respondents in a large retail company that had recently rolled out a 'comprehensive' workplace HIV/AIDS initiative across the company's numerous subsidiaries. Although the interventions and fundamental practices had been integrated in the different business units under the guidance of the same managers, the programme outcomes proved to be radically different (Multinational Diversified Retail Company; Human Resources Executive Respondent 2, 2006).

5.2.2.2 Inattention to the Importance of the HIV/AIDS Manager

Further scepticism arose from the impression that 'best practices' were a part of a process that could simply be disassembled, transferred and re-assembled in another company. The process manager - in this case the HIV/AIDS manager – was seen by respondents to have a crucial role in affecting the success of 'best practice' interventions. An experienced consultant in the field made a relevant suggestion that

'best practice' may have been more dependent on the company's HIV/AIDS manager than any other factor:

> Some companies may show some good results, not because it's the particular way in which it has been done but because the people who have been doing it have been very good (Private Consultant Respondent 2, 2006).

The concern was, therefore, that 'best practice' interventions were, too often, presented as 'ready-made' practices that could be easily replicated by other companies without due concern for the role the HIV/AIDS Manager and/or Champion played in the overall success of the intervention.

5.2.2.3 Inattention to Continuous Improvement

Respondents in the research also raised concerns over the concept's exclusive undertone. 'Best practice', as a respondent remarked; "implies we know what is best, and I don't think anyone has clue [about what is best]" (International HIV/AIDS Researcher Respondent, 2006). As such, 'best practice' was seen to imply an action in the superlative; a method that remained unmatched and required no further improvement.

The concept was, therefore, considered antithetical to the ethos of constant improvement and practice development. As people were still getting ill and dying from HIV/AIDS in workplaces in many South African companies, there was a strong feeling that much more needed to be done and that no workplace HIV/AIDS intervention could be considered to be 'best practice' until these objectives had been more closely met. For this reason, there were suggestions that future examples of 'best practice' would need to ensure that companies included ongoing improvement initiatives in their workplace strategies and programmes.

5.2.3 Marginal Uptake of 'Best Practice' Codes and Guidelines

The literature review strongly suggested that the assortment of codes and guidelines for workplace HIV/AIDS interventions would be an obvious and, preferred resource for companies, consultants and disease management providers to use when implementing and modifying workplace HIV/AIDS programmes. However, from the

outset of the study, it was apparent that the codes and guidelines were not being used as widely as the literature review may have suggested.

Of the thirty-nine respondents to this study, only two spontaneously reported using any of the codes and guidelines; the one respondent was a consultant in the field and the other, a respondent from a private company that was looking to expand its programme. Deliberate prompting by the researcher around the potential use of specific codes and guidelines elicited only three additional positive responses. Two of these respondents were from the same public-listed retail company and the other represented a private industrial company.

Although prior informal conversations with people working in the field of HIV/AIDS introduced a number of reservations regarding the concept, ‘best practice’; there were few signs to suggest that the codes and guidelines were considered with similar reservation. However, the content analysis made apparent that - in the minds of the research respondents - the two entities were closely intertwined and that there was no clear divide between ‘best practice’ and the codes and guidelines.

Within the context of this research, the close link between ‘best practice’ and the codes and guidelines brought added significance to the observed lacklustre uptake of the codes and guidelines. This association afforded the researcher opportunity to explore the reasons behind the low usage of the codes and guidelines as a proxy for understanding the scepticism surrounding ‘best practice’.

In addition to this, the deliberate examination of the reasons for the codes and guidelines led naturally to an exploration of what – if any – methods companies, consultants and researchers were using to stay abreast of contemporary HIV/AIDS interventions.

5.2.3.1 Reasons for Marginal Uptake of the Codes and Guidelines

Several themes emerged for the marginal uptake of the codes and guidelines. A number of the consultants that were interviewed attributed the low uptake to managers not being aware that resources exist:

> I don't think the companies I have worked with even know UNAIDS has a set of best practice guidelines and has an office right here in Pretoria. They never think of the ILO, UNAIDS or the WEF (Private HIV/AIDS Consultant Respondent 4, 2006).

However, the prevailing themes outlined as reasons for the marginal uptake, focused on the conscious decision of the various respondents not to use them. Respondents either accused them of being too theoretical or suggested that they were not bound by regulation which would have ensured a measure of enforced uptake and implementation. An interview with a respondent representing a multinational diversified retail company crystallised these themes in the following assertion:

> I think the codes do drive the process to a certain degree, but I think they are perhaps too theoretical and don't have enough regulatory clout for us to adopt more of their good features (Human Resources Executive Respondent 2, 2006).

In addition to these two reasons, it was evident that managers were increasingly being overwhelmed by a large amount of information available on workplace HIV/AIDS programmes. A number of respondents reported that, because of the time required, the reading of the codes and guidelines had been superseded by a number of more immediate concerns like compliance with *Occupational Health and Safety Act of 1993* and the corporate reporting initiatives of the GRI and King Reports.

5.2.3.1.1 Information Overload

The fact that the majority of respondents admitted knowing about the codes but acknowledged not actively using them to organise their interventions, opposed earlier line of reasoning that suggested the codes and guidelines were not used because organisations were not familiar with them. Moreover, this observation ran parallel with

the submission from Vass (2004), that larger companies were, in fact, well informed about the major sources of information on HIV/AIDS workplace programmes.

However, what was perhaps more immediately apparent during the course of the study, was that most respondents were struggling to keep pace with the amount of information available on HIV/AIDS workplace programmes. A respondent representing a large private company which was in the early stages of implementing an HIV/AIDS programme remarked how they had, “filled three lever arch files with information on HIV/AIDS programmes” and were; “still uncertain of what components to implement” (Large Security Services Group; Industrial Relations Manager Respondent, 2006).

The content in the literature review provided ample evidence for the amount of information available on workplace HIV/AIDS programmes (during the course of the interviews, the researcher collected a further four workplace HIV/AIDS guidelines that were not uncovered during the preliminary literature search). The evidence collected strongly suggested that there was a surfeit of information that had created a ‘clutter problem’ and, as Gladwell (2000) suggests, had made it difficult to *get any one message to stick.*

Despite acknowledging the abundance of information contained in the various codes and guidelines, respondents reported using them chiefly to access information on the regulatory and legislative enactments that pertain directly to HIV/AIDS management in the workplace. For this reason, the author was concerned that - for the most part - the codes were not being used effectively to implement and improve workplace responses beyond the enactments contained the *Labour Relations Act, No. 66 of 1995*, the *Employment Equity Act, No. 55 of 1998* and other related Acts.

Amongst increases in business requirements and regulations that include; Sarbanes Oxley, King Commission and Broad-Based Black Economic Empowerment compliance requirements, the lesser priority afforded to HIV/AIDS literature was striking. One respondent commented how HIV/AIDS documents had been; “relegated to the bottom of inbox” (Security Company Subsidiary; Human Resources Executive Respondent 1, 2006), along with, as a respondent from another large private company remarked; “one of the other less critical issues we have to deal with” (Large

Diversified Transportation Company; Human Resources Executive Respondent 6, 2006).

5.2.3.1.2 Lack of Authority

The perceived lack of authority and enforcement attached to the codes and guidelines was considered to be a further reason for the lacklustre uptake. There was an overwhelming belief that, even though workplace programmes are presided over by a number of legal enactments, the 'best practice' codes and guidelines and more specifically, the HIV/AIDS reporting guidelines; were defenceless documents that were easily circumvented. A service provider in the field made the following observation:

> The King Commission recommendations, the GRI, SAICA and the JSE listing requirements are all meek and mild and can be effectively managed with a good deal of PR spin (Disease Management Consultant Respondent 1, 2006).

In view of the powerlessness of the codes and guidelines, the attitude of several respondents toward the workplace HIV/AIDS codes and guidelines was less than reverent A respondent representing a large private company provided corroboration for this observation by saying the following:

> The GRI requirements and the JSE requirements have come and gone, we haven't looked at them and none of the other companies have done anything either. If there is an audit done tomorrow - so what? (Company HIV/AIDS Practitioner Respondent 4, 2006).

Most respondents considered the codes and guidelines akin to adaptable forms of instruction. This contention was illustrated in the response recorded during an interview with a manager from a large private company: "we don't take any guidelines word for word; we take what we can and develop our own response" (Occupational Health and Safety Manager Respondent 2, 2006).

The absence of obligation to comply with provisos of the codes and guidelines, appeared to be significant driver behind the variant implementation of 'best practices' and served to substantiate Dickinson's observation that; "managers may sometimes

deliberately select which aspects of 'best practice' they wish to implement" (Dickinson, 2005:11).

These perceptions also raised important questions around the need to govern certain standards of practice in accordance with recognised 'best practice' and, whether a measure of regulation would really improve the scale and quality of the response to HIV/AIDS in the workplace.

5.2.3.1.3 Theoretic Disposition

A number of respondents (from the group of company respondents in particular) alluded to the codes and guidelines as being too academic and of limited practical use. A senior HIV/AIDS manager – despite not having direct knowledge of the content in the codes and guidelines - made the following assertion; "I am not an academic and have not read any of the codes and guidelines and very much doubt whether any of my colleagues would have done so either" (Multinational Gold Mining Company; HIV/AIDS Practitioner Respondent 1, 2006).

Respondents generally conceded that the codes and guidelines provided 'blanket' guidance on managing HIV/AIDS in the workplace; and, as such, they needed to greatly adapted to specific organisational needs and contexts. A respondent representing a large private company verified this concern by stating:

> The codes give you a guideline of what your practices should be; however, the biggest challenge for us is to find ways to adapt the recommendations and to put those practices into practice (Support Services Manager Respondent, 2006).

Similarly, another respondent remarked that; "the codes don't provide information on the cultural nuances that the business finds itself in" (Diversified Retail Company, Human Resources Executive Respondent 2, 2006).

5.2.3.2 Sun-Section Conclusion

The reasons for the low uptake of the codes and guidelines highlighted the need for guidelines that were simplified and straight forward to use in the workplace. In several instances the portfolio of the interviewee extended well beyond only

managing the organisation's HIV/AIDS programme. A number of respondents had human resources, administration and broader occupational health functions which required substantial time commitments. Understandably, a complex and lengthy guideline was unlikely to be read and/or implemented.

Although a measure of regulatory enforcement was likely to improve the response of companies to a degree, the evidence suggested that this may not have be a sustainable solution in the longer-term and would have been difficult to regulate because a clear standard of practice had yet to be established.

5.2.4 Persistence of 'Best Practice'

Despite reservations regarding the use of the term, 'best practice' to describe various workplace HIV/AIDS interventions; the unabated use of the term - and various adaptation of the term - within management circles, raised counter arguments to the prior submissions that the concept, 'best practice' had been entirely devalued. More importantly, the fact that all respondents to this research were able to instantly recognise and relate to the concept 'best practice' across several corporate contexts led to suggestions that the concept may have merit in certain instances.

Furthermore, it was clear that 'best practice' was not only about what was written in specific codes and guidelines. From the evidence unearthed during the course of the research, company representatives, consultants, experts and disease management providers were using a number of alternative methods to establish what the 'best' ways were to manage HIV/AIDS in the workplace.

This section explores the reasons for the persistence of 'best practice' within the context of workplace HIV/AIDS programmes and investigates alternative ways for companies to determine how 'best' to manage HIV/AIDS in the workplace.

5.2.4.1 Need for ‘Best Practice’

In an attempt to circumvent the awkwardness associated with defining ‘best practice’, several managers, consultants and academics sought to create a range of innovative phrases to use instead:

> I am not sure about the concept ‘best practice’ – I favour ‘*good practice*’. Some people I have worked with are intent on modernising the term to ‘*innovative practice*’ (Private Consultant Respondent 1, 2006).

> I really don’t believe there is best practice, I believe there is ‘*current practice*’; it’s just that some are better than others (Company HIV/AIDS Practitioner Respondent 4, 2006).

> I think ‘best’ is a problem word and would prefer to see a concept like ‘*successful practices*’ (Private Consultant Respondent 2, 2006).

> ‘Best practice’ is a bothersome term; ‘*current best practice*’ is something that makes more sense to me (HIV/AIDS Business Coalition; Director Respondent 2, 2006).

Although these examples of re-ordered prose clearly diminished the term, ‘best practice’, the mere fact that various adaptations had been constructed, served to suggest to the researcher that there was an underlying need - if not for ‘best practice’ - for a concept with similar appeal. Moreover, the fact that none of the adapted phrases listed above had yet to be widely adopted, raised suggestions that ‘best practice’ was likely to remain a commonly used parlance within workplace HIV/AIDS literature.

The universal familiarity respondents had with the term, ‘best practice’ was notable: all respondents instantly recognised ‘best practice’ as a well-known management concept. This finding was important because it demonstrated that the concept ‘best practice’ also needed to be evaluated from a viewpoint outside of the strictly literal interpretations employed by many respondents in the preceding section.

The outcomes of this evaluation highlighted three specific instances in which 'best practice' was found to have played a significant role in advancing the uptake and quality of workplace HIV/AIDS interventions:

- strategic communications;
- external benchmarking and;
- the basis for standards of practice.

5.2.4.1.1 Strategic Communications

The use of 'best practice' as a strategic communications tool by a variety of organisations at both national and international levels, including UNAIDS, the ILO, SADC and the GBC, pointed to the worth of 'best practice' in shaping the response of companies in pre-determined strategic directions.

A respondent from a disease management provider company illustrated the importance of 'best practice' in setting clear direction in the following comment; "if you don't have a concept of best practice - people won't know where to aim" (Disease Management Consultant Respondent 2, 2006). Toward this end, another respondent recounted how a representative from one of their suppliers, which was in the early stages of implementing an HIV/AIDS programme, had been "pointed in the right direction by a bunch of 'best practices' from the internet" (Company HIV/AIDS Practitioner Respondent 4, 2006).

Another respondent made the observation that 'best practice' examples were a good way to promote the uptake of effective interventions; "you should be punting good practice and 'best practice' particularly in situations when you want organisations to learn "(Private Consultant Respondent 1, 2006).

Of course, this did not mean that 'best practice' could be considered to be "the proverbial one shoe that would fit every company" (Company HIV/AIDS Practitioner Respondent 4, 2006) but the evidence did suggest that it proved to be a good reference point for HIV/AIDS mangers who were in the process of instituting and modifying aspects of their workplace programmes.

5.2.4.1.2 External Benchmarking

Respondents from a number of companies with more advanced programmes reported using 'best practices' intervention as an external benchmark for their own programmes:

> We definitely use 'best practices' as a benchmark. By focusing on the 'best practices' of other companies, we are able to take the good things and make them our own (Diversified Retail Company, Human Resources Executive Respondent 3, 2006).

Comments like these were particularly prevalent among a group of companies who were in the process of auditing their programmes and looking at ways to improve certain components. In a similar vein, a respondent from an international business agency reported that they had developed a 'best practice scorecard' because their member companies (typically large multinational companies) were looking for a way to benchmark their HIV/AIDS programmes against international norms (HIV/AIDS Agency Director Respondent 1, 2006).

These observations raised the suggestion that baseline data - outcomes data in particular - that related to 'best practices' could be used to promote continuous improvement efforts in company programmes.

5.2.4.1.3 Basis for Standards of Practice

The association between 'best practice' and standards of practice was an interesting theme that emerged during the course of the study. In several instances, 'best practice' was considered to be the starting point for standards of practice and many of the standards that had been established were reportedly based on 'best practices'. Toward this end, a respondent representing a business coalition on HIV/AIDS pointed out that the standard they had just established was specifically based on 'best practice': "our standard was based on specific examples of 'best practice' as observed in our member companies" (HIV/AIDS Agency Director Respondent 1, 2006). Furthermore, examples of 'best practice' examples had also been used by two companies to develop standards for their suppliers (Large Utility Company; HIV/AIDS Practitioner Respondent 4, 2006; Multinational Consumer Products Company; Healthcare Executive Respondent 4, 2006).

5.2.4.2 Other Sources of 'Best Practice'

The marginal uptake of the codes and guidelines gave rise to two important concerns; firstly where were companies then accessing information on how to design and implement 'best practice' HIV/AIDS programmes, and, secondly, how reliable were alternative resources?

Reassuringly, most respondents in this study appeared to have remained interested in finding out what the 'best' way was to manage HIV/AIDS in the workplace and a number of different methods were being used to access information on successful interventions. It was apparent that information was drawn from a wide-range of resources and a number of different examples of workplace HIV/AIDS interventions.

Interestingly, the methods of acquiring information appeared to be concentrated across similar channels for private and public-listed entities. Experts, consultants and service providers, on the other hand, used more disparate information channels. Of concern in both categories was the relatively limited number of respondents who reported regular use of evidenced-based literature.

Overall, the content analysis pointed to three dominant avenues that respondents reportedly explored in their attempts to acquire information regarding 'best practice', namely;

- networking;
- the internet and;
- interactions with HIV/AIDS service providers.

5.2.4.2.1 Networking

Most respondents pointed to the practices of other companies as influencing the practices instituted within the companies they represented. A respondent from a multi-national company made the remark that: "there is definite cross-pollination between companies; no organisation can expect do this on their own" (Healthcare Executive Respondent 2, 2006).

All of the public-listed companies included in the sample were reportedly members of the GBC or SABCOHA (four held dual-membership). Only two of the large private companies reported being members of either organisation. Companies that were

members of SABCOHA or the GBC reported acquiring a great deal of information on 'best practices' from other member-companies during conferences and other semi-structured networking fora.

An experienced consultant in the field of workplace programmes verified the importance of social networking by making the following observation: "there is a lot of word-of-mouth within the networks of those who manage [workplace] HIV/AIDS programme" (Private Consultant Respondent 2, 2006). Similarly, a respondent from a large public-listed retail company observed how freely the HIV/AIDS community shares information:

> I find the South African AIDS community has a good abundance mindset. I have made contact with a number of companies and have never had any problems accessing information on best practices (Human Resources Executive Respondent 3, 2006).

While conducting the interviews for the research, the author witnessed this first-hand. During four interviews the respondent with whom the researcher was meeting, reported having recently met with a representative from a large private industrial company. It appeared as if the industrial company was about to implement a workplace HIV/AIDS programme for the first time and this representative was meeting with representatives from other companies which already had workplace programmes in place. The industrial company representative was clearly networking as a means of collecting information on the 'best' way to design and implement their HIV/AIDS workplace programme.

A further significant finding was that respondents from the Tourism and Hospitality, Automotive and Safety and Security Industries all reported early involvement in industry-specific HIV/AIDS initiatives. These interactions had resulted in the publication of industry-specific practice guidelines and regular meeting schedules to discuss workplace HIV/AIDS interventions. The author considered this to be a promising development, in that it pointed to information sharing at an industry level and the publication of 'best practices' that were focused on specific industry challenges and constraints.

Some company respondents reported the establishment of internal company fora to facilitate networking between representatives from their internal business units.

Public-listed companies - in particular those with a number of business subsidiaries - were found to use internal forums to share information on the successes and failures of different HIV/AIDS interventions. A representative from a large public-listed retailer recounted how their company had built an internal human resources forum to design the company's workplace HIV/AIDS programme:

> We got together and put all the resources together; we listened to all the contributions and looked at the different environments within which we operate and then made a call of what was going to work best for our people and our company (Human Resources Executive Respondent 3, 2006).

Networking was, therefore, not only observed as part of formal business HIV/AIDS fora, but also - and perhaps more significantly - on an informal basis. More promising, however, was that companies appeared to be engaging in the transfer of information that was more focused on interventions within specific industries and business units.

5.2.4.2.2 Internet

Those involved in the design, implementation and adaptation of workplace HIV/AIDS interventions were found to enjoy reasonably good internet access. As one of the HIV/AIDS consultants interviewed alleged that; "getting information is not difficult; most managers turn to the internet nowadays" (Private Consultant Respondent 2, 2006). Accordingly, respondents from all four groups reported a considerable reliance on the internet as a means of acquiring information on various workplace HIV/AIDS interventions.

The reported websites were categorised into two subsets: 'company-specific' websites that promote certain aspects of a specific company's HIV/AIDS programme (e.g. Unilever, Harmony Gold Mining), and 'shared-information' websites that collate and report on the successes and failures of a range of company HIV/AIDS programmes (e.g. UNAIDS, GBC, SABCOHA).

More respondents reported visiting 'company-specific' websites for information on HIV/AIDS interventions than 'shared-information' websites. Although the research was not equipped to explore this issue in great detail, it was apparent that 'company-specific' websites were perceived to be more practically relevant:

> I like to ensure that our programme keeps up with the leaders in the field. For this reason I keep in touch with BMW, BP, Unilever, Daimler and Vodacom and often visit their websites to track new developments (Corporate Social Responsbility Manager Respondent, 2006).

This assertion by a respondent from a respondent representing a multinational food and beverage company demonstrated an element of competitive curiosity that appeared to be fuelling the interest in 'company-specific' websites.

5.2.4.2.3 Role of HIV/AIDS-Related Service Providers in Information Transfer

The key role of service providers in providing information and advices regarding workplace practices was a further noteworthy finding of this study. An experienced researcher noted that, despite the abundance of resources available with regards to HIV/AIDS interventions, companies were more likely to rely on the expertise of an outside consultant or service provider:

> There are definitely a wide range of sources of information. I would imagine the majority are guided by their disease management providers (DMPs), the benefit managers and the medical aids. I would also guess that an awful lot of information is obtained from consultants and other service providers (International HIV/AIDS Researcher Respondent, 2006).

Toward this end, a respondent representing a company who had recently implemented a workplace HIV/AIDS programme argued that, in many cases, the implementing and running of a workplace programme was a complex undertaking and, therefore, required appropriate skill and experience:

> The management of HIV/AIDS is involved; it is a subject that you need to know about and have experience in. That is why we decided to bring in the relevant people and expertise (Large Diversified Industrial Company; Human Resources Executive Respondent 5, 2006).

A further interesting finding was that most of the service providers that were interviewed recognised the important role they played in facilitating workplace interventions. Several reasoned that, in view of the complex nature of the issues surrounding the disease in the workplace; know-how and information exchange was

their fundamental value-add. A consultant with more than twenty years of experience observed that:

> In the field, it is the consultants who are teaching the managers of these programmes; they even adopt the phrases that consultants use. Managers don't have the time and, as long as the programme is in place, they are not interested (Private HIV/AIDS Consultant Respondent 4, 2006).

This observation was supported by an assertion made by a public-listed company respondent:

> The service providers have extensive experience in this area and they transfer the concepts between companies. They are there to pick up best practices and put them together for different companies (Diversified Retail Company, Human Resources Executive Respondent 3, 2006).

As companies were found to be greatly reliant on the capacity of service providers for programme design and implementation, the obvious question that arose was: where were the service providers then acquiring their information on 'best practice'?

With the level of uptake of the codes and guidelines among service providers observed to be remarkably similar to that of the other respondents in this study, the answers to this question were found to gravitate toward unsystematic information gathering along similar themes to those presented in the preceding two sections, namely; networking and the internet.

A service provider in the field of 'workplace wellness' remarked; "we've gone to school on the development of our own initiatives - we've compiled our own adaptation of how we perceive the environment" (Disease Management Consultant Respondent 1, 2006). Another respondent with extensive experience in the field of disease management commented; "I have sort of grown up in the realm of HIV. I don't have any particular sources of information" (Disease Management Consultant Respondent 2, 2006).

These statements raised obvious concern regarding the standards of practice endorsed by many service providers. Although this observation appeared to be less ominous for those companies who relied on providers with extensive experience in

the field of workplace HIV/AIDS interventions, it did suggest that those companies who relied on new – and perhaps, less experienced operators for advice - may have been significantly disadvantaged in terms of the quality of advice received. In conclusion, a consultant respondent referred to this situation as follows: “there are a number of inexperienced people out there who are not doing anyone any favours” (Private Consultant Respondent 2, 2006).

5.2.5 Section Conclusion

The findings in the first part of this section clearly pointed to the wide-ranging reservations regarding the term, ‘best practice’. Although this uncertainty appeared to be a result of a limited understanding of the concept and the relative youthfulness the field of study, there was also concern that ‘best practice’ often overlooked the effect of different organisational contexts and the importance of the HIV/AIDS practitioner in determining the success of various workplace interventions. In addition, there was a feeling that ‘best practice’ did not always embrace the ethos of continuous improvement.

Furthermore, the observed marginal uptake of the codes and guidelines and the various reasons for this, raised concern regarding the relevance of ‘best practice’ in promoting the uptake of successful workplace HIV/AIDS programmes.

Despite numerous attempts to re-characterise the term, ‘best practice’ serving to illustrate literal frustrations the concept, these attempts also served to demonstrate the need for a concept with similar motivational elements to those associated with ‘best practice’.

Moving away from the more literal interpretations of ‘best practice’ the value of ‘best practice’ as a strategic communications tool for governments and ‘high-level’ business agencies and coalitions in promoting the uptake of successful workplace HIV/AIDS interventions could not be discounted. Toward this end, ‘best practice’ was found to be an effective method to direct the approach of companies to HIV/AIDS in specific strategic direction. Moreover, ‘best practice’ remained a valuable concept in providing companies with competitive external benchmarks and thereby promoting the efforts to continuously improve the interventions included in workplace programmes.

The close association between ‘best practice’ and standards of practice was a further important finding. This pointed directly to the potential use of ‘best practice’ as a basis for establishing future standards of practice’. However, for the concept to be successfully used in this regard; the principles of ‘best practice’ would need to be more well-defined and methods would need to be established to accurately measure and evaluate examples of ‘best practice’.

5.3 ‘Best Practice’ Definition

5.3.1 Section Introduction

Although various definitions of ‘best practice’ were found to exist within the literature (Chapter 3), defining the concept in the interviews was observed to be somewhat more challenging. Many interviewees were visibly uncomfortable when asked to define the term ‘best practice’ and the extent of discomfort and hesitation observed during the course of the research clearly pointed to a limited appreciation of what the concept ‘best practice’ really means.

Of greater concern, however, was the researcher’s observation that many respondents appeared to be ill-equipped to objectively question and evaluate the examples of ‘best practice’ described in various literary compilations and discussion forums. This was worrying because many managers were considered to be vulnerable to instituting ‘best practice’ workplace interventions that were not always entirely suited to the context within which their company operates nor the people that make up their workforces.

To illustrate the importance for managers to clearly understand the concept ‘best practice’, consider the *SADC Framework for Developing and Sharing Best Practice on HIV/AIDS*. Six steps are listed to improve HIV/AIDS programming in companies. The term, ‘best practice’, forms the common denominator for five of the six steps (SADC, 2006):

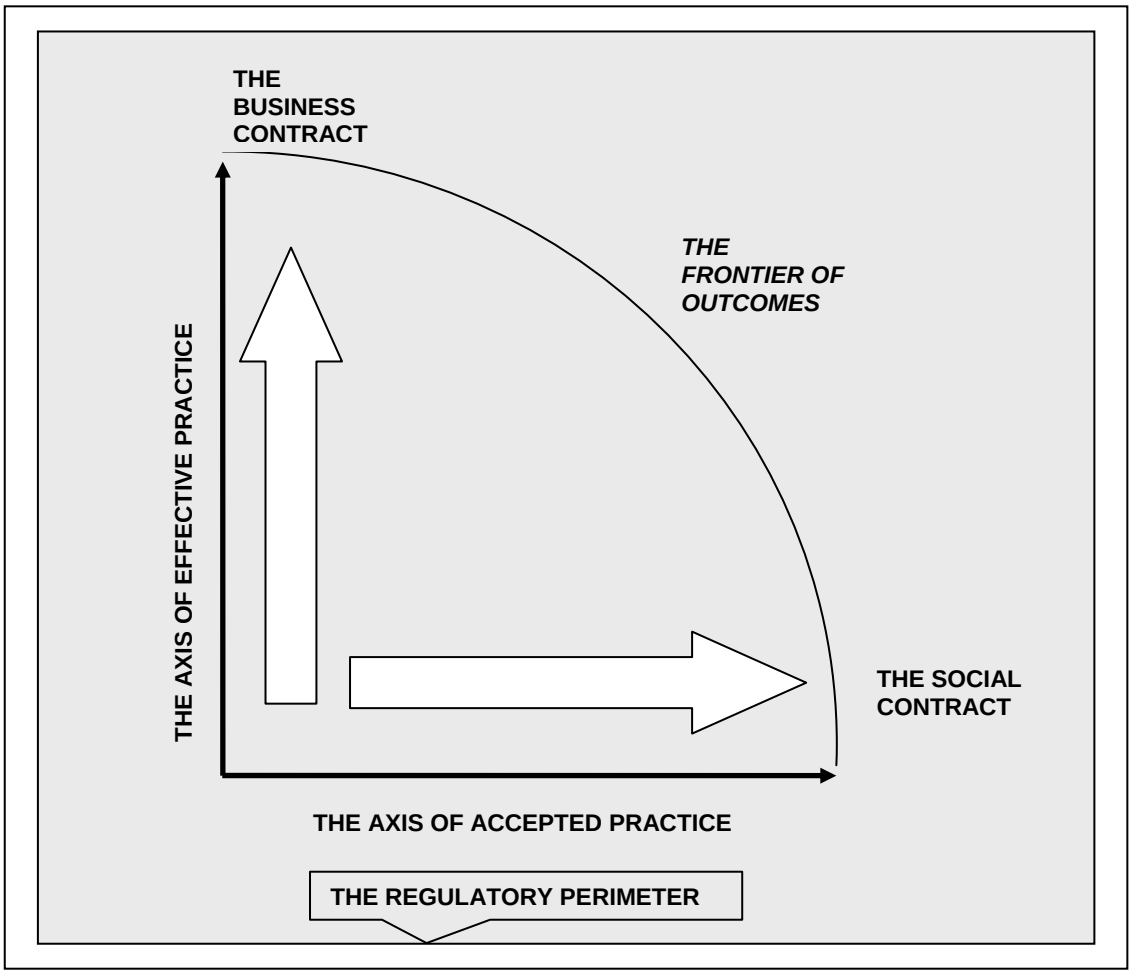
- Identify ‘*best practice*’
- Document ‘*best practice*’
- Verify ‘*best practice’*
- Disseminate *‘best practice’*
- Integrate *‘best practice’* into programmes

This is, of course, not the only example of a workplace HIV/AIDS document that depends on an understanding of what ‘best practice’ really means; recall the numerous codes and guidelines and assortment of publications relating to ‘best practice’ in the literature review.

The aim of this section is, therefore, to establish a conceptual definition for 'best practice' that was based on recurring themes observed in the literature review and the research content analysis. To achieve this, the author analysed dominant themes from the literature review to form a robust research instrument and used the conceptual framework developed in Chapter 2 (Figure 2.2) to frame and synthesise the responses recorded during the course of the in-depth interviews. In-so-doing the researcher was able to develop a conceptual definition that was based both on literary evidence and a shared understanding of respondents regarding the meaning of 'best practice'.

Figure 5.1 is an upfront illustration of the elements of the conceptual framework. What follows in the remainder of this section is a detailed description of how these elements were derived from the interviews and brief detail regarding the expected interrelation of the elements.

Figure 5.1 Conceptual Framework for Workplace HIV/AIDS Programmes



5.3.2 Conceptual Dimensions of Workplace HIV/AIDS Programmes

In this sub-section three primary dimensions for successful workplace HIV/AIDS interventions are put forward. The first two dimensions, *the Axis of Effective Practice* and *the Axis of Accepted Practice*, provide the foundation for the framework. The model's third dimension emphasises a further important finding of this research, namely; the visible need for a renewed focus on outcomes of specific workplace interventions.

In addition to these primary dimensions, the existence of a theoretical 'regulatory perimeter' was found to be an important consideration in the development of the conceptual definition for 'best practice'. In the model, the 'regulatory perimeter' delineates the specific regulatory and legislative margins within which the conceptual framework is bound.

5.3.2.1 Effective Practice and Accepted Practice

During the interviews respondents put forward a wide range of definitions for 'best practice'. To enhance the researcher's appreciation of the diverse definitions, reference was continually made to the preliminary conceptual framework detailed in Chapter 3 of the report. Frequently the definitions for 'best practice' - as recorded during the interviews - would relate closely to the constituents of the preliminary framework. A number of definitions ran parallel to the *Accepted Practice axis* of the framework:

> 'Best practice' is any practice that works to incorporate the principles of employee well-being, non-discrimination and confidentiality (Multinational Healthcare Company; HIV/AIDS Practitioner Respondent, 2006).

> 'Best practice' is about complying with social norms and doing the right thing for your employees (Large Diversified Industrial Services Company; Human Resources Executive Respondent 5, 2006).

Several more definitions did, however, lean heavily toward specific business imperatives and elements that ran parallel to those included in the *Effective Practice axis* of the preliminary framework:

> ’Best practices’ are practices that are easily measured against set objectives and targets like absenteeism and productivity (Human Resources Executive Respondent 2, 2006).

> ‘Best practice’ is the best way of doing something at the least possible cost (Human Resources Executive Respondent 4, 2006).

Interestingly, only one respondent simultaneously included elements along both axes:

> ‘Best practice is about having the most effective outcome for the company and for its workers (Large Diversified Industrial Services Company; Support Services Manager Respondent, 2006).

The prevailing themes that emerged from the content analysis of recorded definitions compared well to the substance and structure of the preliminary ‘best practice conceptual framework’. This helped the researcher verify that ‘best practice’ HIV/AIDS interventions were, as originally anticipated, likely to simultaneously fulfil the requirements of two fundamental organisational relationships, namely; the social contract and the business contract. Toward this end, a representative from one of the largest HIV/AIDS service providers described how HIV/AIDS was the employer’s responsibility on two distinct levels: “the one is on a *HR level* – it costs employees their health; and the other is the *financial level* - it costs the company and its shareholders money” (Disease Management Consultant Respondent 2, 2006).

5.3.2.1.1 Social Contract

The literature review alluded to a number of social forces that were associated with HIV/AIDS in the workplace. From the content analysis, it was clear that respondents were also acutely aware of strong social pressures that were affecting their businesses. Moreover, the evolving nature of the social contract continued to bring about significant changes to the role of companies in society.

Although part of the social contract is clearly defined in formal laws and regulations, the greater part the social contract with regard to HIV/AIDS is semi-formal. This part was found to encompass several less tangible expectations of stakeholders. Within this semi-formal component, several interviewees reported that their management of

HIV/AIDS was influenced - directly and indirectly – by the growing number of social expectations and intensifying pressure from workers, communities, investors, lobby groups and, labour unions in particular, to shape the way their companies responded to HIV/AIDS in the workplace:

> When our programme started in 1990 and management started to take the expectations of our workers more seriously; our first step was to have an onsite meeting with all our stakeholders. We knew we needed to start with the workforce and ensure that we had the buy-in from the unions (Multinational Consumer Products Company, Nurse Practitioner 2, 2006).

> The unions often give us trouble when we want to conduct prevalence surveys. That is the main reason we are now using actuarial analyses instead (Multinational Healthcare Company; HIV/AIDS Practitioner, 2006).

> There is a big drive from the unions to enforce HIV/AIDS management. We realised that we would need to shape-up when we could not answer them on issues related to HIV/AIDS (Security Services Company Subsidiary; Human Resources Executive Respondent 1, 2006).

> Increasingly investors are interested in something more than the 'bottom-line' and they are beginning to ask questions about other things. Sometimes when it's a toss-up between one and the other they may just choose the other (Multinational Diversified Mining Company, Healthcare Executive Respondent 1, 2006).

The evolving social contract was deemed to not only deepen the level of involvement required with the direct stakeholders (consumers and employees and their dependents) but also - and increasingly - to widen the involvement with a broader set of stakeholders such as the community within which the company operated. During the course of one interview, one of the company's peer educators who was invited to sit in on the interview made the following assertion:

> You need to understand that people are a big part of our business and HIV/AIDS is affecting our people and our communities. Therefore, our practices need to focus on people and reach further into the surrounding communities (Employee respondent living with HIV/AIDS, 2006)

The fact that workplace HIV/AIDS interventions were required to have a large element of social acceptance brought added significance to understanding the elements of the social contract within the context of evaluating 'best practice' interventions. However, according to several interviewees; understanding the social expectations of a broad set of stakeholders and appreciating the fluid nature of these expectations was not easy. Toward this end, formalised corporate social responsibility was seen to be only part of the overall evaluation. As on respondent noted; "unless people see why it's the right thing to do, it is going to be difficult to enforce" (Healthcare Executive Respondent 2, 2006).

The evaluation of 'best practice' from the standpoint of the social contract was, therefore, found to require careful examination of the specific social expectations of stakeholders and a broad appreciation of the emerging social issues that were, perhaps, not yet part of the social contract:

> Five years ago we weren't even thinking about community initiatives. Now that is happening, we need to consider what the next demands are going to be (HIV/AIDS Business Coalition; Director Respondent 2, 2006).

To assist companies in achieving this and to help them evaluate examples of 'best practice' from a social contract point of view, the author identified the dominant social themes that emerged during the course of the study. These themes included the following:

- the human rights framework;
- equality and non-discrimination;
- the level of socio-cultural acceptance and;
- fundamental business ethics and values.

Although this list clearly does not include all social dimensions; alignment of particular interventions along the abovementioned dimensions was expected to provide companies with an indication of whether the intervention broadly met expectations of the company's social contract.

5.3.2.1.2 Business Contract

As important as it may have appeared to be for company respondents to protect the social contract and the general well-being of a large set of stakeholders, it was also

clear that the primary purpose of most companies and managers who participated in the research was to create and protect value for investors. Toward this end, a respondent from the consultant category made the following assertion relating to the alignment between workplace HIV/AIDS programmes and the business imperatives of most companies: “there are very few companies who would take from shareholder profits to fund a soft project” (Private Consultant respondent 2, 2006).

Understandably, the elements of the business contract were - in most cases - built on the implicit understanding that the company would ensure acceptable and sustainable returns for investors. Therefore, it was clear that in most companies the critical measure of business success remained closely related to short-term sustainability (private company respondents, in particular) and productivity:

> In 2005 we realised that we were beginning to lose man-hours on the shop floor. We realised then that we needed to look beyond our (HIV/AIDS) education programmes to programmes that would deliver on our business imperative of improving productivity (Multinational Diversified Retail Company; Human Resources Executive respondent 2, 2006).

As a critical measure of ‘best practice’, the researcher attempted to identify recurring themes in the content analysis that would assist companies in evaluating ‘best practice’ interventions from the standpoint of the business contract. The following four elements were recognised as dominant themes in this regard:

- ease of implementation,
- effectiveness,
- affordability and;
- sustainability.

Sustainability of the workplace interventions was considered by respondents to be particularly important factor for the evaluation of ‘best practice’ from a business contract perspective. As there was no available cure for HIV/AIDS, several respondents highlighted the risk associated with long-term commitments to employees in terms of providing them with ART. In keeping with this, respondents also questioned whether community outreach programmes and the provision of ART for employee life-partners and dependents could be considered ‘best practice’ if they were not going to be affordable in the longer term.

Although these elements were found to assist in the evaluation of ‘best practice’ from the standpoint of the business contract, most of the research respondents repeatedly highlighted the need for a clearer business case. However, there was also recognition – from the expert and consultant category, in particular - that a large amount of work remained before the quantitative aspects of various interventions would be fully understood within, and across, a range of different businesses and industries, a discussion point that is expanded upon in later sections.

5.3.2.1.3 Conclusion

The foundation for the conceptual framework for ‘best practice’ was, therefore, formed through a conciliation of interventional forces that simultaneously meet the requirements of the business contract and the social contract. Although the interventional forces that lead to fulfilment of the social and business contracts were not always found to be diametrically opposed, they were oftentimes found to be less than acutely related. It followed, therefore, that ‘best practices’ represents careful consideration and balancing of the trade-offs between the social and business contracts (Figure 5.1).

5.3.2.2 Outcomes Dimension

During the research the author found that, on several occasions, ‘best practice’ definitions to be more aligned to the input side of process as opposed to the outcomes of process. The guidelines and codes all make reference to specific practices that companies were required to implement so as to realise successful HIV/AIDS programmes. Along similar lines, a number of respondents appeared focus more intently on implementing interventions as opposed to the overall outcomes of the interventions and the workplace programme overall.

A respondent representing a multinational company likened this situation and the workplace HIV/AIDS programmes of many companies to a collection of processes that resulted in modest outputs:

> In AIDS there are so many processes around the workplace responses - people have a done all kinds of things and they will tell you what kind of things they have done and all about the fantastic structures and policies they have put in place. But what are the outcomes of all those things? I liken the responses of those companies to that of an unproductive factory - everybody is doing something all day long, but nothing comes out! (Multinational Diversified Mining Company; Healthcare Executive respondent 1, 2006).

This assertion was supported by findings in a recent GBC Report that questioned the attempts by companies to measure the outcomes of their programmes. Results presented in the counselling and testing category of the *2006 GBC Baseline Report,* recounted that of the fifty-five percent of surveyed companies reported to have VCT services in place, only twenty-five percent of these companies monitored the uptake rates.

The prevention category presented a similar statistic whereby; eighty-two percent of companies included in the survey, reported providing information on HIV/AIDS as part of their prevention programme, but only forty-one percent of companies conducted surveys and assessments to validate the effectiveness of these programmes (GBC, 2006c).

These findings provided empiric evidence for the author's concerns that, because many companies were reportedly not measuring outcomes, several accounts of 'best practice' may have been widely uninformed.

Several respondents – in the consultant and expert category, in particular - did however, point to the fact that HIV/AIDS interventions could only be regarded as being the most successful methods once the outcomes had been measured and compared with the outcomes of similar interventions. Toward this end, some respondents suggested that 'best practices' needed to become more closely aligned with outcomes; the essence of which was captured in the following assertion; "we need to move from focusing on process indicators to focusing on outcome indicators; otherwise we can't tell whether those processes matter at all" (International HIV/AIDS Researcher respondent, 2006).

Reassuringly, the linkage between ‘best practice’ and outcomes was presented as a common theme in the content analysis of all four groups of respondents. Very few interviewees were able to offer a definition of ‘best practice’ without making reference to outcomes. An expert in the field of workplace HIV/AIDS programmes submitted the following definition:

> ‘Best practice’ is the most efficient and logical way, which would be the most likely way, of achieving a favourable outcome (Private Consultant respondent 2, 2006).

Stressing the importance of outcomes in defining ‘best practice’ other respondents tendered, perhaps, more colloquial and palatable versions:

> ‘Best practice’ is about what should be done and what could be done to improve outcomes for the business and the employees (Large Diversified Industrial Services Company; Support Services Manager respondent, 2006).

> ‘Best practice’ is about achieving a desired outcome within the resources that you have available (HIV/AIDS Business Coalition; Director respondent 2, 2006).

> ‘Best practice’ is about good outcomes and measurable outcomes. I'm not interested in all that other stuff; we've been talking about it for years. All I want to know is; what are the outcomes? (Multinational Diversified Mining Company; Healthcare Executive respondent 1, 2006)

In the interviews where outcomes were not mentioned, most respondents made reference to the word ‘effective’ as part of their definition. Consideration of the Collins Dictionary definition of ‘*effective*’ as being a practice ‘*capable of producing a result*’; substantiated the importance of including outcomes in the definition of ‘best practice’.

Despite the reassurance of several respondents including outcomes in the definition of ‘best practice’, a number of concerns were raised by the consultants and experts interviewed during the study regarding the overall lack of measurement and monitoring of outcomes in several companies. An occupational health practitioner warned that the management of HIV/AIDS in the workplace had become caught up in practices rather than outcomes:

> The danger with best practice is that we are concentrating on process rather than results. We shouldn't be auditing programmes on their components but rather on their outcomes (Occupational Health Consultant respondent 1, 2006).

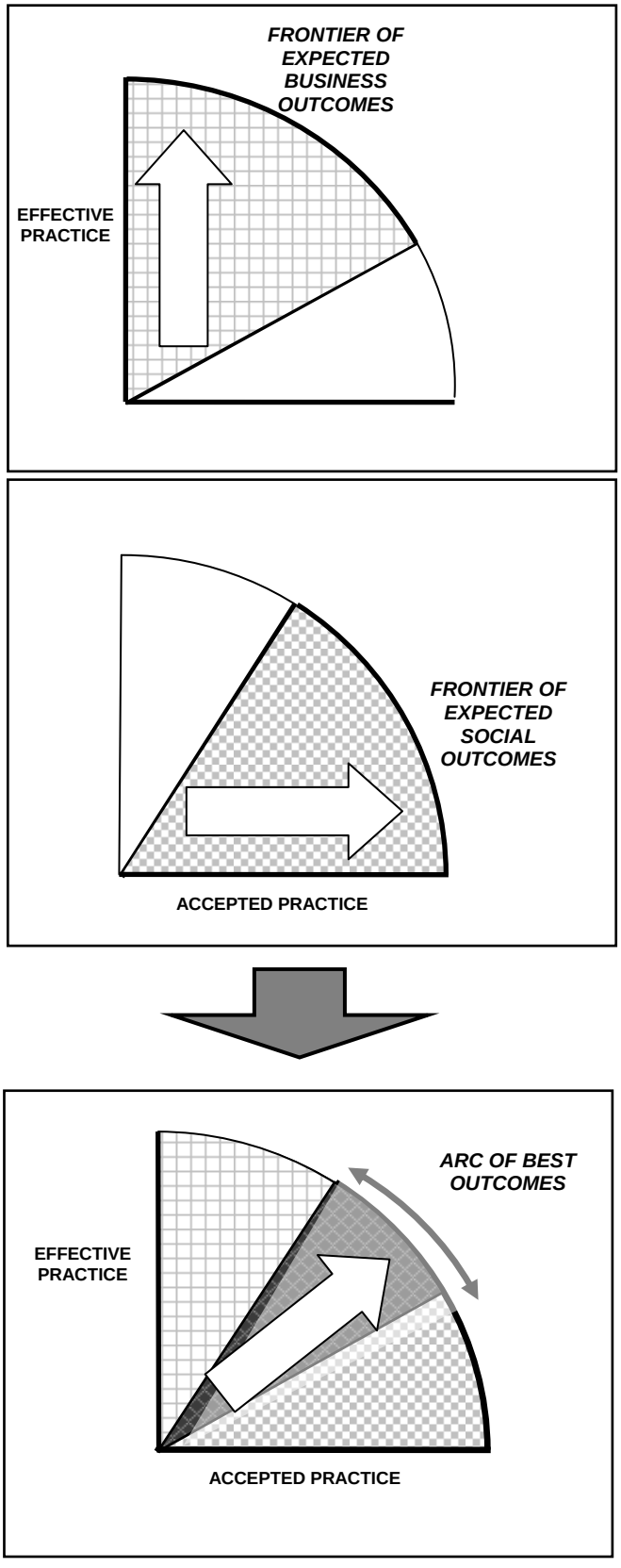
Similarly, the Chief Executive Officer of SABCOHA, Brad Mears, contended in a SABCOHA report: "if employers want to achieve success, they must know before embarking upon a programme, what success means" (Ellis and Terwin, 2005).

As a result of significance attached to outcomes, the third dimension of the conceptual framework for 'best practice' includes a strong outcomes element (Figure 5.1). On a conceptual level, the *Frontier of Outcomes* incorporates the outcomes from the model's two primary axes and, in-so-doing, represents the range of possible outcomes that a workplace programmes could be expected to achieve within the ambits of a company's social and business contracts.

5.3.3 Defining 'Best Practice'

This sub-section provides a brief summary – based on the outcomes of the content analysis - of how the author proposed that 'best practice' may be generically defined. Figure 5.2 illustrates the principal elements of the model along with the interrelationship of these elements and may be used as an outline for the remainder this sub-section.

Figure 5.2 Foundation of 'Best Practice'



5.3.3.1 Wedge of 'Best Practice'

Workplace interventions that meet the requirements of the business contract were found to fall within a range. Any interventions that fall outside of this range are unlikely to fulfil the requirements of the business contract.

Similarly, interventions which fall within the ambit of *Accepted Practice* and thus meet the requirements implicit in the social contract were expected to fall within a specific range. The borders for this range were found to be dependent on the accepted societal norms of the organisation's environment.

The overlapped area formed through merging these two ranges results in a wedge-like shape. This wedge represents the range of practices which simultaneously fulfil the requirements implicit in both the business and social contract. The observation that several examples exist of interventions that simultaneously fulfil the requirements of the business contract and the social contract suggests that 'best practice' could be, conceptually, defined by this wedge-shaped area.

Instances may, however, arise whereby management needs to make concessions outside of the *Wedge of Best Practice* to ensure long term positive outcomes. Consider specific negotiations with a labour union that may force management to make a specific concession more toward the *Accepted Practice* axis. However, in terms of 'best practice', it is important to ensure that there is long-term payback on this concession and that the programme is ultimately steered toward 'best outcomes'.

5.3.3.2 Arc of Best Outcomes

As a result of the importance attached to outcomes by respondents during the research, the researcher was forced to include a strong outcomes dimension in the conceptual definition of 'best practice'. The *Arc of Best Outcomes* represents the optimal outcomes of well-balanced workplace interventions. This was based on the underlying *Frontier of Outcomes* dimension as alluded to earlier in the section (Figure 5.1).

The *Arc of Best Outcomes* was built on a clear understanding that 'best outcomes' represents a situation where there is no HIV/AIDS associated morbidity and no

HIV/AIDS related mortality. In other words; no employees get sick as a result of HIV/AIDS and no employees die as a result of HIV/AIDS.

This description of 'best outcomes' aligns well with Brian Brink's proposals regarding outcomes. In a recent speech at the *UN General Assembly Special Session on HIV/AIDS*, Brink called for companies to aim for the 'four zeroes' as the most important outcomes in their HIV/AIDS workplace programmes (Brink, 2006):

- zero new infections
- zero employees or dependants get sick or die from HIV/AIDS
- zero babies are born HIV-positive and;
- zero tolerance of any breach of the human rights framework.

Brink (2006) reasoned that companies needed to believe that these targets were achievable. Evidence in this research, suggested that a renewed focus on outcomes would allow HIV/AIDS managers to put a stake in the ground and actively manage the present from the future.

5.3.3.3 Conclusion

'Best practice' was, therefore, defined as any workplace intervention that would simultaneously meet the requirements implicit in the business contract and the social contract in a manner that advanced the overall workplace programme toward a state of 'best outcomes'.

5.3.4 Skewed Practice

The conceptual framework made it clear that 'best practices' would be constrained by the margins of the *Wedge of Best Practice*. Toward this end, interventions falling outside of the shaded region were considered unlikely to advance the overall programme toward achieving 'best outcomes'. For this reason, the author reasoned that any intervention skewed beyond the shaded area could not be considered to be an example of 'best practice'.

Consider the fated practice of pre-employment testing by way of an anecdotal account from one of the respondent in the study as an example:

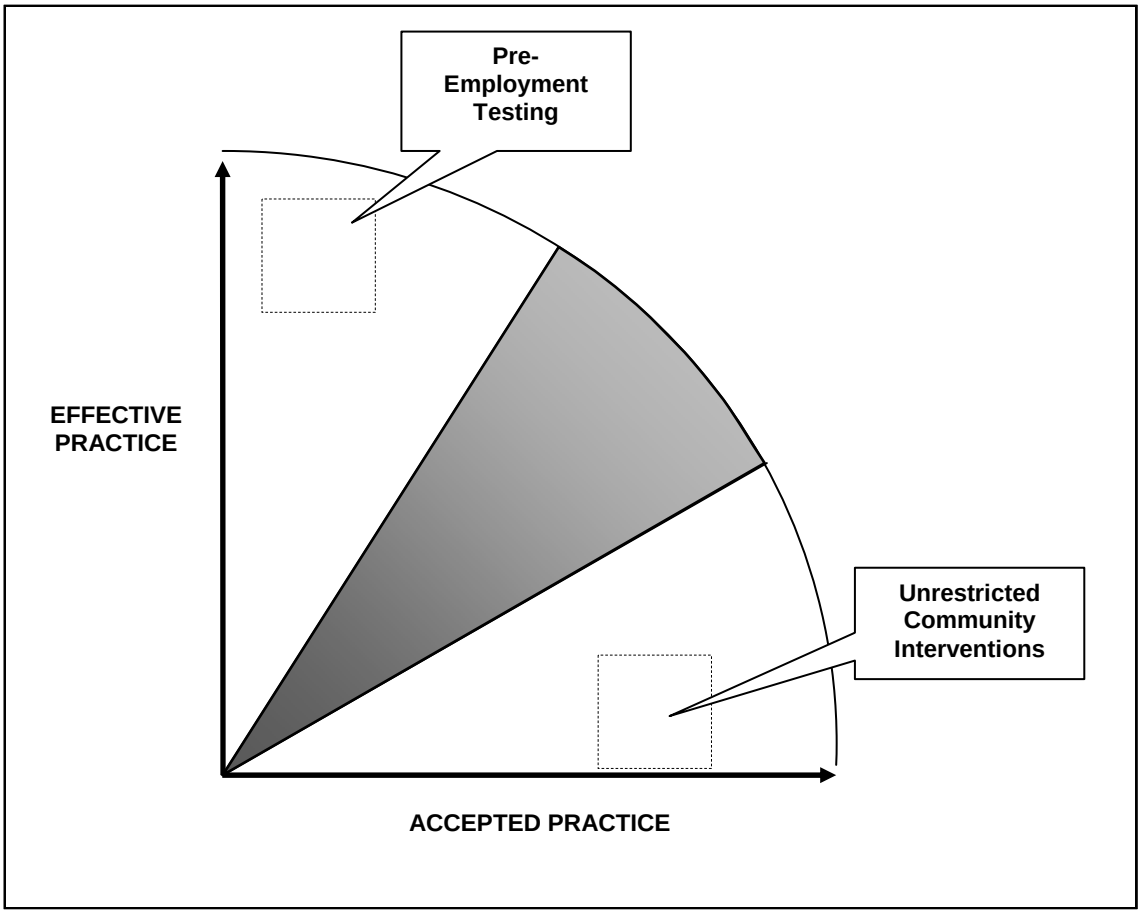
> I used to work on a mine during the early eighties when HIV was just becoming a recognised business risk. I can remember the truck arriving with people from Uvamboland on a weekly basis: thirty people would be loaded off the truck and tested [for HIV] and; then thirty people would be loaded back on the truck and sent back to Uvamboland (Diesease Management Consultant respondent 2, 2006).

This account, although disturbing in a historical context, illustrates a skewed practice that satisfied the requirements of the business contract to effectively manage risk but, had overwhelming disregard for all the elements of the social contract. Were the practice of pre-employment HIV testing still legal, it would have been charted to the extreme left of the conceptual framework. This notion of 'skewed practice' has been illustrated in Figure 5.5.

Of course, the practice of pre-employment HIV testing has been prohibited by enactments in *Employment Equity Act, No. 55 of 1998* and such practices would fall outside the 'regulatory perimeter' of the conceptual framework.

Conversely, practices skewed toward the requirements of the social contract were deemed to put the requirements of the business contract at risk. Consider the recent moves toward involving the surrounding communities in the organisational HIV/AIDS interventions. While these practices would, almost certainly, meet the requirements of the corporate social responsibility and stakeholder expectations, the question from many respondents was whether these practices would be affordable in the longer-term and whether they would continue to allow for companies to deliver sustainable shareholder returns. For these reasons, company interventions that involved unrestricted portions of the community were considered by some respondents to fall beyond the bounds of the *Wedge of Best Practice*.

Figure 5.3 Schematic Representation of Skewed Practices



5.3.5 Different Levels of 'Best Practice'

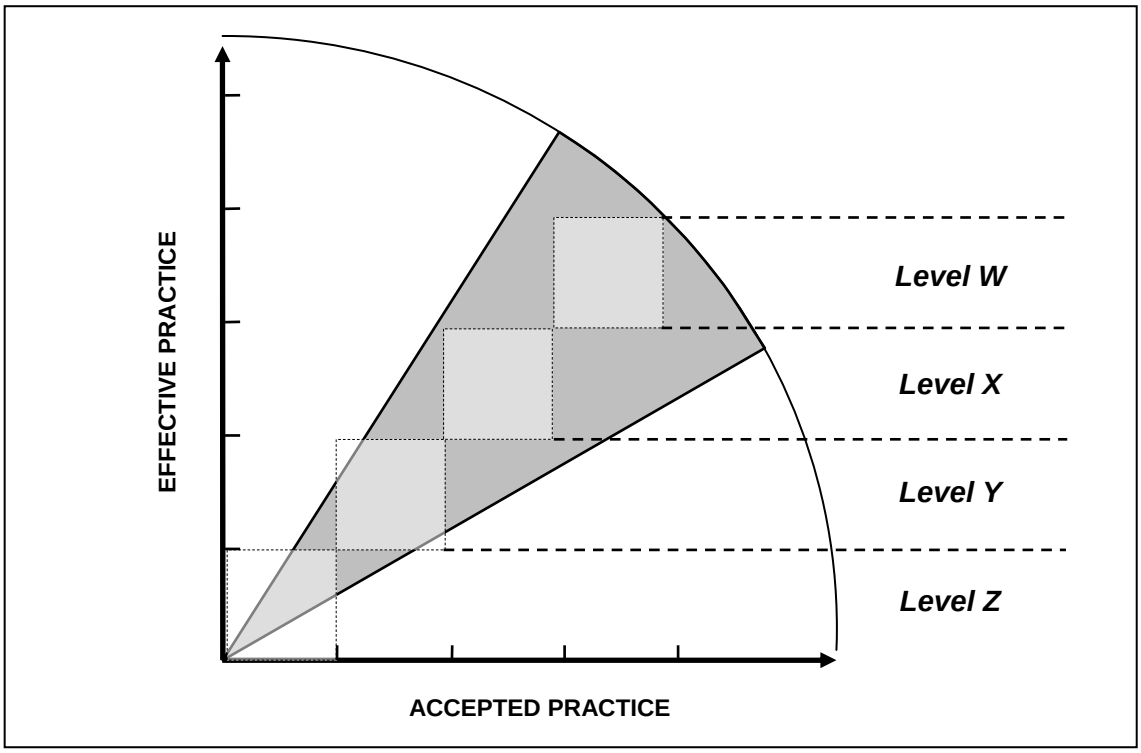
It was clear from the interviews conducted with respondents during this study that their workplace HIV/AIDS programmes were typically built on a number of individual interventions each contributing differently to the overall outcomes of the workplace programmes. In addition, there was a clear indication from the data that for workplace programmes to effectively achieve 'best outcomes' they required firstly; sufficient capacity to achieve 'best outcomes' and secondly; effective integration of interventions included in the programme.

> 'Best practice' is about taking an organisation through a capacity building growth path, without missing any steps, you have to be sure that you're laying the foundation for sustainable practice. (Disease Management Consultant respondent 1, 2006).

As a result of these observations, there was clear indication that the definition of 'best practice' had to incorporate different levels of 'best practice'. The fundamental difference in these levels appeared to be related to the differing capacity of various interventions to achieve 'best outcomes'. In view of the differing levels of mortality outcomes between a typical education intervention and a full-coverage ART programme, the incorporation of discrete levels appeared to be a reasonable expectation of the conceptual model.

Although Figure 5.4 illustrates how the different levels of 'best practice' may have been included the conceptual framework, the determination of these levels and the consensus-driven constituents of these levels is probably better developed in future studies.

Figure 5.4 Levels of 'Best Practice'



5.3.6 Section Conclusion

This section undertook a detailed exploration of the concept, 'best practice' from first principles. The reasons for this exercise were based on the researcher's observations that respondents had a limited appreciation of what 'best practice' really means and were, therefore, inadequately equipped to objectively question and

evaluate various examples of ‘best practice’ as presented in a range of HIV/AIDS publications and business fora.

The investigation focused on the contents of the literature review and the detailed analysis the data collated from the in-depth interviews. This allowed for the researcher to develop a conceptual framework for ‘best practice’ that was based on firm literary evidence and a shared understanding from research respondents regarding the meaning of ‘best practice’

Three elements were found to make up the primary dimensions of ‘best practice’:

The first dimension was adherence to the social contract. Strong and evolving social forces meant that ‘best practice’ workplace interventions needed to incorporate an understanding of the expectations and intensifying pressures from a large – and growing - set of stakeholders.

The second dimension was compliance with the business contract. The imperative of companies to create and protect shareholder value manifested in the need for ‘best practice’ HIV/AIDS interventions to be affordable, sustainable, easy to implement and effective in terms of improving the overall objectives of businesses.

The third dimension was the renewed focus on the specific outcomes of workplace interventions. A clear need was found to exist for companies to begin to aim for a state of ‘best outcomes’ wherein there was neither HIV/AIDS-related morbidity nor mortality. This was an important finding of this study and highlighted the point that ‘best practice’ needed to be more intimately related to measurable outcomes.

Furthermore, the capacity of workplace programmes to achieve ‘best outcomes’ was found to depend on two variables, firstly; the capacity of individual interventions to promote good measurable outcomes and secondly; the effective integration of interventions in line with achieving ‘best outcomes’. This finding resulted in the incorporation of yet-to-be defined levels of ‘best practice’ in the conceptual model.

5.4 Principal Components of Comprehensive Workplace Programmes

5.4.1 Section Introduction

During the literature review the author described the outcomes of a desk-top analysis of the various codes and guidelines. These outcomes were important for two reasons: firstly; they provided the underlying content for the research instrument and secondly; they enabled the establishment of a theoretical level of consensus regarding nine principal components of comprehensive workplace HIV/AIDS programmes.

The purpose of this section was to analyse the responses to the research questionnaire and, therefore, the level of agreement between research responses and the theory included in the codes and guidelines regarding the interventions that were perceived to make up successful workplace HIV/AIDS programmes. The overall the aim of this section was, therefore, to draw-out the parallels between views of respondents in the field with the theoretical consensus regarding the nine principal components of comprehensive workplace programmes and of specific 'best practice' interventions.

5.4.2 Current Level of Agreement

The desktop analysis, performed as part of the literature review, highlighted broad content overlap between the various codes and guidelines which served to suggest that the research was likely to find widespread agreement regarding 'best practices' between the views expressed by research respondents and the content included in the codes and guidelines. However, the credibility of this assumption was significantly diminished by the research finding that pointed to the marginal uptake of the codes and guidelines.

The fact that respondents were found to be using methods other than the codes and guidelines to inform their responses to HIV/AIDS in the workplace, raised significant doubt regarding the congruence between current workplace thinking and the content included in the codes and guidelines. As a result, the research questionnaire was instrumental in establishing whether respondents agreed with the principal

components of comprehensive workplace HIV/AIDS programmes and, more specifically, with the 'best practice' interventions as listed in the questionnaire.

The fact that the research questionnaire was closely aligned with the content in the codes and guidelines, afforded the researcher good opportunity to identify discrepancies between what respondents perceived 'best practice' to be and what the codes and guidelines listed as 'best practice'. Moreover, the specificity of the statements included in the questionnaire deliberately left little room for respondent misinterpretation and aimed at improving the rigour of the questionnaire's results.

5.4.3 Research Questionnaire Results

A few respondents pre-empted the outcomes of the questionnaire through suggestions that the principal components and the specific interventions that comprise comprehensive workplace HIV/AIDS programme were increasingly recognised:

> I think we know what should be an optimal response: there are 25 or 26 [interventions] that make-up an optimal response. The idea is now for companies to take those interventions and to prioritise them based on what level they're at in their response (Private Consultant respondent 1, 2006).

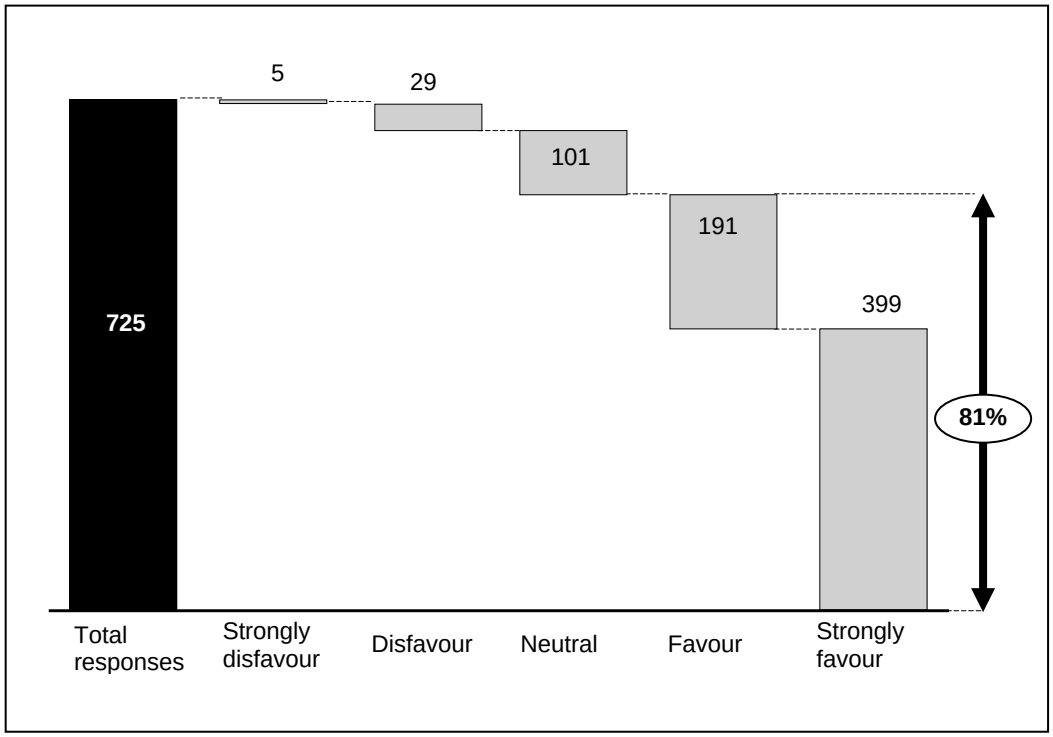
> The programmes are at a level where we definitely know what the programmes should comprise (Disease Management Consultant respondent 1, 2006).

> I definitely think the principal components of 'best practice' are understood and transferable across large South African companies (Company HIV/AIDS Practitioner respondent 1, 2006).

Analysis of responses to the questionnaire verified this empiric evidence that suggested that the components of successful workplace programmes were widely known. Toward this end, there was definite congruence between the views of respondents and the content laid out in the codes and guidelines.

Figure 5.5 outlines the distribution of responses to the research questionnaire (Appendix D includes a table of the full list of results for the questionnaire).

Figure 5.5 Distribution of Responses to the Research Questionnaire

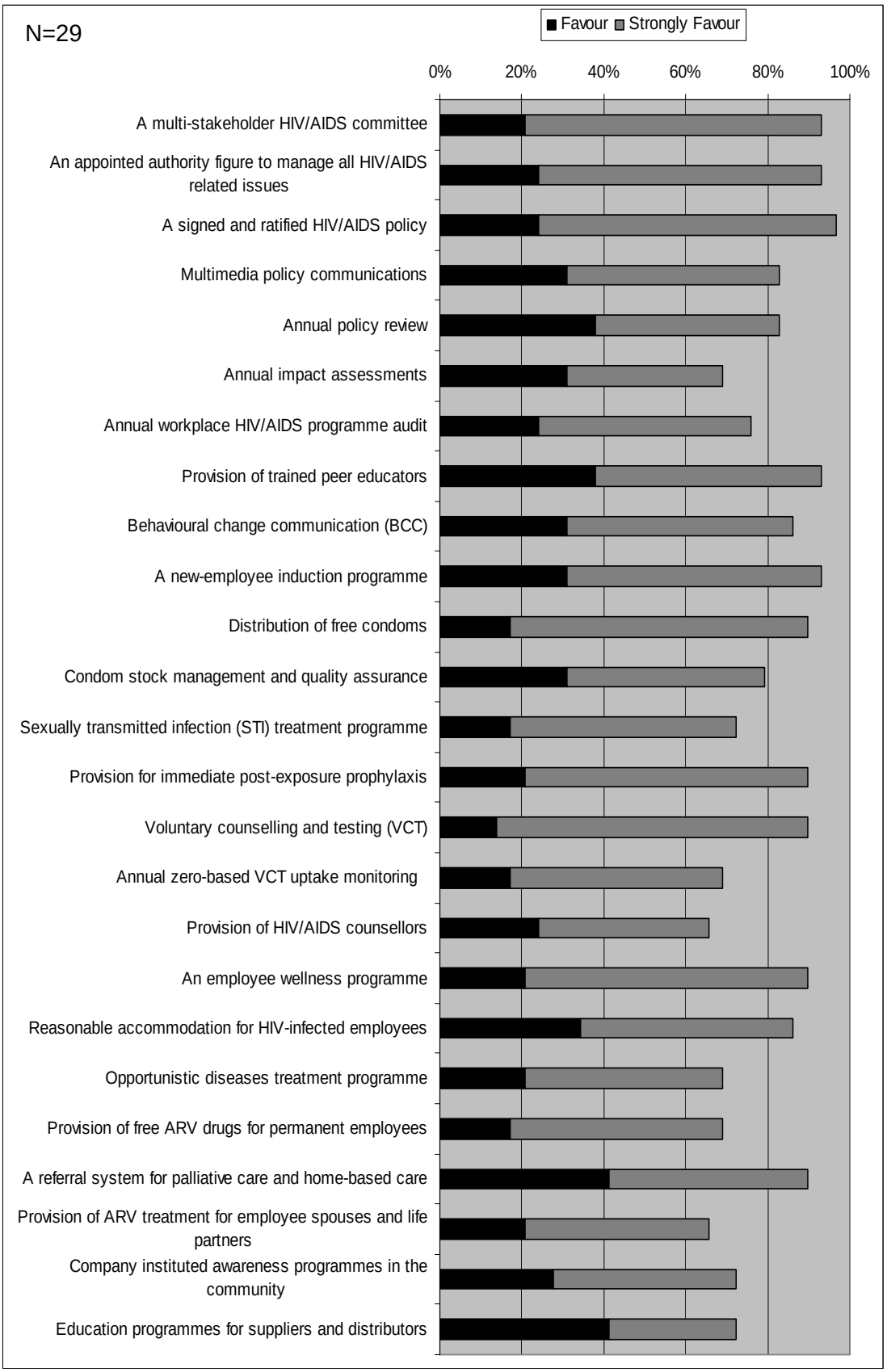


The data analysis demonstrated, firstly; a high level of agreement regarding principal components of comprehensive workplace programmes and secondly; a clear alignment regarding the specific 'best practice' interventions listed in the questionnaire. Moreover, the responses from all four categories of respondents demonstrated remarkable similarity.

The vast majority of respondents either favoured or strongly favoured the 'best practice' interventions as laid out in the questionnaire. Eighty-one percent of all the responses were marked either 'favour' or 'strongly favour'. This was despite the initial expectations from the author that responses to the questionnaire would be more evenly weighted between the two extremes of the Likert scale.

Figure 5.6 charts the degree to which the respondents either favoured or strongly favoured the principal components of 'best practice' as listed in the questionnaire.

Figure 5.6 Distribution of the 'Favour' and 'Strongly Favour' Responses to the Questionnaire



The degree to which respondents favoured the various components of workplace programmes also presented some interesting observations. Firstly, ten components were either favoured or strongly favoured by more than ninety-percent of respondents. These components are listed in Table 5.1.

Table 5.1 Ten Most Highly Favoured Interventions

Research questionnaire statement	'Favour' and 'disfavour' responses (%)
A signed and ratified HIV/AIDS policy	97
A multi-stakeholder HIV/AIDS committee	93
An appointed authority figure to manage all HIV/AIDS related issues	93
Provision of trained Peer Educators	93
A new employee induction programme	93
Distribution of free condoms	90
Provision for immediate post-exposure prophylaxis	90
Voluntary counselling and testing	90
An employee wellness programme	90
A referral system for palliative care and home-based care	90

(N=29)

The least favoured components still yielded favourable responses overall. The apparent reason for 'Provision of HIV/AIDS counsellor' being one of the least favoured interventions appeared to stem from the fact that several respondents were not entirely familiar with the term, 'HIV/AIDS counsellors' and of the role they played in HIV/AIDS programmes.

Furthermore, the finding that 'Provision of ARV treatment for employee spouses and life partners', was one of the least favoured statements served to confirm earlier observations that extended workplace interventions were not always considered to be 'best practice'.

Table 5.2 Two Least Favoured Interventions

Research questionnaire statement	'Favour' and 'disfavour' responses (%)
Provision of HIV/AIDS counsellor	66
Provision of ARV treatment for employee spouses and life partners	66

(N=29)

A further interesting finding related to the order of the questionnaire. As the order of statements in the questionnaire arose directly from the order of interventions listed in most of the codes and guidelines - which generally started out with the relatively generic components of workplace HIV/AIDS programmes such as, an HIV/AIDS policy and an awareness campaign – the interventions listed in first part of the questionnaire were considered by the researcher to be less contentious and easier for companies to implement. By contrast, interventions listed in the latter half of the questionnaire were considered to be more onerous for companies to implement.

With this in mind, the researcher expected to find that the respondents would strongly favour interventions listed earlier in the questionnaire and show less preference for interventions listed toward the end of the questionnaire. However, this trend was not as dramatic as the author had originally anticipated.

Despite observations that the level of agreement did decline somewhat in the latter part of the questionnaire, a high number of respondents still favoured the 'advanced' interventions like the provision of free ART and the involvement of suppliers and distributors in company programmes.

The literature review made the suggestion that earlier corporate responses were related more closely to policy and awareness; interventions that had since been proved to have little impact on the overall incidence and prevalence of the disease in the workplace. The observed acceptance of interventions previously considered beyond the capacity of several organisations, therefore, highlighted an evolution of company responses toward a broader and somewhat more advanced solution-space. This observation was important because it showed that corporate response to HIV/AIDS appeared to moving toward acceptance that a more holistic and integrated

approach would be required to effectively counter the effects of the disease in the workplace.

5.4.4 Section Conclusion

The research questionnaire provided the researcher with opportunity to test the theoretical level of consensus between what the literature suggested ‘best practice’ was and what research respondents considered ‘best practice’ to be. Toward this end, a high level of consensus was clearly demonstrated on two levels: in the first instance; there was uniform response regarding the nine principal components of comprehensive workplace programmes. In the second instance; the results of the questionnaire were able demonstrate a high level of agreement regarding the specific ‘best practice’ examples listed in the questionnaire.

The high degree to which respondents, in principle, favoured the specific interventions listed in the research questionnaire pointed to a convergence between the literary knowledge base and the general understanding of HIV/AIDS managers in practice.

Furthermore, there was evidence to suggest a growing level of maturity in the way large South African companies responded to HIV/AIDS. The positive response to interventions previously considered to be more onerous for companies to implement was a positive finding. This illustrated advancement in understanding that large South African companies needed to adopt a more holistic and integrated approach their response to HIV/AIDS in the workplace.

Despite the relatively small size of the sample (N=29) and the fact that the outcomes of the research questionnaire were unlikely to be statistically significant, the findings of the research are important for two specific reasons. Firstly; the findings provided a clear indication of the level of agreement regarding the principal components of comprehensive workplace programmes and of the interventions that would typically have made-up these components in practice. Secondly, the fact that the research questionnaire was received so well by respondents and appeared to withstand the rigour of the investigative process meant that the format and content of the research questionnaire could potentially be transposed into more detailed future research in this subject line.

5.5 Uptake and Continuity of 'Best Practice'

5.5.1 Section Introduction

The preceding sections pointed toward broad agreement amongst companies, consultants and disease management providers regarding the components of a comprehensive workplace HIV/AIDS programme, an observation that lent support to support to Dr. Brian Brink's observation that:

> The debate is no longer about the merits of prevention versus testing, treatment and care. We now understand that all of these are needed on a much greater scale than anything achieved to date (WEF, 2005:4).

One of the problems observed, however, was the divide between what companies considered to be 'best practice' and what interventions were ultimately being implemented. This phenomenon was observed at regular intervals during the course of the interviews for this research. Company respondents would often favour certain 'best practice' examples in the questionnaire and then openly admit to the researcher that those interventions were not always as readily implemented in practice. This finding ran parallel with recent business reviews that reported similar discrepancies on a much greater scale both locally (Ellis and Terwin, 2003; Ellis and Terwin, 2004; Ellis and Terwin, 2005) and internationally (WEF, 2005).

The reasons for these discrepancies were found to exist on two distinct levels. The first level related to the non-committal stance of organisations against HIV/AIDS in the workplace. This appeared to stem primarily from a lacklustre response of organisational leadership and the absence of a clear business case for many interventions.

The second level related to the many challenges associated with implementing and sustaining successful workplace interventions. Despite a clear commitment to fighting HIV/AIDS in the workplace, organisations still faced several hurdles in effectively implementing examples of 'best practice'. These obstacles were found to include, amongst others, limited buy-in from middle management, the geographic spread of operations and complexities associated with the continuum of care,

5.5.2 Limited Leadership 'Buy-In'

In the foreword for a recent SABCOHA report, Brad Mears, the Chief Executive Officer of SABCOHA, emphasised that leadership remained the key to overcoming the epidemic (SABCOHA, 2005). Within this research several representatives recognised the crucial role of clear leadership in forwarding 'best practice' within their companies.

A respondent from one of the public-company remarked; "we're in a fortunate position where our CEO is more than prepared to put in as much money as is required to make the programme work" (Company HIV/AIDS Practitioner respondent 1, 2006). Another respondent remarked how their workplace programme would not have developed without the backing of senior management:

> 'Best practice' for me is starting at the top. We started at the bottom - we started with the workforce and had total buy-in from the unions, but until we had the CEO driving it; it was never going to work (Multinational Consumer Products Company; Company Nurse Practitioner 2, 2006).

Two reasons were found to exist for the reluctance of organisational leadership to commit to the uptake of 'best practice' workplace HIV/AIDS interventions: firstly; the absence of a clear business case meant that business leaders did not have compelling evidence that 'best practice' interventions would make sound business sense. This was of particularly relevance in the group of private company respondents where financial constraints were more evident. Secondly; the relative absence of standards of practice and regulatory enforcement meant that the uptake of effective practices was largely voluntary.

5.5.2.1 Absence of a Clear Business Case

Successful HIV/AIDS programmes require leadership commitment and lasting financial endorsement from the company's Executive and/or Board. To sustain support from the Board, HIV/AIDS managers - from large private companies in particular – reported that were required to submit motivation by way of detailed cost-benefit analyses:

> We have reached a stage where we know, more or less, what we should be doing; what we need now is the evidence to convince our board that our programme will deliver returns (Company HIV/AIDS Practitioner respondent 3, 2006).

Several respondents reported that they relied on information from the public domain to inform their business case. However, because clear quantitative data was often difficult to find, many respondents expressed doubt regarding the existence of the business case for several 'best practice' interventions. Three respondents, each with wide experience across several companies, expressed similar reservation regarding the existence of a business case:

> I'm not sure that there's such a sound business case. Treating is costly and not treating is costly. There is very little data that confirms that business can minimise the problem and very few companies will take from shareholder profits to fund a soft project (Private Consultant respondent 2, 2006).

> Many people are able to make a list of the different components of workplace HIV/AIDS programme, but if we look at each one in isolation we don't really know whether it is effective on its own and whether it should be a part of the overall programme construct at all. After ten years we really shouldn't be doing this anymore – we are asking businesses to make an investment in something which we have not accurately defined the return (International HIV/AIDS Researcher respondent, 2006).

> I think the jury's out as far as the business case is concerned. There is actually little evidence to suggest that a business case exists and there is no definitive evidence to conclude this [matter] (HIV/AIDS Business Coalition; Director respondent 2, 2006).

These observations closely paralleled Connelly's suggestion that the lack of the research into the finances required to implement HIV/AIDS programmes was nothing new (Connelly, 2002) and, that more needed to be done to effectively define the business case. In a similar vein, one respondent remarked that a clear business case would diminish the need for regulatory enforcement:

> Enforcement is unlikely to make a difference; what we need to do is clearly define the business case and in-so-doing increase pressure exerted on companies by their shareholders (Occupational Health Consultant respondent 1, 2006).

There was a belief amongst some respondents that mining companies, in particular, had already done extensive cost-benefit analyses and that these companies would not have instituted 'best practice' programmes unless there had been clear benefits to instituting these programmes. However, a representative from one of the large mining companies reported that, until recently, a full cost-benefit analysis had not been performed and that the results of the current study would only be available in June, 2007 (Company HIV/AIDS Practitioner respondent 1, 2006).

Aside from the debate regarding the availability of data on the business case, there were also questions regarding the transferability of the data between different companies and different contexts. A respondent from a security company pointed out that, even if the data were available on the business case for other companies, it was debatable whether it would be relevant to industry in which they operated (Large Security Service Group; Human Resources Executive Respondent 7, 2006).

5.5.2.2 Relative Absence of Standards and Regulatory Enforcement

Ellis and Terwin (2005) suggested that most large and multinational companies were motivated to provide HIV/AIDS services to employees due to external pressures from regulatory bodies, shareholders, activists and unions. However, several respondents in this study highlighted the fact that several regulatory guidelines were easily escaped from:

> The King Commission recommendations, the GRI, SAICA and the JSE listing requirements are all meek and mild and can be effectively managed with a good deal of PR spin (Disease Management Consultant respondent 1, 2006).

> The GRI requirements and the JSE requirements have come and gone, we haven't looked at them, none of the other companies have done anything either; if there is an audit done tomorrow - so what?(Company HIV/AIDS Practitioner respondent 4, 2006).

The relative absence of regulations and/or standards of practice was a contentious topic in the research. As the principal components of workplace HIV/AIDS programmes were increasingly recognised, several respondents called for measures of enforcement to advance the response of a greater proportion of companies in South Africa to HIV/AIDS:

> We are reaching a plateau in our response, somehow the extent of these programmes needs to be widened. We have to find a way to persuade other companies to get onboard (Company Nurse Practitioner 2, 2006).

A number of respondents considered the implementation of standards of practice as a way of convincing managers to take cognisance of HIV/AIDS as a business imperative. As one consultant pointed out: "established standards allow for HIV/AIDS to fit into some sort of management thinking" (Private Consultant respondent 1, 2006).

Toward this end, the management of HIV/AIDS in the workplace was often mentioned in parallel with regulations that related to occupational health and safety. The *Occupational Health and Safety Act of 1993* was considered to have laid a firm legislative foundation for governing the health and safety of all employees. A number of respondents questioned why HIV/AIDS interventions had not been included in this realm:

> In the same way organisations are accountable for occupational health and safety, so too they should be accountable for the standard of their HIV/AIDS programme (Private HIV/AIDS Consultant respondent 4, 2006).

> People are happy with standards around safety; I think it makes sense to establish standard along the same sort of principal. Many companies I've worked with are comfortable with this thinking (Private Consultant respondent 1, 2006).

Further investigation confirmed that, although the Act mandated - as far as was reasonably practical - a working environment that was safe and without risk to the health of its employees, it made no specific provision for the management of HIV/AIDS in the workplace.

A further argument put forward for instituting a minimum standard of practice was the increasing propensity of employees to move more frequently between different jobs. A respondent for a large healthcare company made the following assertion:

> There is currently nothing that says Company-X needs to provide similar benefits to Company-Y. If, for instance one of our employees with HIV/AIDS left the group, for whatever reason, and went to another company; what would happen to that employee if the standard of the other company's programme was not similar to that of ours? (Multinational Healthcare Company, Company HIV/AIDS Practitioner respondent 2, 2006).

A measure of enforcement - by way of a minimum standard of practice and/or legal regulation - was, therefore, widely considered to be a viable method for moving the HIV/AIDS in the workplace to a more obverse position in the minds of business leadership. One respondent representing a large private company suggested that; "the guidelines should be enforced in some way, if only to assist us in moving the issue of HIV/AIDS onto the Board meeting agenda" (Support Services Manager respondent, 2006).

5.5.3 Implementation Challenges

Numerous company respondents - from a number of public-listed companies in particular - reported that, despite a firm commitment from organisational leadership, the implementation of 'best practice' was oftentimes the most challenging aspect of achieving good results from the workplace HIV/AIDS programme. The reasons for this ranged between limited buy-in from middle managers, to logistical complexities and employee resistance to behavioural change.

5.5.3.1 Middle Management Buy-In

The role of middle managers in implementing various organisational systems and processes cannot be underestimated. Within the context of HIV/AIDS, ineffectual management at ground-level was seen to be particularly harmful to achieving 'best outcomes'. A response from a representative of a large retail company highlighted this concern:

> The biggest worry we have is getting middle management to manage this correctly. Often these managers don't even know how to manage absenteeism let alone complex HIV/AIDS interventions (Human Resources Executive respondent 3, 2006).

The lacklustre engagement of middle managers and line managers was considered an important impediment to the implementation of 'best practice'.

> Our middle-managers are happy to see money taken out of their budgets but, because they are not willing to actively participate in the process, our practices are showing only marginal improvement (Human Resources Executive respondent 2, 2006).

Moreover, unless middle managers were personally motivated or were offered incentives to improve programme performance, 'best practices' and more importantly, 'best outcomes', were unlikely to be achieved.

> It is difficult to get middle-managers to take responsibility for the implementation of HIV/AIDS programmes. If, however, you link HIV/AIDS programme outcomes to their bonuses, then things suddenly change (HIV/AIDS Business Coalition; Director respondent 2, 2006).

5.5.3.2 Geographic Spread of Operations

The geographic spread of business units within large companies appeared to pose a further hurdle for the implementation of 'best practice' in large companies. A respondent representing a large private company described how it was 'unfeasible' to include one their business units, that was sub-contracted to a rural mine and

comprised only twelve full-time employees, in the company HIV/AIDS programme (Support Services Manager Respondent, 2006).

The varying levels of literacy in different parts of South Africa presented an added problem for companies with geographically dispersed business units. A respondent representing a large retail company described how the company HIV/AIDS programme, which was designed with the demographics of their urban employees in mind, had failed to achieve the same outcomes in semi-rural areas of Kwazulu-Natal because of the disparate literacy levels (Human Resources Executive Respondent 2, 2006).

Innovative methods were, however, identified to counter the problems associated with widely spread business units. A respondent from a public-listed company described how the company had overcome the problem of geographical spread by engaging in a cost-sharing relationship with a large retail company and in so-doing both companies are able to share mobile VCT facilities when servicing business units in remote locations (Occupational Health and Safety Manager 1, 2006).

5.5.3.3 Complexities Associated with the Continuum of Care

A further factor highlighted during the data collection was the existence of disparate facilities and standards of care between the public and private health systems. In South Africa, three of the four treatment models described by Connelly and Rosen (2004) and Connelly and Rosen (2006), as a means for companies to make treatment and care available to workers, referred to the private-health models. The fourth model incorporated the largely untested clinic provider approach.

According to several respondents, a significant challenge for their workplace programmes was to ensure post-employment transfer of HIV-positive employees on ART to either public health or NGO sites for continued administration of ART.

Large private companies, in particular, those which had yet to scale up their response to include provision of treatment; cited the wide gap between the workplace and the public health sector as a major deterrent for providing ART. The concern was mainly around the responsibility the company had to employees on company-provided ARTs that would - for whatever reason - no longer form part of the

company's employ. This concern was echoed by one of disease management providers who pointed out that employers were reluctant to become; "tied to the possible ramifications of an indefinite employer/employee relationship" (Diesease Management Consultant Respondent 2, 2006).

5.5.3.4 Dependence on Employee 'Buy-In' and 'Behavioural Change'

As employee subscription to workplace HIV/AIDS programmes is a voluntary undertaking, the link between 'best practice' and 'best outcomes' was found to be tempered by employee buy-in and behavioural change. The capacity of workplace programmes to truly affect employee behaviour and to achieve the elevated goals of 'best practice' and 'best outcomes' was tested in the remarks made by several respondents:

> When it comes to AIDS the only thing that is holding us back is behaviour change (Corporate Social Responsbility Manager Respondent, 2006).

> People not being prepared to commit themselves to lifelong chronic treatment are a major impediment to improving our outcomes (Healthcare Executive Respondent 2, 2006).

In a similar vein, a number of interviewees lamented the poor conversion rates from the VCT programme to the disease management programme. A respondent representing a large disease management provider echoed this sentiment by asserting; "we are highly successful with VCT and only moderately successful with getting people onto treatment" (Diesease Management Consultant Respondent 2, 2006).

Unsystematic anti-retroviral compliance proved to be a further problem. A respondent from a public listed company recounted several instances where employees were found to be sharing their medication with their spouses and life-partners (Multinational Healthcare Company, Company HIV/AIDS Practitioner respondent 2, 2006). Yet another challenge noted by respondents was the increasing number of employees who voluntarily stop treatment to explore alternative (often traditional) modes of therapy.

The limited uptake of medical aid by employees is further challenge that was raised during the study. Although many companies had widened employee access to medical aid schemes and had typically undertaken to pay fifty-percent of the premium (Connelly and Rosen, 2006), only a minority of employees were found to have electively subscribed (Multinational Healthcare Company, Company HIV/AIDS Practitioner respondent 2, 2006; Human Resources Executive Respondent 3, 2006; Human Resources Executive Respondent 7, 2006). Low-wage workers were understandably reluctant to join medical aid schemes because the co-payment was considered too high:

> Even though an employee's premium may be little more than R250 [per month], that may represent more than twenty-percent of that person's salary. We cannot realistically expect workers to spend twenty-percent of their salaries on medical insurance (Multinational Healthcare Company, Company HIV/AIDS Practitioner respondent 2, 2006).

5.5.3.5 Stigma

In response to the question on what affects the uptake of 'best practice', several respondents indicated that stigma remained a significant impediment to a successful programme. This was unsurprising in view of a recent SABCOHA study that reported more than seventy-five percent of the companies surveyed indicating that stigma and discrimination had undermined the effectiveness of their HIV/AIDS programmes (SABCOHA, 2005)

An emergent concern in this study, however, was the indirect effect that stigma was found to have on several managers responsible for workplace HIV/AIDS programmes. Numerous respondents appeared fatigued by the persistence of stigma. A respondent from a public-listed company disconcertingly portrayed the stigma innuendo as follows:

> If we were dealing with a blood pressure epidemic, and there was a certainty that you would be dead in eight years if your blood pressure was not treated; we would undoubtedly have seen just about everyone checking their blood pressure and going onto treatment (Healthcare Executive Respondent 1, 2006).

5.5.4 Section Conclusion

The uptake and continuity of ‘best practice’ was found to be dependent on a number of factors, each with little relation to the fundamental scepticism around ‘best practice’ as a management concept. Although some of these issues related closely to previous research findings regarding the uptake of workplace HIV/AIDS interventions, three specific factors highlighted some emergent concerns.

Firstly; the complexities associated with the continuum of care was an issue that was notable in a number of companies. For many companies, the steadily decreasing prices of ART had made it viable for them to explore provision of treatment for employees. Although this was a promising finding, there was still significant concern regarding the availability of healthcare models that would alleviate the risks of having to treat employees (and past employees) indefinitely.

Secondly, the apparent ease with which companies were found to escape the implementation of specific workplace HIV/AIDS strategies highlighted the need for integrated systems and processes that would allow for routine – and perhaps regulated - measurement of programme outcomes.

Thirdly; it was evident that an ill-defined business case continued to impede the uptake of ‘best practice’ interventions. For companies to commit to long-term HIV/AIDS initiatives, further robust evidence would need to exist for the cost/benefit trade-offs of various interventions.

6 Conclusions and Recommendations

The slow mounting pressures on South African companies to respond to HIV/AIDS in the workplace have resulted in the growth in demand for information relating to successful workplace interventions. To fulfil this demand, an increasing number of HIV/AIDS agencies, business fora and service provider companies have come into existence. In addition, a wide-range of guidelines and publications that relate specifically to 'best practices' have been published. As part the literature review for this research, fourteen codes and guidelines and several more 'best practice' publications were analysed.

The overlapping content between the various codes and guidelines provided reassurance that a theoretical level of consensus existed regarding the components of successful workplace programmes. Toward this end, juxtaposition of findings from the in-depth literary analysis with the findings from the field research allowed for the identification of nine principal components of comprehensive workplace HIV/AIDS programmes.

Despite the high level of consensus regarding the principal components of successful programmes, a number of factors continue to impede the uptake and continuity of successful workplace interventions. The limited commitment from organisational leadership remains a significant obstacle in the uptake of successful workplace HIV/AIDS interventions. This was driven primarily by a lack of a clear business case and the relative absence of regulated standards of practice. In addition, implementation challenges such as inadequate and uncertain access to public health facilities to ensure the continuum of care for workers infected with HIV and the geographic spread of business operations are significant limiting factors in the sustained uptake of effective HIV/AIDS therapies.

Furthermore, the marginal uptake of the various codes and guidelines is impeding the transfer of information regarding successful workplace interventions. Despite suggestion that the codes and guidelines would be an obvious and preferred reference point for implementing and modifying workplace programmes, only two respondents reported actively using any of the codes and guidelines to design and implement various aspects of their programmes. The remaining respondents reported chiefly using them to access information regarding the regulatory and

legislative enactments that pertain directly to the management of HIV/AIDS in the workplace. This highlights the need for workplace HIV/AIDS literature that is more attuned to the specific informational needs of companies and provides evidence-based recommendations that that concisely map practical implementation parameters.

As an important point of reference in most HIV/AIDS codes and guidelines; the concept ‘best practice’ has been brought into spotlight. Within the context of workplace HIV/AIDS programmes, ‘best practice’ is, however, a nebulous management concept. Despite the definitions put forward by the ILO, UNAIDS and SADC - and observations that that these definitions exhibit broad content overlap – the real meaning of ‘best practice’ has remained somewhat elusive. As a result, many HIV/AIDS decision-makers have limited appreciation of what the concept really means and are rarely equipped to objectively evaluate various examples of ‘best practice’ listed in the codes the codes and guidelines.

This has potentially rendered several companies vulnerable to implementing questionable ‘best practice’ interventions and has raised doubt around the validity of the concept in the workplace HIV/AIDS programmes. Questions have been specifically raised around the practical usefulness of ‘best practice’ and its contextual relevance in a range of business environments across large South African companies. The perceived inattention of ‘best practice’ to different operating conditions across and within large organisations pointed to a need for more specific ‘best practices’. Toward this end, the emergence on industry-specific HIV/AIDS fora in the Security and Tourism and Hospitality industries was an encouraging finding.

Turning away from discussions around more literal interpretations of ‘best practice’; the value of ‘best practice’ was found to exist in its benchmarking characteristics and the concept’s universal appeal and motivational attributes.

A simple research observation that all respondents were able to instantly recognise and relate to the concept ‘best practice’ across several corporate contexts confirmed the appeal of ‘best practice’ across large South African companies. Moreover, the importance of ‘best practice’ in advancing the strategic agendas of governments and organisations such as the ILO, UNAIDS and the GBC, in terms of promoting the uptake of effective workplace HIV/AIDS interventions, illustrated the concept’s

motivational powers. Furthermore, the unabated use of the term - and various adaptations of the term – demonstrated the need, if not for ‘best practice, a concept with similar qualities for companies to aspire toward.

However, to ensure that ‘best practice’ is of practical use to companies and for HIV/AIDS agencies to fully leverage the motivational attributes of ‘best practice’ requires that the concept be developed along two critical dimensions:

Firstly; steps should be taken to ensure that ‘best practice’ is relevant to business. An ill-defined business case and the lack of business parameters that relate to specific operating environments continue to impede the uptake of successful workplace interventions Therefore, examples of ‘best practice’ need to be framed in a clear business context and the differences in organisational operating environments should be explicitly accounted for.

Secondly; in promoting effective workplace HIV/AIDS interventions, the focus should be shifted from ‘best practice’ *inputs* to the *outcomes* of ‘best practice’ interventions. The movement from a notion of ‘best practice’ to a notion of ‘best outcomes’ was an important theme that emerged during the course of the research and highlights the need for workplace HIV/AIDS strategies to establish a renewed focus on the outcomes of workplace interventions. Without a clear focus on measurable outcomes, several accounts of ‘best practice’ will continue to be misinformed.

6.1 Ensure that ‘Best Practice’ is Relevant to Business

To ensure that ‘best practice’ is relevant to business, the evidence-base needs to reflect relevant business imperatives such as cost/benefit profiles and risk mitigation measures. In addition, accounts of ‘best practice’ should make mention of the prevailing forces of an evolving social contract and the environmental parameters that affected the implementation and outcomes of proposed ‘best practice’ intervention.

6.1.1 Frame ‘Best Practice’ in a Business Context

Persistent questions around the business case – in both this research and several other publications – highlight the need for in-depth analysis of the cost/benefit implications of various workplace HIV/AIDS interventions. As a significant factor

affecting the uptake of ‘best practice’ interventions, steps need to be taken to quell the uncertainty that surrounds the business case. A continually revised and comprehensive analysis of overall business costs associated with HIV/AIDS will be required to effectively achieve this. This analysis will require detailed estimates of the direct and indirect costs associated with HIV/AIDS and in-depth analysis of the costs/benefit relationship of ‘best practice’ workplace interventions.

Although measurement of the direct costs of HIV/AIDS is relatively straightforward; measurement of the – potentially more significant - indirect costs associated with HIV/AIDS has proved to be infinitely more difficult. This is partly because factors like ‘*loss of tacit knowledge’* and *‘declining morale’* (Table 2.1) are inherently difficult to quantify and partly because so many organisations are unaccustomed to measuring the effect that these factors have on business costs. However, because indirect costs have proved to be a significant driver of the total cost associated with HIV/AIDS and, therefore, a dominant factor in establishing the business case, a great deal more needs to be done to accurately define these costs.

The direct costs of implementing ‘best practice’ interventions also need to be more accurately quantified. As several interventions require significant upfront capital investments - either for healthcare infrastructure and/or labour - and ongoing budget allocations to cover operating costs, the precise level of investment should be included when recording examples of ‘best practice’.

Moreover, for ‘best practice’ interventions to demonstrate a favourable cost/benefit relationship the level of economic benefit associated with these interventions should be measured and reported. This will require a collaborative research effort whereby companies assume responsibility for instituting systems and processes that will allow for research data collation and the overall quantification of direct economic benefits.

Furthermore, companies require a clear view of the organisational capacity that is required to effectively implement ‘best practice’ interventions. As organisational capacity encompasses both resources and capabilities, examples of ‘best practice’ should aim to include information along both dimensions. Resource requirements for ‘best practice’ interventions could be as simple as equipment and facilities or as intangible as management systems and technical processes. Therefore, the importance of these organisational capabilities within the operations, human

resources, occupational health and risk management functions cannot continue to be overlooked in future accounts of ‘best practice’.

Finally, explicit mention should also be made of the social forces that govern ‘best practices’. The evolving social contract as discussed in Section 5.3 highlights the need for examples of ‘best practice’ to make specific mention of the pressures encountered from workers, surrounding communities, investors, lobby groups and labour unions in implementing the intervention.

6.1.2 Account for Differences in Organisational Operating Environments

One of the reasons for the emergent scepticism surrounding ‘best practice’ is the limited reference the concept makes to differences in organisational operating environments. The need for ‘best practices’ to account for organisational context does, however, not necessarily mean that specific industry and business ‘best practices’ should be developed. Rather, examples of ‘best practice’ should aim to give a detailed description of the environment in which the intervention has been implemented. To achieve this, ‘best practice’ examples should include factors unique to the industry in which an organisation operates and the effect that the organisation’s geographic location may have had on the intervention.

Industry factors to consider could include; the degree of labour intensity, the levels of employee skills and the existence of organised labour movements. ‘Best practice’ in labour intensive industries is likely to differ from ‘best practice’ in more capital intensive industries on the basis of the scale to which interventions need to be rolled out and the level of involvement with the workforce. The differences of ‘best practice’ between industries with more highly-skilled labour to industries that predominantly employ semi-skilled labour force is likely to manifest in the different communication strategies and specific healthcare provider models. The existence of strong labour movements is likely to drive the social forces impacting ‘best practice’.

Geographic factors to consider include epidemiological trends and levels of HIV/AIDS prevalence in different geographic regions. These factors have significant influence on the level of business risk as a result of HIV/AIDS which in turn influence ‘best practice’ risk management strategies and principles. In addition, these factors shape ongoing capacity planning for specific HIV/AIDS interventions.

A further important geographic factor to consider in the appraisal of ‘best practices’, is the alignment of the intervention with public healthcare strategies and facilities. As workplace HIV/AIDS strategies are often closely linked to government strategies, workplace strategic planning often differs fundamentally between different regions. The reliance of several workplace HIV/AIDS healthcare provider models on public-health facilities means that the level of access to public healthcare should, therefore, be outlined as part of the description of ‘best practices’.

Of course, these are not the only environmental factors that potentially impact ‘best practice’. Specific examples of ‘best practice’ should, therefore, include any further significant environmental nuances and challenges.

6.2 Establish a Renewed Focus on Outcomes

The research identified a well established level of agreement regarding nine principal components of comprehensive workplace HIV/AIDS programmes. Moreover, the convergent interest in specific interventions found to make up these components highlighted a growing level of maturity in the way large South African companies are responding to HIV/AIDS in the workplace.

However, the need for a renewed commitment from companies and researchers to focus on outcomes, and more specifically, ‘best outcomes’ was a key finding of the research. Three specific reasons account for this observation:

Firstly; without a clear understanding of the outcomes achievable through implementing various interventions, several accounts of ‘best practice’ will continue to be misinformed. A renewed focus on the outcomes of specific interventions is likely to improve the quality of ‘best practice’ examples and will assist companies in gauging the measurable differences of ‘best practice’ interventions. In addition, well-defined measurable outcomes are likely to promote the continuous improvement of ‘best practice’ interventions over time.

Secondly; companies need to know what success means. In this regard, well-defined outcomes of ‘best practice’ interventions will provide companies with a clear sense of direction. This is true for both companies that plan to implement specific interventions

for the first time and for companies that seek to improve various aspects of their HIV/AIDS workplace programme.

Finally; amidst the growing number of expectations and intensifying pressures from a range of different stakeholder groups, there is likely to be a gradual shift from examining HIV/AIDS programme inputs to analysing the results of various workplace HIV/AIDS efforts.

In establishing a renewed focus on outcomes, the research highlighted the need for ‘best practice’ interventions to simultaneously address outcomes across the dimensions of a relatively rigid business contract and a rapidly evolving social contract. The conceptual framework developed as part of the research requires that companies measure the performance of interventions across both of these elements.

In previous sections the need for clear business outcome parameterisation across a range of different operating environments was outlined. In terms of social outcomes, the need exists for renewed focus on the primary health measures of morbidity and mortality. Although several different variables exist against which to measure the success of ‘best practice’ interventions, the variables that should continue to matter most are those of morbidity and mortality. Moreover, the promotion of interventional outcomes in accordance with the notion of ‘best outcomes’ is likely to increase the level of external benchmarking between companies and drive continuous improvement of workplace HIV/AIDS interventions.

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APPENDICES

Appendix A: Researcher's Letters to Respondents

DR. RONALD WHELAN
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Tel: **+27(0) 11 455 5659**
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E-mail: **ronaldwhelan@doctor.com**

Date

Attention: ***Respondent's Title and Name***
Respondent's Position
Organisation

Dear ***(Respondent's Title and Name)***

Thank-you for your interest in the research as discussed.

Together with Professor David Dickinson from the WITS Business School, I am looking at the concept of 'best practice' for workplace HIV/AIDS interventions.

The purpose of the research is to determine what the perceptions are regarding the notion of best practice and to explore the factors that affect the uptake and continuity of best practice in workplace HIV/AIDS programmes.

The data collection will comprise an interview and diminutive questionnaire. Together, the interview and questionnaire should take no longer than 45 minutes to complete. Please find the questions for the interview and questionnaire attached.

Should you wish, I can assure that your participation and input to the research will remain in confidence and anonymous. A summation of the research outcomes will be forwarded to your offices when the research is completed.

Please do not hesitate to contact me should you require any further information.

I look forward to learning your views and opinions during our scheduled appointment.

Yours sincerely

Ronald

Ronald Whelan

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Interview Questions and Research Questionnaire

Workplace HIV/AIDS interventions in large companies: the origins, perceptions and factors affecting the uptake and continuity of best practice.

DATE: ***01/01/01***

RESPONDENT: ***Respondent Title and Name***
Respondent's Organisation
Respondent's Position

SCHEDULED APPOINTMENT: ***Appointment Time and Date***

CONTENTS:

Section A: The background questions
Section B: The semi-structured interview questions
Section C: The questionnaire

NOTE:

The interview will take the form of a semi-structured discussion regarding the concept of 'best practice' for workplace HIV/AIDS programmes. To conserve time the questionnaire (Section B), may be completed prior to the interview.

I look forward to our meeting.

Kind Regards,

Ronald

Appendix B: Interview Questions and Research Questionnaire for Respondents Representing Public-Listed Companies and Large Private Companies

Section A:

Background information:

1 What is the respondent's professional background (e.g. medical/HR)?

2 What is the respondent's organisation or group to which he/she belongs?

3 What is the respondent's position in the organisation or group?

- How long has the respondent been in the position?

Section B:

Questions related to the concept 'best practice' in workplace HIV/AIDS programmes:

1 Please provide a brief history of how the workplace HIV/AIDS policy was developed?

- Who developed the HIV/AIDS policy?
- What was the respondent's role in the policy development?

2 With regards to HIV/AIDS workplace programmes; how would you define the concept 'best practice'?

3 What sources of information has your company used to establish the constituents of 'best practice' for workplace HIV/AIDS programmes?

- Please specify the codes and guidelines used.

4 Do the practices of other companies influence your organisation's response to HIV/AIDS in the workplace? If so; where does your organisation acquire this information?

5 Does the company set policy implementation targets and objectives?

- What information does the company use to establish the targets and objective parameters?

6 Do you think the available guidelines and codes of 'best practice' are of practical use in:

- Implementing programmes
- Modifying existing programmes

7 Has the lack of enforceability of the codes and guidelines influenced your company's uptake of 'best practice'? How?

8 Do you think the implementation of 'best practice' has been limited by the relative lack of accepted standards against which to measure interventions?

9 Do you think the concept 'best practice' is transferable across different companies and sectors?

10 What are the factors that affect the implementation of 'best practice' in your company?

- What factors impede the implementation of 'best practice' in your organisation?

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Section C – The Questionnaire

A list of workplace HIV/AIDS programme components, as assimilated from a range of different sources, is included in the table below. Please indicate the degree to which **the organisation you represent,** favours or disfavours the components as listed:

Implemented	Components of workplace HIV/AIDS programmes	Strongly disfavour (Sd)	Disfavour (D)	Neutral (N)	Favour (F)	Strongly favour (Sf)
	1. A multi-stakeholder HIV/AIDS committee	Sd	D	N	F	Sf
	2. An appointed authority figure to manage all HIV/AIDS related issues	Sd	D	N	F	Sf
	3. A signed and ratified HIV/AIDS policy	Sd	D	N	F	Sf
	4. Multimedia policy communications	Sd	D	N	F	Sf
	5. Annual policy review	Sd	D	N	F	Sf
	6. Annual impact assessments	Sd	D	N	F	Sf
	7. Annual workplace HIV/AIDS programme audit	Sd	D	N	F	Sf
	8. Provision of trained peer educators	Sd	D	N	F	Sf
	9. Behavioural change communication (BCC)	Sd	D	N	F	Sf
	10. A new-employee induction programme	Sd	D	N	F	Sf
	11. Distribution of free condoms	Sd	D	N	F	Sf
	12. Condom stock management and quality assurance	Sd	D	N	F	Sf
	13. Sexually transmitted infection (STI) treatment programme	Sd	D	N	F	Sf
	14. Provision for immediate post-exposure prophylaxis	Sd	D	N	F	Sf
	15. Voluntary counselling and testing (VCT)	Sd	D	N	F	Sf
	16. Annual zero-based VCT uptake monitoring	Sd	D	N	F	Sf
	17. Provision of HIV/AIDS counsellors	Sd	D	N	F	Sf
	18. An employee wellness programme	Sd	D	N	F	Sf
	19. Reasonable accommodation for HIV-infected employees	Sd	D	N	F	Sf
	20. Opportunistic diseases treatment programme	Sd	D	N	F	Sf
	21. Provision of free ART drugs for permanent employees	Sd	D	N	F	Sf
	22. A referral system for palliative care and home-based care	Sd	D	N	F	Sf
	23. Provision of ART treatment for employee spouses and life partners	Sd	D	N	F	Sf
	24. Company instituted awareness programmes in the community	Sd	D	N	F	Sf
	25. Education programmes for suppliers and distributors	Sd	D	N	F	Sf

(Respondent Title and Name – Organisation)

26. Do you think that anything should be added or removed from the list of components in Section

Appendix C: Interview Questions and Research Questionnaire for Respondents in the Expert and Consultant Category

Section A:

Background information:

1 What is the respondent's professional background (e.g. medical/HR)?

2 What is the respondent's organisation or group to which he/she belongs?

3 What is the respondent's position in the organisation or group?

- How long has the respondent been in the position?

Section B:

Questions related to the concept 'best practice' in workplace HIV/AIDS programmes:

1 With reference to workplace HIV/AIDS programmes; how would you define the concept 'best practice'?

2 Where, in your opinion, are companies acquiring their information on 'best practice'? Please indicate specific:

- codes of best/good practice and;
- guidelines of best/good practice.

3 Is the lack of enforceable guidelines and codes affecting company uptake of 'best practice'? Why?

4 What role do organisations like the GBC and SABCOHA play in facilitating 'best practice'?

5 Are companies using the examples of 'best practice' to:

- implement programmes?
- modify existing programmes?

6 Do 'best practice' benchmarks provide suitable framework for:

- good corporate governance?
- corporate reporting?
- the establishment of accepted standards of performance?

7 Is the relative absence of formal standards of 'best practice' impeding the response of companies to HIV/AIDS in the workplace?

8 Do you think it may be too soon to compare the success of various programmes and initiatives?

9 Do you think companies are ready to adhere to formal standards for workplace HIV/AIDS programmes?

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Section C: The Questionnaire

A list of workplace HIV/AIDS programme components, as assimilated from a range of different sources, is included in the table below. Please indicate the degree to which **the organisation you represent,** favours or disfavours the components as listed:

Components of workplace HIV/AIDS programmes	Strongly disfavour (Sd)	Disfavour (D)	Neutral (N)	Favour (F)	Strongly favour (Sf)
1. A multi-stakeholder HIV/AIDS committee	Sd	D	N	F	Sf
2. An appointed authority figure to manage all HIV/AIDS related issues	Sd	D	N	F	Sf
3. A signed and ratified HIV/AIDS policy	Sd	D	N	F	Sf
4. Multimedia policy communications	Sd	D	N	F	Sf
5. Annual policy review	Sd	D	N	F	Sf
6. Annual impact assessments	Sd	D	N	F	Sf
7. Annual workplace HIV/AIDS programme audit	Sd	D	N	F	Sf
8. Provision of trained peer educators	Sd	D	N	F	Sf
9. Behavioural change communication (BCC)	Sd	D	N	F	Sf
10. A new-employee induction programme	Sd	D	N	F	Sf
11. Distribution of free condoms	Sd	D	N	F	Sf
12. Condom stock management and quality assurance	Sd	D	N	F	Sf
13. Sexually transmitted infection (STI) treatment programme	Sd	D	N	F	Sf
14. Provision for immediate post-exposure prophylaxis	Sd	D	N	F	Sf
15. Voluntary counselling and testing (VCT)	Sd	D	N	F	Sf
16. Annual zero-based VCT uptake monitoring	Sd	D	N	F	Sf
17. Provision of HIV/AIDS counsellors	Sd	D	N	F	Sf
18. An employee wellness programme	Sd	D	N	F	Sf
19. Reasonable accommodation for HIV-infected employees	Sd	D	N	F	Sf
20. Opportunistic diseases treatment programme	Sd	D	N	F	Sf
21. Provision of free ART drugs for permanent employees	Sd	D	N	F	Sf
22. A referral system for palliative care and home-based care	Sd	D	N	F	Sf
23. Provision of ART treatment for employee spouses and life partners	Sd	D	N	F	Sf
24. Company instituted awareness programmes in the community	Sd	D	N	F	Sf
25. Education programmes for suppliers and distributors	Sd	D	N	F	Sf

(Respondent Title and Name – Organisation)

26. Do you think that anything should be added or removed from the list of components in Section C?

Appendix D: Tabulated Results of the Research Questionnaire

Components of workplace HIV/AIDS programmes	Strongly disfavour (Sd)	Disfavour (D)	Neutral (N)	Favour (F)	Strongly favour (Sf)
1. A multi-stakeholder HIV/AIDS committee	0	0	2	6	21
2. An appointed authority figure to manage all HIV/AIDS related issues	0	0	2	7	20
3. A signed and ratified HIV/AIDS policy	0	0	1	7	21
4. Multimedia policy communications	0	0	5	9	15
5. Annual policy review	0	0	5	11	13
6. Annual impact assessments	2	3	4	9	11
7. Annual workplace HIV/AIDS programme audit	0	3	4	7	15
8. Provision of trained peer educators	0	0	2	11	16
9. Behavioural change communication (BCC)	0	0	4	9	16
10. A new-employee induction programme	0	0	2	9	18
11. Distribution of free condoms	0	0	3	5	21
12. Condom stock management and quality assurance	0	1	5	9	14
13. Sexually transmitted infection (STI) treatment programme	0	2	6	5	16
14. Provision for immediate post-exposure prophylaxis	0	0	3	6	20
15. Voluntary counselling and testing (VCT)	0	2	1	4	22
16. Annual zero-based VCT uptake monitoring	0	3	6	5	15
17. Provision of HIV/AIDS counsellors	1	3	6	7	12
18. An employee wellness programme	0	0	3	6	20
19. Reasonable accommodation for HIV-infected employees	0	2	2	10	15
20. Opportunistic diseases treatment programme	0	3	6	6	14
21. Provision of free ART drugs for permanent employees	0	1	8	5	15
22. A referral system for palliative care and home-based care	0	0	3	12	14
23. Provision of ART treatment for employee spouses and life partners	1	3	6	6	13
24. Company instituted awareness programmes in the community	0	1	7	8	13
25. Education programmes for suppliers and distributors	1	2	5	12	9