

AN INVESTIGATION INTO YOUNG WOMEN WORKERS' EXPERIENCES OF THE HIV AND AIDS  
RESPONSE OF SMALL AND MEDIUM SIZED ENTERPRISES IN A SEMI URBAN AREA IN  
KWAZULU-NATAL

by

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I declare that AN INVESTIGATION INTO YOUNG WOMEN WORKERS' EXPERIENCES OF THE HIV AND AIDS RESPONSE OF SMALL AND MEDIUM SIZED ENTERPRISES IN A SEMI URBAN AREA IN KWAZULU-NATAL is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



26/11/2014

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## **ABSTRACT**

Young women working in SMEs are increasingly being affected by HIV and AIDS, and SMEs are expected to respond to HIV and AIDS through workplace policies and programmes. This requires commitment from SMEs to help young women who face various gendered vulnerabilities to HIV and AIDs. The study, whose purpose was to investigate young women workers' experiences of the HIV and AIDS response of small and medium enterprises in a semi urban area in KwaZulu-Natal, used a qualitative approach and collected data from three SMEs in Pietermaritzburg during the period of the study. Findings of the study indicate that the majority of respondents from all three SMEs agree on experiencing limited or no HIV and AIDS policies and programmes in SMEs. With reference to incomplete or limited responses, two SMEs provide financial assistance for funerals. However, some aspects such as education and awareness, monitoring, management commitment, provision of medical aid, facilitation of peer education, appointment of an HIV officer and more were not evident. Thus recommendations were made on how SMEs should respond, and future research ideas were outlined.

<b>CONTENTS</b>	<b>PAGE</b>
Declaration	ii
Acknowledgements	iii
Abstract	iv
Table of contents	v
List of tables	x
List of figures	xi
Abbreviations	xii

**CHAPTER ONE**  
**INTRODUCTION TO THE RESEARCH PROBLEM**

1. Introduction	1
1.1 Background information	1
1.2 The research problem	2
1.3 The purpose of study	3
1.4 The objectives of the study	4
1.5 The research questions	4
1.6 Definitions of key terms, concepts and variables	5
1.7 Context of research	6
1.7.1 Women and HIV vulnerability	6
1.7.2 Women's access to employment	7
1.7.3 Impact of HIV and AIDS on SMEs	8
1.7.4 SME responses to HIV and AIDS	9
1.7.5. Behaviour change models in HIV and AIDS prevention	11
1.7.6 Conclusion	12

## CHAPTER TWO

### THEORY AND LITERATURE REVIEW

2.1	Introduction	13
2.2	HIV and AIDS demographics	13
2.3	Population projections	16
2.4	Workforce projections	18
2.5	Young woman's labour market share	19
2.6	Education levels of the female labour force	19
2.7	Female skills levels	20
2.8	Wages of young women	22
2.9	HIV and AIDS and economic growth	23
2.10	HIV and AIDS attrition in SMEs	24
2.11	Costs of HIV and AIDS to SMEs	25
2.12	Cost impact model	26
2.13	Why SMEs should respond to HIV and AIDS	30
2.14	Why SMEs are responding or failing to respond	31
2.15	Intervention strategies that work for young women	33
2.16	Theoretical framework	35
2.16.1	Gender and power theory and the major tenets	36
2.16.1.1	The sexual division of labour	38
2.16.1.2	The sexual division of power	39
2.16.1.3	The structure of cathexis	39
2.16.2	Explaining young women's general vulnerabilities to HIV and AIDS using the gender and power theory	41
2.17	Conclusion	45

**CHAPTER THREE**  
**RESEARCH METHODOLOGY**

3.1	Introduction	46
3.2	The chosen design	47
3.2.1	Data collection method	49
3.2.2	Sampling techniques	50
3.2.3	Data analysis and interpretation	53
3.3	Reflecting on the role of the researcher	55
3.4	Demographic profile	56
3.5	Auditability,credibility and appropriateness	57
3.6	Ethical considerations	57
3.7	Pre-test or pilot study	60
3.8	Limitations	60
3.9	Summary	61

**CHAPTER FOUR**  
**YOUNG WOMENS' PERCEPTIONS OF HIV POLICIES AND PROGRAMMES IN**  
**SMEs**

4.0	Introduction	62
4.1	Characteristics of participants	62
4.2	Young women's experiences of HIV policies and programmes in SMEs	63
4.2.1	Non-implementation of HIV policies and programmes in SMEs	63
4.2.2	Facilitation or provision of HIV and AIDS counselling and testing	65
4.2.3	Appointment of HIV and AIDS officer/peer educators	67
4.2.4	Supply of male and female condoms	68
4.2.5	Provision of medical aid/payment for the treatment of HIV related illnesses	70
4.2.6	HIV information distribution and management support	71
4.2.7	Protection of women from sexual exploitation	73
4.2.8	Provision of resources for funerals	74

4.2.9	Provision of any other assistance	76
4.2.10	Factors hindering or promoting SME responses`	77
4.2.11	Summative Conclusion	81

## **CHAPTER FIVE**

### **MANAGEMENTS' PERCEPTIONS OF HIV AND AIDS ISSUES IN SMEs**

5.0	Introduction	83
5.1	Perceptions on the causes of HIV and AIDS infections	83
5.2	Absenteeism in SMEs	86
5.3	Ill-health retirement in SMEs	88
5.4	HIV and AIDS related deaths in SMEs	89
5.6	Effect of HIV and AIDS on workplaces	90
5.6	Measures taken to respond to HIV and AIDS	92
5.7	Conclusion	94

## **CHAPTER SIX**

### **DISCUSSION OF RESULTS**

6.0	Introduction	95
6.1	Theory of gender and power	96
6.2	Intervention strategies in SMEs	96
6.3	Limited services provided by SMEs	104
6.4	Expectations of young women in respect of SMEs' responses to HIV and AIDS	105
6.5	Factors hindering or promoting SME responses to HIV and AIDS	106
6.6	Impact of HIV and AIDS on SMEs	107
6.7	Summary	109

**CHAPTER SEVEN**  
**CONCLUSION**

7.1	Introduction	111
7.2	Limitations	112
7.2.1	Study site	112
7.2.2	Gender	112
7.2.3	The sample size	112
7.3	HIV and AIDS and access to health	112
7.4	Recommendations for SMEs	112
7.5	Future research ideas	114
7.6	Summary	116
7.7	References	116
	Appendices	129
	Appendix 1 Interview guide for management	130
	Appendix 2 Interview guide for young women	133

<b>List of tables</b>	<b>Page</b>
Table 1: Women's share of adults with HIV and AIDS	15
Table 2: HIV prevalence estimates and the number of people living with HIV and AIDS	16
Table 3: Estimated annual population growth rates 2001-2011	18
Table 4: Labour participation rates 2012	19
Table 5: Unemployment by level of education	21
Table 6: Real mean and monthly earnings 2001-2005	22
Table 7: Cost of HIV and AIDS to business	25
Table 8: Summary of HIV and AIDS issues	29

<b>List of figures</b>	<b>Page</b>
Figure 1: Cost impact model	27
Figure 2: Three part structural model (from Connell's theory of Gender and power 1987)	37
Figure 3: Visual depiction of Mkondeni area	47
Figure 4: Map of Mkondeni area	52

## ABBREVIATIONS

**AIDS** Acquired Immuno Deficiency Syndrome

**GBC** Global Business Coalition

**HIV** Human Immuno Virus

**ILO** International Labour Office

**SABCOHA** South African Business Coalition on AIDS

**OIs** Opportunistic Infections

**PLWHAs** People Living with HIV and AIDS

**STIs** Sexually Transmitted Infections

**UNAIDS** Joint United Nations Programme on HIV/AIDS

**WHO** World Health Organization

**UNHCR** United Nations High Commissioner for Refugees

**UNICEF** United Nations Children's Fund

**WFP** World Food Programme

**UNDP** United Nations Development Programme

**UNFPA** United Nations Population Fund

**UNESCO** United Nations Educational, Scientific and Cultural Organization

# CHAPTER ONE

## INTRODUCTION

### 1.0 Introduction

There is persuasive evidence that young women in particular are more vulnerable to infection by HIV than their male counterparts are. According to the former UN Secretary General Kofi Annan, there are fourteen seropositive women for every ten seropositive men in sub-Saharan Africa (UNAIDS, 2010). South African women account for three quarters of all women worldwide with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (Faulk and Usunier, 2009). Among young people aged 25 to 29 in South Africa, for example, women have 32,7% HIV prevalence compared to 15.7% for men (South Africa Country Progress Report 2010). The social and economic factors that influence vulnerability to HIV and AIDS include poverty, cultural factors, gender inequality and lack of knowledge. Most literature has established clear links between these factors and the transmission of HIV and AIDS (Abertyn, 2008; Faulk and Usunier, 2009).

Given the effects of HIV and AIDS on business, that is, lower productivity, higher absenteeism and lower profits, it is vital to interrogate whether South African SME enterprises are both acknowledging and responding to HIV and AIDS. Although the effectiveness of workplace programmes in both large companies and SME's has been evaluated (Barnet and Whiteside, 2005; Connelly and Rosen, 2005; SABCOHA, 2011) little or no comprehensive research into young women's experiences of the responses of SMEs to HIV and AIDS exists. This is a study focusing on young women workers' (with high vulnerability to HIV infection) experiences of the response of SMEs to HIV and AIDS, and whether such responses meet young women's socio-economic realities and vulnerabilities.

### 1.1 Background information

Global statistics show that 36 million people are living with HIV (UNAIDS, 2010). According to UNAIDS (2010), more than 60 million people have been infected with HIV

since the epidemic began three decades ago. By far the worst affected region, sub-Saharan Africa is now home to 26.6 million people living with HIV and AIDS. Although the rate of new HIV infections is slowly decreasing in some African countries, the total number of people living with HIV continues to rise, especially as the effects of treatment roll-out become more apparent. The 1.3 million people who died of HIV-related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global 1.8 million deaths attributable to the epidemic (UNAIDS, Report on the Global AIDS Epidemic, 2010).

In South Africa, one in three deaths were HIV and AIDS related in 2011 (Actuarial Society of South Africa, 2011). Institute of Futures Research (2011) found that HIV and AIDS have drastically limited the population growth of South Africa to 50.6 million instead of allowing it to increase to 55 million in 2012. In 2006, one million more women than in 2004 had HIV and AIDS (UN, 2010). Since then, the proportion has increased. Today, nearly a third of South African pregnant women are HIV positive (US Centre for Disease Control, 2011).

## **1.2 The research problem**

The central research problem this study is investigating is the supposed dissatisfaction of young women working in SME enterprises in KwaZulu-Natal in respect of workplace HIV and AIDS interventions. Sprague (2008) mentions that women in South Africa face a particular disadvantage when it comes to accessing information on HIV transmission, prevention and care, negotiating safer sex and accessing treatment and support for HIV and AIDS. On the other hand, Faulk and Usunier (2009) argue that business may help young women by taking a leadership role in the provision of HIV and AIDS education, awareness programmes, condom distribution and provision of facilities necessary for the provision of treatment. However, credible body of literature reviewed shows that the response by the majority of South African-based SMEs to the HIV and AIDS pandemic has been unhurried, weak or incomplete (SABCOHA, 2010: Connelly and Rosen, 2005).

This research investigates young women workers' experiences related to the HIV and AIDS response of three SMEs to determine whether such responses meet the needs of young women's socio-economic realities and vulnerabilities. Management was interviewed to develop a deeper understanding of the policy and programmes of SMEs. The research seeks to recommend intervention strategies for SMEs relevant to vulnerable young women who are infected or affected by HIV and AIDS.

### **1.3 The purpose of the study**

The purpose of the study is to investigate young women workers' experiences of the response of SMES to HIV and AIDS in KwaZulu-Natal. The study also seeks to highlight the importance of introducing workplace policies and programmes in the prevention and management of HIV and AIDS for the benefit of young women and SMEs at which they work. The South African Country Progress Report (2010) showed that the economically active women population aged between 25 and 29 years had the highest HIV prevalence rate of 32.7%. For men in the same age group, the prevalence is 12% (Department of Health, 2007). The Actuarial Society of South Africa (2011) reiterated that the HIV positive rate of women is higher than that of men in all age groups. Women in younger age groups are four times more likely to be HIV-infected than men. Among the 20 to 24 year-old age group, HIV prevalence is roughly 24% for women and 6% for men (Department of Health, 2007). HIV and AIDS threaten young women's contribution to the country's economy due to chronic absenteeism from work as well as from resultant illness and subsequent death.

SMEs are companies that employ between 20 and 300 employees (National Small Business Act, 1996). SME's are often less mechanised and use more manual labour, thus providing more local work prospects for young women (The Economic Intelligence Unit Limited, 2004). Statistics South Africa (2010) reveals that SMEs provide 14% of formal employment in South Africa. This, in turn, injects income into poorer communities, which contributes towards positive economic growth in the macro economy. Whilst SMEs are still to be investigated about their provision of HIV and AIDS prevention information to young women, the increasing prevalence of HIV and AIDS in

South Africa still presents an escalating threat to the growth of SMEs and the South African economy as a whole.

#### **1.4 The objectives of the study**

The study investigates young women workers' experiences of SMEs' responses to the HIV and AIDS epidemic in KwaZulu-Natal. Young women's experiences of the policy and programmes are analyzed. The study:

1. Explores the experiences of young women working in SMEs in terms of workplace programmes and policy on HIV and AIDS.
2. Assesses the perceptions of young women with regard to the impact of workplace programmes.
3. Develops a deeper understanding of the impact of HIV and AIDS on SMEs in KwaZulu-Natal.
4. Analyzes how SMEs in KwaZulu-Natal are responding to the HIV and AIDS epidemic.

#### **1.5 The research questions**

The following questions guide this research:

1. What intervention strategies relevant to vulnerable young women infected or affected by HIV and AIDS can be employed in SMEs?
2. Are workplace programmes effective in facilitating the reduction of vulnerability to HIV for young women?
3. How are SMEs experiencing the impact of HIV?
4. How are SMEs responding to the HIV and AIDS epidemic in KwaZulu-Natal?

## 1.6 Definitions of key terms, concepts and variables

The following concepts and terms, defined below, are central to the researcher's understanding of the research problem:

**Women's increased vulnerability to HIV and AIDS:** refers to those factors that put women at greater risk of HIV infection. These include biological factors, relationship power imbalances, lack of sexual autonomy, economic dependence and high rates of violence against women. Such factors make them particularly vulnerable to HIV.

**Socio-economic vulnerability:** According to Le Cour, Im-em and Leliovre (2002), the socio-economic vulnerability of a woman refers to those social and economic circumstances and situations that increase the possibility of not preventing HIV infection or increases the risk of being exposed to HIV.

**SMEs:** These consist of companies that employ between 20 and 300 employees (National Small Business Act 1996).

**Workplace:** The workplace encompasses a huge range of organizations and includes SMEs. The diverse nature of these workplaces in terms of race, ethnicity and gender affects the impact of HIV and AIDS, the responses mounted, and the way in which research on HIV and AIDS is conducted. Types of workplaces present a useful classification for researchers, practitioners and policy makers.

**HIV and AIDS policy:** is a thorough document that outlines an organisation's attitude, beliefs and chosen actions towards the epidemic and covers issues of awareness, prevention and treatment action plans.

**The human immune deficiency virus (HIV):** is a retrovirus that causes AIDS. HIV targets the T4 or CD4 subset of T lymphocytes, which regulate the immune system (Stine 2010).

**Peer educator:** Peer education is an approach to health promotion in which community members are supported to promote health-enhancing change among their peers. The idea is that ordinary lay people are in the best position to encourage health behaviour to each other (UNAIDS 2010).

**HIV officer:** a health practitioner appointed by an SME to deal with all matters relating to HIV and AIDS.

## **1.7 Context of research**

Women make up the majority of people infected with HIV in sub-Saharan Africa (Kim and Watts, 2010). More than three million people in South Africa out of over five million infected with HIV are women (HRSC, 2011). An estimated one in three women are HIV positive in South Africa and the numbers are growing because of women's socio-economic, cultural and biological vulnerability to HIV and AIDS (UNAIDS 2010). According to WHO (2011), South African national prevalence surveys suggests that 55% of the HIV infected population are women and girls. Statistics show that KwaZulu-Natal province has the highest HIV antenatal prevalence rate of 38.7% compared with the national average of 29.3% (South African Country Progress Report, 2010). In 2010, the Eastern Cape HIV antenatal prevalence rate stood at 27.6%, Limpopo 20.7%, Northern Cape 16.2% and Western Cape 16.1%. All these provinces were in the range below that of KwaZulu-Natal (South African Country Progress Report, 2010).

### **1.7.1 Women and HIV vulnerability**

Studies have demonstrated that the social context and position of women in South Africa, as well as cultural factors and norms, have been significant in increasing HIV transmission among women (UNAIDS, 2008). Shisana, Zungu and Zuma (2010) also found that poor women are less likely to be knowledgeable about HIV and AIDS and are more likely to engage in risky sexual practices with a partner. There is evidence suggesting that the relationship between poverty and HIV has detrimental effects on the health of a woman in particular (Sprague, 2008). Researchers have postulated that in many disadvantaged contexts, poverty and gender inequalities together create and foster conditions where high-risk behaviours become prevalent. For example, in contexts where gendered inequalities influence access to needed resources, poor women can access resources through sexual networking with men (Shisana et al, 2010). Biologically, women are more susceptible to contracting HIV due to the greater area of mucous membranes exposed during sex, as well as the higher viral content in male sexual fluids (Sprague, 2008).

Poor economic conditions and poverty increase women's vulnerability to HIV and AIDS. Shisana et al (2010) agreed with Chazan (2007) and linked vulnerability to HIV infections to financial constraints imposed on the young woman. Chazan (2007) notes that women with less income and high expenditure needs often feel the pressure to supplement their meagre earnings and this can lead them to risks of sexual exploitation. Studies have demonstrated that the need for money, services, commodities and status in South Africa have been significant in increasing HIV transmission among women who are trapped into using sex as a commodity in exchange for goods, services, jobs, money, accommodation or even status (Department of Health, 2007; UNAIDS, 2008).

UNAIDS (2010) argues that access to information is one of the challenges amongst many other cultural aspects increasing women's vulnerability to HIV and AIDS. The gender social order has resulted in education being seen as less important for women and many women of rural origin have limited literacy skills in their home language and even more so in an "inherited language" (UNAIDS, 2011). Most HIV and AIDS messages are delivered in written form and a large bulk of messages are in English. As a result, accessing HIV and AIDS information for young poor women with low levels of literacy is difficult.

### **1.7.2 Women's access to employment**

South Africa has made great strides in gender equality and is now 6<sup>th</sup> out of 134 countries on the United Nations gender related development index (GDI) global ranking compared to its occupation of the least position 10 years ago (UNDP, 2011). Since South Africa's independence in 1994, essential constitutional reforms were done to ensure access to opportunities for women in all sectors including the labour market. Consequently, more women are entering the labour market, including SME's, than ever before (Sprague, 2008).

Working and having income remains, for many, a critical approach for fighting poverty and attaining sustainable livelihoods, and it is an important freedom (Chazan, 2007). However, the working situation or the nature of recruitment systems that are used in

recruiting young women into jobs can determine the level of vulnerability to HIV. Absence of organized recruitment systems, shortage of accommodation and low income levels in SMEs for young women may cultivate conditions in which vulnerability occurs. Young women may be forced to access jobs and accommodation through sexual networking if these issues are not addressed. Therefore, the vital issues for women entering the SME labour market include safe recruitment, better income and access to accommodation so that vulnerability to HIV and AIDS can be reduced.

Employment can reduce but does not always eradicate poverty. Research conducted in South Africa, illustrated that gender is linked to lower levels of income (Gilbert & Soskolne, 2003). Therefore, poverty, which reduces the power of women to control their circumstances and make choices, can remain a pervasive problem for young women even if they are working in small to medium enterprises due to their low income. Whereas it is apparent that complete eradication of poverty is not be guaranteed through working in SMEs, the critical matter is whether SMEs' can act as sources of HIV and AIDS prevention information for young women.

### **1.7.3 Impact of HIV and AIDS on SMEs**

In order for South Africa as a nation to be able to increase employment opportunities, reduce the effects of poverty and raise government revenue to improve the general welfare of most of the populace, the country requires economic growth (SABCOHA, 2011). The impact of HIV and AIDS on South African economic growth has been and will continue to be profound. Impact studies undertaken in South Africa looked at the effect of HIV and AIDS on economic growth (Barnet and Whiteside, 2005). The results revealed that South Africa's economic growth would be better without HIV and AIDS.

The rising prevalence of the epidemic has an impact on operational efficiency and costs, subsequently reducing SME profitability and productivity. The BER (2006) survey revealed that HIV and AIDS has reduced labour productivity and has increased absenteeism in SMEs, resulting in less profitable organizations. The economic effect has been noticed in terms of an increase in labour turnover rates, loss of experience and skills and increased recruitment and training costs.

Human Science Research Monograph (2006) noted that even where SMEs try to protect themselves against the impact of HIV and AIDS in the workplace through modifying employee working conditions, they cannot escape the effects it is having on the broader society of which they are part. HIV and AIDS pushes people further into poverty as households lose their breadwinners and savings are consumed by the costs of health care and funerals, thereby affecting consumer demands and expenditure patterns.

SABCOHA (2011) noted that the impact of HIV and AIDS threatens long-term sustainability of companies. On the market, the demand for products falls as households diverts disposable income to medical expenses. The SABCOHA (2011) study established that HIV and AIDS could potentially cause a reduction in market volume of 12.5% over a ten-year period. Over and above this, human resource costs, healthcare costs and HIV programming costs increase, and this impacts on the profitability of the company as a whole.

Current estimates suggest that by 2020, the epidemic will have a marked negative impact on company costs, productivity and demand for products, resulting in a negative impact on the South African economy as a whole (Lewis, 2010). It will affect the company through direct costs related to employee benefits, recruitment and training; through indirect costs, such as increased absenteeism and morbidity on the job; and through universal costs, for instance, through declining employee morale and disrupted succession planning (IFC against AIDS and SABCOHA, 2011).

#### **1.7.4 SME responses to HIV and AIDS**

International and national surveys have revealed that most SMEs have not assessed the impact of HIV on their business (Connelly and, 2005:10; SABCOHA, 2011, Faulk and Usunier, 2009, IFC against AIDS and SABCOHA, 2011). Larger companies have mainly led the response, whilst many of the SMEs do not appear to be concerned until HIV impacts on them directly. The results of a recent SABCOHA study (2010) indicate

that most companies have not done any research on the actual or potential impact of HIV and AIDS on their labour force, production costs or customer base.

In order to effectively combat the effect that the epidemic is having on business, it is important for SMEs to implement a sustainable and broadly communicated HIV and AIDS policy, which will assist in addressing the impact that the epidemic will ultimately have on their profitability and productivity. Research by Connelly and Rosen (2005) has reinforced that very few SMEs have implemented HIV and AIDS policies nor initiated HIV and AIDS awareness campaigns. Hawarden (2007) stated that out of 20 SMEs surveyed in central Gauteng, only 35% had HIV policies. Varied reasons were given for not implementing HIV policies.

Hawarden (2007) cited that the stigma surrounding HIV and AIDS caused many companies to refrain from implementing policy. Employees may discriminate against each other once workers' HIV positive status is publicly known. Not believing that their key employees are affected (believing that only low-skilled black employees are vulnerable) and the fact that implementing HIV policy is not a legal requirement were some of the reasons advanced by SMEs for not addressing HIV in the workplace. Hawarden (2007) noted that management believed that the cost of replacing employees lost due to HIV and AIDS is modest and that it wasted production time for employees to participate in HIV programmes. These were some of the other reasons advanced for not implementing policy.

IFC against AIDS and SABCOHA (2011) seconded findings relating specifically to SMEs' by Hawarden (2007). They all agree that SMEs feel that they are not affected by the pandemic. The authors determined that HIV and AIDS response was low due to management ignorance, lack of information and a lack of willingness to pay for such services. While SMEs are slow to respond, different institutions caution that for SMEs in the most affected regions of the world, including South Africa, HIV and AIDS will have major consequences for profitability and productivity (UNAIDS, 2011).

A study of 20 SMEs (with 20 to 200 employees) in Gauteng in 2007 found that SMEs generally invest little in employee benefits. The same study also found that managers did not regard HIV and AIDS as a major cause of labour turnover or as having a major impact on production costs, and that generally, concern about HIV and AIDS was not high (Hawarden, 2007; SABCOHA, 2011).

While the response of large companies to HIV and AIDS varies (Dickinson, 2004), a number of surveys have indicated that the response of SMEs lags behind that of larger corporations (SABCOHA, 2011). Many SMEs' shift responsibility of HIV and AIDS matters to government (GBC, 2006). SMEs cannot rely on the state to provide but can establish HIV programmes on their own.

Significantly, some current responses to the pandemic recognize the importance of the workplace as a site for ongoing HIV prevention and for introducing programmes that will educate and empower women in order to reduce women's vulnerability to HIV infection (IFC against AIDS and SABCOHA, 2011). Given the national trends of declining life expectancy and increasing mortality, especially premature mortality for young women of reproductive age, it is reasonable to ask whether or not those South African SMEs have established HIV and AIDS workplace programmes (Sprague, 2008).

#### **1.7.5 Behaviour change models in HIV and AIDS prevention**

The AIDS Risk Reduction Model (ARRM) is one of several stages of change models. Developed by J.A. Catania, it posits that change is a process, and that individuals move from one step to the next as a result of a given stimulus. In the ARRM, an individual must pass through three stages: behaviour-labelling, commitment to change and taking action. Interventions are more likely to be successful if they target the audience at the relevant stage. The ARRM combines aspects of the Health Belief Model, the Diffusion of Innovation Model, and Social Cognitive Theory. Programs that use the AIDS Risk Reduction Model focus on clients' risk assessment, influencing the decision to reduce risk through perceptions of enjoyment or self-efficacy and clients' support to enact the change (e.g., access to condoms, social support).

The model is useful in assisting development interventions to influence the sexual lives of community members and to reduce their own HIV-infection vulnerabilities. This model helps in developing personal and social coping mechanisms and acting upon solutions to difficult situations like negotiating safer sex as well as becoming less dependent on men for survival.

### **1.7.6 Conclusion**

Understanding young women's experiences of the responses of SMEs to HIV and AIDS is neither irrelevant nor trivial. This research is important as it advocates for business to come to the fore in helping young women by taking a leadership role in the provision of HIV and AIDS education, awareness programmes, condom distribution and provision of facilities necessary for the provision of treatments. The research seeks to recommend intervention strategies for small and medium size enterprises relevant to vulnerable young women who are infected or affected by HIV and AIDS.

## **CHAPTER TWO**

### **THEORY AND LITERATURE REVIEW**

#### **2.1 Introduction**

In this chapter, the researcher provides a review of literature pertaining to young women workers' experiences of HIV and AIDS response of SMEs. Whereas this chapter is not an exhaustive review of all the works published on this topic, it is an appraisal of selected and recent work that is relevant to the study. The analysis starts from a broad overview of the HIV and AIDS demographics in South Africa and then moves on to the future projections of the effects of HIV and AIDS on the population, workforce and the South African economy at large. In this chapter young women's labour market share, young women's education levels and their wages are summarised and discussed. The literature review proceeds by outlining the potential impact of HIV and AIDS on economic growth in KwaZulu-Natal and South Africa. The research report progresses to an analysis of HIV and AIDS attrition in SMEs and the costs of HIV and AIDS to SMEs. The literature then tackles on the issue of why SMEs should respond to HIV and AIDS. The intervention strategies that work for young women are then discussed. However, the literature review will remain incomplete without discussing the appropriate theoretical framework. In this chapter, studies from 1979 to 2010 on gender and power are summarised and discussed. The literature review will indicate the usefulness of employing the theory of gender and power with regard to women's health. The review will go through women's social risk for disease and how they addressed through a variety of strategies, from education to policy.

#### **2.2 HIV and AIDS demographics**

South Africa has one of the top HIV prevalence rates on the globe, and KwaZulu-Natal is the most highly affected province in South Africa (Statistics South Africa, 2012). Statistics derived from the results of annual, clinical and secret antenatal surveys undertaken at clinic sites show that South Africa is the most affected country in Africa (UNAIDS, 2010). Current estimates indicate that 26.4% of KwaZulu-Natal's work force is HIV-positive, compared to 15.9% in the rest of the country (Matthews, George and Gow,

2009). Albertyn (2008) has linked poverty to HIV and AIDS vulnerability to HIV infection in KwaZulu-Natal. Poverty is also much higher than the national average, with a third of KwaZulu-Natal's population living below the US\$2-a-day poverty line. Whilst the responses of SMEs in KwaZulu-Natal to HIV and AIDS are uncertain, recent evidence indicates that economic growth continues to lag behind that of the rest of the country, and poverty is rising faster in KwaZulu-Natal than in other provinces (Chazan, 2007). A key strategy for fighting the constraints imposed by HIV and AIDS on economic growth, particularly on the growth of SMEs lies in understanding the response of SMEs to HIV and AIDS and the reasons why they are responding or failing to respond to the epidemic. Household surveys estimating the impacts of the epidemic validate the severe negative effects imposed on infected individuals and their households (Casale and Whiteside, 2006). These household-level surveys captured detailed non-economic impacts and typically overlooked SME responses to HIV and AIDS, which can have direct or indirect consequences for both infected and uninfected population groups and the economy at large.

South African demographics are influenced by the high incidence of the HIV and AIDS pandemic. In 2011, about 5.38 million South African people lived with HIV. By then the country's HIV and AIDS prevalence rate for those aged 15-49 was estimated at 16.6%, the world's fourth highest proportion (CIA World Fact book,2011), though in 2004 the estimated rate of 18.8% (16.8% - 20.7%) was even higher (SSA, 2011). Among 15-24 year-olds, women account for about 90% of new HIV infections (UNAIDS, 2011). In 2011, HIV incidence among 20-29 year-old women was more than six times higher than for men of the same age (UNAIDS 2011). As an assortment of reports emphasize, South Africa young women's vulnerability to HIV infection in the face of gender power inequalities is worsened by the fact that they increasingly have older partners, more often than not are targeted by older men for sex, and in general find very little support and guidance. In everyday life, a great deal of emphasis is placed on men's dominance over women and girls. Women and girls, in contrast, are widely expected to be submissive and innocent on sexual matters (HSRC, 2009). As UNAIDS (2011) argues, young women's subordinate status with regard to men is a critical factor influencing their

greater risk to infection, placing gender issues at the centre of the HIV prevention challenge.

The weightiness of HIV and AIDS continues to be felt mainly by young women because of their level of infection and because caring for a sick family member is considered a women’s task. HIV prevalence remains disproportionately high for women in the 25-29 year age group, where a nationwide survey in 2008 found one in three (32.7%) to be HIV positive – the same proportion as in 2002 (HSRC, 2009).The table below depicts the acknowledgement by UNAIDS (2009) that HIV prevalence is higher for women.

**Table 1: Women’s share of adults with HIV and AIDS.**

HIV and AIDS		
Adults (15+) with HIV in thousands		Women’s share of adults (15+) with HIV
Total	Range	%
5 400	4700-6200	59

**Source: UNAIDS (2009)**

Many women worldwide, like men, have benefited from improvements in healthcare during the last century, such as innovations in medical services, access to education, and improvements in living and working conditions. More than 10 years have been added to women’s life expectancy in some countries as a result (Doyal, 2001). Nevertheless, South African women seem not to be enjoying these health achievements: HIV still disproportionately affects women of reproductive age. Table 2 below indicates HIV prevalence estimates and the number of people living with HIV and AIDS between 2001 and 2011.

**Table 2: HIV prevalence estimates and the number of people living with HIV and AIDS, 2001-2011**

Year	Prevalence			Incidence adult 15-49	HIV population (millions)
	Women 15-49	Adult 15-49	Total Population		
2001	17.4	16.0	9.4	1.72	4.21
2002	17.7	16.2	9.6	1.59	4.37
2003	18.0	16.2	9.7	1.58	4.49
2004	18.1	16.2	9.8	1.63	4.59
2005	18.3	16.2	9.9	1.73	4.69
2006	18.9	16.6	10.2	2.11	4.87
2007	18.9	16.5	10.2	1.54	4.95
2008	18.9	16.4	10.3	1.43	5.02
2009	19.1	16.4	10.4	1.45	5.13
2010	19.3	16.5	10.5	1.43	5.26
2011	19.4	16.6	10.6	1.38	5.38

**Source: SSA (2011) Midyear Population estimates**

### **2.3 Population projections**

Thurlow, Gow and George (2009) used the provincial version of the ASSA-2003 model from the Actuarial Society of South Africa (ASSA, 2005) to calculate approximately the overall population projections for KwaZulu-Natal. The model created annual population estimates with and without the effects of HIV and AIDS for the period 1985-2025. The ASSA model disaggregated the total population by province, gender, racial group (African, Asian, Colored and White) and one-year age intervals. The model emphasized that HIV is spread via heterosexual sexual activity amongst adults, who it divided into risk groups according to sexual behaviour. The calibration of the model was based on epidemiological and medical research, population census data, and HIV prevalence data from antenatal clinic surveys and mortality statistics.

In this model HIV, prevalence was found to be severe in the working-age, especially younger, females (20-34 years) and slightly older males (35-49 years) (US Centre for Disease Control, 2011). Moreover, the prevalence of HIV and AIDS was found to be heavily concentrated within KwaZulu-Natal. Given the large population of KwaZulu-Natal, it is clear that it forms the epicentre of South Africa's HIV pandemic. The effects of this concentration are evident in the population projections from the ASSA model. The long-term implications of HIV and AIDS for population growth are pronounced. Without its effects, the adult population of South Africa is predicted to reach 36.4 million by 2025. AIDS deaths reduce this adult population by 7.8 million people, which is more than a quarter of the expected population in 2025. The predicted loss of life in KwaZulu-Natal is even more bedazzling, with the adult population depleted by two-fifths due to HIV and AIDS. The HIV prevalence rate is estimated to begin falling and AIDS-related sickness and death declining after 2020. Despite the fact that the pandemic is predicted to change in its scale and concentration among working age women, it will still have grave implications for South Africa's workforce (Thurlow et al, 2009).

Already, Table 3 below by SSA (2011) implies that the rate of growth for the South African population has declined between 2001 and 2011. The estimated overall growth rate declined from approximately 1.33% between 2001-2002 to 1.1% for 2010-2011, confirming Thurlow et al's prediction above.

**Table 3: Estimated annual population growth rates, 2001-2011**

Period	Male	Female	Total
2001-2002	1.42	1.25	1.33
2002-2003	1.40	1.22	1.30
2003-2004	1.37	1.19	1.28
2004-2005	1.35	1.17	1.25
2005-2006	1.32	1.14	1.23
2006-2007	1.30	1.11	1.20
2007-2008	1.27	1.09	1.18
2009-2010	1.22	1.03	1.12
2010-2011	1.20	1.0	1.10

**Source: Statistics South Africa (2011)**

#### **2.4 Workforce projections**

Matthews et al (2008) developed an AIDS Projection Model to estimate the size of the number of employees in the presence and absence of HIV and AIDS. The model distinguished among three occupation levels (managers, skilled workers, and labourers), gender, two racial groups (African and Other), and three age cohorts (20-34, 35-49 and 50-64). The AIDS Projection Model combined the population projections of the ASSA model with HIV test data from the firm-level survey, and used this information to predict the impact of HIV and AIDS on the employee size for different occupational groups. It provided the critical link between the population projections described above and the economic impact. Prevalence was significantly higher for the middle age cohort, which is consistent with observed national trends. These survey results clearly indicate that it is inappropriate to make broad generalizations about the sectoral and occupational trends of HIV prevalence. Therefore, the calibrated AIDS Projection Model that produces occupation-based workforce projections greatly provided a crucial link between the economic growth impacts of HIV and AIDS and its effects on young women.

## 2.5 Young women's labour market share

Statistics South Africa (2012) mentioned that women between 25 and 50 years of age showed rather high labour participation, with rates over 60%, though consistently lower than the male labour participation rates, which were all over 80% for these age groups. The rates were highest for those aged 35-39, both for women (69.0%) and for men (87.6%). For the 15-19 year-olds, the labour participation rates remained quite low at 7.7% for girls of that age and 11.5% for boys, while in the 20-24 age cohort about half of all was economically active at 47.1% of the young women of that age, against 56.1% of the young men. With 63.8% for the females and 81.2% for the males, the labour participation rates for the 25-29 year-olds are considerably higher. Though information on labour market streams is lacking, these figures show that the South African economy is now creating jobs for young women who are the main participants in this study.

Table 5 below shows that more women than men are now in employment.

**Table 4: Labour force participation rates, 2012**

POPULATION OF WORKING AGE (15-64 years)									
	Jan-Mar,2011	Apr-Jun,2011	Jul-Sep,2011	Oct-Dec,2011	Jan-Mar,2011	Qtr to Qtr change	Year on year change	Qtr to Qtr change	Year on year change
	Thousand	Thousand	Thousand	Thousand	Thousand	Thousand	Thousand	Percent	Percent
Both sexes	32314	32435	32555	32670	32786	116	472	0.4	1.5
Women	16 642	16695	16747	16797	16847	50	205	0.3	1.2
Men	15672	15740	15808	15873	15939	66	267	0.4	1.7

**Source: Statistics South Africa (2012)**

## 2.6 Education levels of the female labour force

Literacy does not seem to be a serious hitch for South African women and girls. The adult literacy rate in 1999-2006 was, according to UNDP (2008), nearly 88%; by far the highest in sub-Saharan Africa. Nevertheless, this rate still implies that about 4.2 million adult South Africans are not functionally literate, meaning that they can neither read nor write. Different to elsewhere in the region, the gender gap is small or non-existent in literacy. In 1999-2006 the overall male literacy rate was 88.5%, against 86.7% overall for women (UNDP, 2008). However, women aged 15-24 years fared even better than

their male counterparts in terms of literacy. In 2007, the literacy rate for 15-24 year-olds was overall 95.4%; 94.6% for men and 96.3% for women, so with nearly 102% women to men parity (UNDP, 2008).

## **2.7 Female skill levels**

Skill levels in the South African labour market have been remarkably upgraded. This is especially true for women. In 1995, less than 21% of the labour force had at least completed secondary education (Dias, Matos and Gonsalves, 2006), whereas in April-June 2009 this proportion was 45%, in formal employment 59% and in informal employment 21% (SSA, 2009). These figures show that South African employed women are closing the educational gap with men, and even going beyond that. In 2009, 50% of the young women employed had completed secondary or tertiary education, the equivalent male share was fixed at 45.5%. The gap in education between the working and the jobless in South Africa is not that wide, though the assertion of Dias et al (2006) for 2003, that there was hardly any gap in education left, seems to some extent overstated. Undeniably, in the South African labour market completion of tertiary education enlarges job opportunities and diminishes the risks of unemployment greatly. Therefore, young women's employment in SMEs has increased. Table 6 below supports the assertion that a sound education diminishes the risk of unemployment.

**Table 5: Unemployment by level of education**

	1995%	2005%
Male none	23.1	26.5
Female none	47.8	41.4
Total none	34.7	34.5
Male incomplete GET	28.7	35.2
Female incomplete GET	46.1	50.3
Total incomplete GET	35.8	49.0
Male complete GET	27.1	39.4
Female complete GET	46.6	45.8
Total complete GET	35.8	49.0
Male matric	21	30
Female matric	34.6	45.8
Total matric	27	38.7
Male diploma/certificate with matric	6.5	9.7
Female diploma/certificate with matric	9.3	16.5
Total diploma/certificate with matric	7.9	13.2
Male degree	3.3	4.4
Female degree	5.0	4.4
Total degree	3.9	4.4

**Source: South African Department of Labour (2012)**

## 2.8 Wages of young women

A range of arithmetical problems frustrates tracing wages and wage inequality in South Africa over time. Observations on trends in the gender compensation gap vary. The World Economic Forum (2012) found that between 2010 and 2011, gender inequality persisted and the difference between male and female wages even grew, with women now earning less by 34% compared to 33% in 2010. Earlier on (SSA, 2008) estimated that the gap between earnings of men and women averaged 33.5 %. For 2012, the average gender pay-gap in South Africa was still at 33.5%, an outcome fitting in with the aforementioned results (World Economic Forum, 2012). The Wage Indicator data for South Africa shows larger gender pay gaps confirming that men earn considerably more than women do.

**Table 6: Real mean and median monthly earnings, 2001-2005**

Male		Female		% Change 2001-2005	
Mean (Std deviation)					
Median	Median	Median	Median	Median	Median
3 025 (6245)	3 125 (4830)	1997 (3232)	2339 (22689)	3	17
1640	1563	899	938	-5	4

**Source: South African Department of Labour (2012)**

The earnings figures presented in the table above clearly show that women continue to earn less than their male counterparts do.

## **2.9 HIV and AIDS and economic growth**

There is a universal agreement that the epidemic causes harm to economic growth. HIV and AIDS do not only affect the economy negatively but also endanger economic progress (UNAIDS, 2011). Thurlow et al (2009) showed that there is reliable information about the rate in which the epidemic is growing but insufficient information on the responses of SMEs and on the rate at which the epidemic is destroying the economy and development potential of the country. Chazan (2007) argues that HIV and AIDS is a serious challenge to the economy. He argues that the South African health care system is put under strain by the impact of HIV and AIDS. In turn, health care puts a strain on the South African economy.

Whilst the South African workplace has its share of the impact of HIV and AIDS, Statistics South Africa (2012) found that infections are increasing in SMEs. Thurlow et al (2009) argued that the impact of HIV and AIDS in SMEs is reflected through loss of production and leads to financial strain. Most SMEs are disrupted by the consequences of HIV and AIDS. Once an employee is absent or too sick to perform duties, the production cycle is disrupted. The only viable option to the SME is to recruit another employee to perform the same duty. For the most part, organizations lose the skills that were possessed by the sick employee and need to recruit new or temporary staff members in order to keep the companies functioning. More money is then spent on recruiting and training the newly hired employees. Moreover, HIV and AIDS affect SME budgets. Some SMEs do not have an efficient system for coping with expected absences of staff, like sick leave, let alone unexpected staff shortages (Holden, 2003). A large proportion of the SMEs' budget is spent on medical benefits. In the context of HIV and AIDS, employers would have to provide employees with early pensions, death cover, funeral cover and disability insurance.

Thurlow et al (2009) conducted two simulations to approximate the impact of HIV and AIDS during the period 2002-2025. The results indicated that HIV and AIDS lowers KwaZulu-Natal's annual GDP growth rate by 1.6% per year (Thurlow et al, 2009). This reduction in annual growth rates means that KwaZulu-Natal and South Africa's

economies are projected to be 43% and 37% smaller, respectively, in 2025 than they would have been in the absence of HIV and AIDS.

### **2.10 HIV and AIDS attrition in SMEs**

Hawarden (2007) mentioned that attrition due to AIDS differed according to skill level, with unqualified workers much more likely to leave the workforce due to AIDS than skilled workers or managers. Connelly and Rosen (2005) added that attrition also varied by industry and location. In the results of their study, they reported that SMEs involved in agriculture and construction in KZN reported losing the highest percentage of employees to AIDS in the two years prior to the study. Studies on SMEs in Gauteng, in contrast, reported having had no HIV and AIDS incidences in that period, showing the high levels of HIV and AIDS infections in KwaZulu-Natal (Centre for health policy, 2006; Connelly and Rosen, 2005). Connelly and Rosen (2005) also investigated how many SMEs had experienced the death of a worker due to AIDS and whether the employees lost were critical to the operations of the company. Managers in 52% of the companies believed they had recorded at least one employee death due to AIDS in a two-year period. Few of these workers were regarded as skilled workers. Of the deaths and other terminations attributed by participants to HIV and AIDS, 69% were among unskilled workers. Firms that reported losing any workers to AIDS were slightly more likely to offer HIV and AIDS services than firms not reporting such losses. Companies losing critical workers were more likely to consider HIV and AIDS among their top five business concerns. Although 52% of companies believed they had lost employees to AIDS in the last two years, only 38% believed that they have HIV-positive employees in their workforce now. Nevertheless, companies that believed they have workers living with HIV were much more likely to provide HIV and AIDS services than other companies. Nearly half (48%) of respondents from firms not now providing HIV and AIDS services stated that they would be motivated to offer such services only if they knew that any of their employees had HIV and AIDS or if more of their employees had HIV and AIDS (Connelly and Rosen, 2005).

## 2.11 Costs of HIV and AIDS to SMEs

On the SME level, HIV and AIDS pose a serious threat to profitability as well as to competitiveness (Hawarden, 2007). Additional costs to the company occur through absenteeism from work due to care giving needs in the family or funeral attendances. Further, there is loss of labour and productivity due to associated illness, emotional and work stress, lower morale of infected and affected workers, increased costs of medical schemes of employees and pension benefits, and loss of skilled labour leading to disruption of production. Lower company performance, increase in market wages for people with scarce skills, increase in training, recruitment, and personnel turnover costs may add to SMEs' HIV and AIDS concerns (Connelly and Rosen, 2005). Previous research in South Africa indicates that HIV and AIDS impose a wide range of costs on large employers that SMEs might also bear (Faulk and Usunier, 2009).

**Table 7: Costs of HIV and AIDS to business**

<b>One employee with HIV and AIDS (individual costs)</b>	<b>HIV and AIDS (organizational costs)</b>
<ul style="list-style-type: none"> <li>• Benefits payments</li> <li>• Medical care</li> <li>• Recruitment of a replacement worker</li> <li>• Training of a replacement worker</li> <li>• Increased leave and absenteeism</li> <li>• Reduced on-the-job productivity</li> <li>• Supervisor's time</li> <li>• Vacancy until replacement is hired</li> <li>• Poorer performance due to replacement's inexperience</li> </ul>	<ul style="list-style-type: none"> <li>• Benefits premiums</li> <li>• Accidents due to sick or inexperienced employees</li> <li>• Litigation over benefits, dismissals, etc.</li> <li>• Production disruptions or service failures due to missing skills, accidents, vacant positions, etc.</li> <li>• Loss of institutional memory and experience</li> <li>• Breakdown of workforce morale and cohesion</li> <li>• Diversion of senior managers' time</li> <li>• Deteriorating labour relations</li> </ul>

**Source: Connelly and Rosen (2005)**

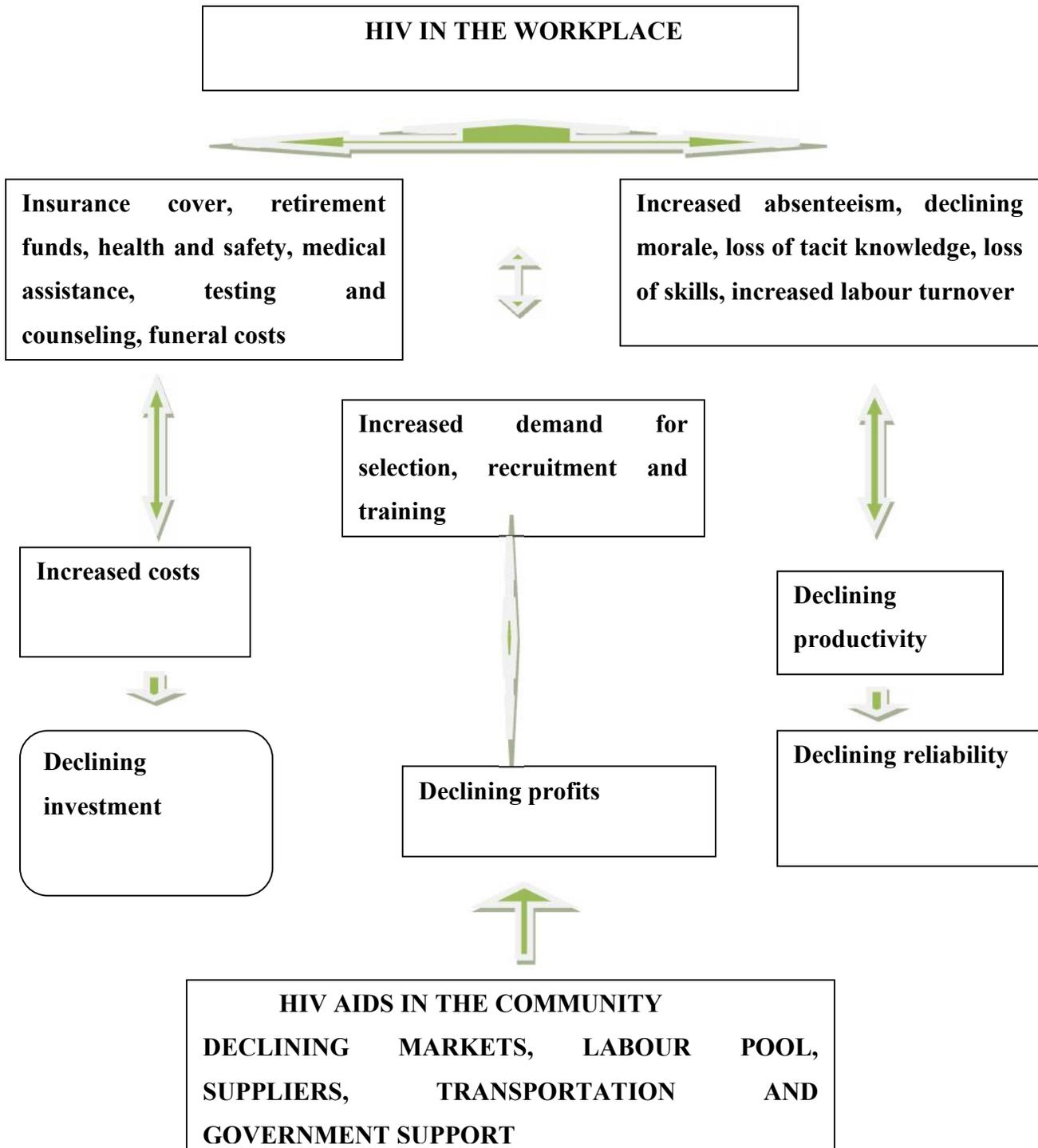
From an employer's perspective, HIV can have an indirect impact on lower labour productivity, increased absenteeism and higher labour turnover related to the pandemic, according to a survey by SABCOHA (2005). Direct costs include increased benefit payments, insurance premiums, and recruitment and training costs. Antiretroviral treatment costs less than the absenteeism, loss of productivity and disability costs that are incurred as an employee becomes ill when treatment for HIV and AIDS is not available (Faulk and Usunier, 2009).

## **2.12 Cost impact model**

The UNAIDS cost impact model reinforced the potential impact of HIV and AIDS on the workplace. According to the UN Model overleaf, the load of HIV and AIDS will affect productivity, profitability and service delivery. HIV and AIDS will affect workplaces through increases in absenteeism, accident rates, deaths, early retirement, disability retirements, industrial disputes and emigration. There will also be increased costs related to increased employee benefits in the form of group life insurance, pensions, funeral benefits and medical aid increases. Employees dying or retiring early will need to be replaced, with increased education and training costs. More trainees might need to be employed and more employees might need to be employed to cover for absenteeism.

Some of the factors that will influence the impact are the number of people affected, the term to death, the rate of the spread of the disease, the highest levels it reaches, the income and skills levels and available support systems (Barnett & Whiteside, 2005). According to Whiteside & Sunter (2000), the impact on the economy will depend on who dies. If the majority of deaths occur amongst the unskilled and the collective individual savings pool is not reduced, in economic terms the survivors could be better off.

**Figure 1 UNAIDS cost impact model**



Source: UNAIDS (2010)

There might be greater competition for skilled workers, so remuneration costs may rise. This could increase the wage differential. There might be increased costs to company clinics and greater support may be required to the community. There could be an impact on employment equity programmes and an increase in the number of foreign employees recruited. Additional costs may also come in the form of taxation as government spending on health and welfare increases (Chazan, 2007). Additional costs will also be incurred to run HIV and AIDS programmes. There will be declining employee morale, loss of experience (tacit knowledge), loss of skills, loss of workplace cohesion, and loss of management time. Competitiveness will be compromised as production targets are not met, delivery times become erratic, quality is unstable, the cost of production increases and selling prices increase in order to attempt to maintain profitability.

Trade unions could mobilize around HIV and AIDS and HIV and AIDS-linked tensions could lead to a strain in labour relations. Companies will find it increasingly difficult to access either foreign capital or internal capital as domestic savings decline and the cost of capital increases. Households will be adversely affected as money is diverted to medical and care expenses (Chazan, 2007).

IFC against AIDS and SABCOHA (2011) state that there will be a reduction in savings and reduced disposable income as expenditure shifts to health and funeral-related expenses. The business environment could be affected as government departments become less efficient, infrastructure deteriorates and government spending is diverted. It is possible that the crime rate will increase as policing becomes less effective (Whiteside & Sunter, 2000). Social systems are likely to be stressed, with a reduction in social capital, increases in discrimination, and disruption in the social relations of production. The business environment will deteriorate.

IFC against AIDS and SABCOHA (2011) in their campaign against HIV in SMEs summarized several aspects that are relevant to SMEs:

**Table 8: Summary of HIV issues**

<p>The large majority of HIV-positive South Africans are in the most productive stage of their lives; basically the country's workforce.</p> <p>Urban areas have higher rates of HIV infection, but rural areas also suffer due to lack of resources, awareness and access to public health facilities.</p> <p>Companies that employ mostly semi-skilled and unskilled workers have been hardest hit by the epidemic.</p> <p>HIV and AIDS indirectly affect businesses by increasing poverty and therefore lessening the demand for goods and services.</p> <p>The loss of a key employee can be disastrous to a small company.</p> <p>The loss of employees has recruitment and training costs associated with it, not to mention the potential downtime.</p> <p>Increased sick leave days or absenteeism of workers taking care of sick relatives or to attend funerals negatively impacts productivity and profits.</p> <p>Employee morale (and therefore productivity and efficiency) is generally lower in companies where workers are ill or dying.</p> <p>Most smaller companies do not have workplace HIV and AIDS programmes, so there is no awareness around preventing HIV and staying healthy if HIV-positive.</p> <p>If companies invest in prevention and treatment programmes, the savings outweigh the costs.</p>
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**Source: IFC against AIDS and SABCOHA (2011)**

### **2.13 Why SMEs should respond to HIV and AIDS**

IFC against AIDS and SABCOHA (2011) reported that several of South Africa's larger firms such as Anglo American, Daimler Chrysler and BMW had invested financially in private HIV workplace programmes. Economic and financial benefits of HIV workplace programmes have been well researched and accepted by large firms in South Africa as substantial enough to invest in.

One should not underestimate the significance of SMEs' engagement on HIV and AIDS. The mere fact that employers have access to employees, i.e. an adult population, every day, is their strongest comparative advantage in the fight against HIV and AIDS, along the other long-established actors such as NGOs, local or international health authorities. In Africa, seventy percent of employed people work in the SME sector (IFC against AIDS and SABCOHA, 2011).

The ILO (2007) outlined the following opportunities for SMEs in combating the HIV and AIDS epidemic:

- SMEs are communities - places where people congregate, discuss and learn from each other.
- SMEs partly cover communities, including the families of workers and adjoining neighbourhood, local schools, faith-based organisations, associations and action groups. This provides opportunities for HIV and AIDS programmes to have a wider impact.
- Workers make up a distinct audience for specified behaviour change programmes.
- SMEs have many networks, structures and institutions, which can provide entry points for prevention and care. They include human resource development training programmes, health and safety structures, and standard setting mechanisms for working conditions, labour relations and the protection of workers rights.

## **2.14 Why SMEs are responding or failing to respond**

Understanding why companies respond in particular ways empowers stakeholders within and beyond the company. It enables us to move from being frustrated when achievements fall short of our ideals to becoming agents who understand what is possible and can help to achieve those possibilities (Dickinson, 2004). However, looking at the sector of SMEs it has to be noted that so far SMEs have not sufficiently shown a better understanding of the businesses role and responsibility to prevent HIV and AIDS and to mitigate the impact of the disease (Hawarden, 2007). A lack of leadership and funds corresponds with a lack of action. Surveys have shown that SMEs are not prepared to dedicate limited time for HIV mitigation activities unless they start to see tangible effects of the pandemic on their business. Most mitigation activities tend to be once-off, informal attempts at education or awareness training. Few firms are implementing comprehensive activities starting with education and awareness building, leading to peer counselling or voluntary counselling and testing.

The Bureau for Economic Research (2004) found that among companies with fewer than 100 employees, 13 per cent had an HIV and AIDS policy and 29 per cent had offered an HIV and AIDS awareness programme, compared with 92 per cent and 94 per cent, respectively, for companies with more than 500 employees (Ellis and Terwin, 2003). It was noted that there is a striking difference between large and small companies. Surveys like that conducted by the Bureau for Economic Research in 2004 can gauge how businesses are responding to the HIV and AIDS epidemic, but they do not reveal what motivates some companies to take action against AIDS while others do not. Given the low level of activity among SMEs, understanding the opportunities and constraints SMEs face in responding to the epidemic is essential to any effort to strengthen the private sector's role in the fight against AIDS.

SMEs face a number of structural constraints to implementing workplace programmes, including a lack of designated human resource personnel and minimal employee benefits (Bureau for Economic Research, 2006). To what extent these constraints have suppressed demand for HIV and AIDS services is not known. SME owners and

managers' knowledge, experience, and attitudes may also affect their willingness to purchase services. Many managers are unconvinced of the effectiveness of HIV and AIDS programmes and question whether an employer should be involved in providing health-related services at all (SABCOHA, 2005). Without relevant information about the potential costs of HIV and AIDS, smaller businesses lack an imperative to invest scarce resources in mitigating the impact of HIV and AIDS. They are also largely unaware of what services are available and how to access them. SABCOHA (2005) aimed to identify and evaluate constraints on SME demand for HIV and AIDS services, to determine the extent to which SMEs can be expected to implement HIV and AIDS programmes, and to identify opportunities for strengthening the role of SMEs in South Africa's fight against AIDS.

HIV and AIDS do appear to be having a negative impact on many SMEs, increasing both direct and indirect costs. Many firms are responding, or trying to respond, but it is difficult for a small business to develop and implement an effective programme (The Lancet, 2005). Another survey, in 2007, found a similar low level of response by smaller businesses (Centre for Health Policy, 2007). The Bureau for economic research (2004) study cited above demonstrated stark differences in HIV and AIDS policies and programmes between large and small businesses. While these surveys consistently documented a lack of HIV and AIDS-related activity on the part of SMEs, none of them was designed to identify or explain the reasons why SMEs fail to act. Understanding the decisions made by SMEs is important because of the significance of smaller businesses to South Africa's economy. SMEs are estimated to have generated 27 per cent of employment and 30 per cent of GDP in South Africa in 2002 (SSA, 2002). These estimates are likely to be conservative. A report by the National Treasury described the contribution of SMEs to GDP and employment to be as high as that of large enterprises and noted that SMEs are particularly important because of the negative growth in job creation by large enterprises and the government sector (SABCOHA, 2011).

## **2.15 Intervention strategies that work for young women**

The literature review has found a number of interventions that work in relation to all aspects of HIV as it affects women, or may be promising. Open Society Institute (2010) documented practices for which there is evidence of success. The study noted that female condoms could reduce HIV transmission by 95%, like the male condom. Partner reduction, particularly concurrent relationships, can be effective in reducing transmission of HIV. The Open Society Institute (2010) detailed STI counselling, diagnosis and treatment as important access points for women at high risk of HIV, particularly in the early stages of the epidemic. Voluntary counselling and testing can help young women know their HIV infection status and increase their protective behaviours, particularly amongst those who test HIV positive.

Young people aged between 15 and 24 years account for an estimated 45% of new HIV infections with young women facing particular risks due to gender norms that value sexual ignorance and limited power in sexual relations (Open Society Institute, 2010). Providing young women with information and service, as well as addressing issues such as gender norms, can reduce the risk of HIV acquisition. Addressing structural factors and the enabling environment, such as gender norms, violence against women, legal norms, woman's employment, income and livelihood, advancing education, reducing stigma and discrimination, and promoting woman's leadership, are critical to effective HIV and AIDS interventions for young women (Open Society Institute, 2010). Encouraging behaviour change through sex and HIV education, mass media and social marketing campaigns and improved communication between adults and young women can increase protective behaviours. Increasing clinic services that are young women friendly, conveniently located, affordable, confidential and non-judgemental can increase use of clinic reproductive health services including VCT.

Antiretroviral treatment (ARVs) is not a cure for HIV but does increase life expectancy (Open Society Institute, 2010). ARVs have been provided to both men and women in resource poor settings with good adherence, good patient retention and good clinical outcomes similar to those in resource rich settings. Studies conducted on ARV

treatment do not include sex-disaggregated data although many of the findings are clearly relevant to women as well as men. Therefore, specifying what works for young women in terms of treatment access and overcoming barriers to adherence is a continuing challenge. HIV prevention in addition to treatment remains a challenge. Given that most HIV transmission occurs through sexual intercourse, it is important to include a sexual and reproductive health (SRH) lens in HIV programming. Promoting contraceptive use and family planning counselling as part of the routine HIV services can increase condom use, contraceptive use, and dual method use, thus averting unwanted pregnancies among young women living with HIV and AIDS.

Prevention efforts for young women have been successful in several countries. Male and female condoms, partner reduction, male circumcision and treating STIs are all important components of prevention efforts. Prevention efforts are also strengthened by addressing factors such as gender norms, violence against women, income and education. Vaccines and micro biocides are being developed and may soon be available for use by young women.

The manner in which health services are structured has an impact on HIV prevention, treatment and care for young women. Young women often need multiple services, including reproductive health and family planning services in addition to HIV prevention, treatment and care.

The Open Society Institute (2010) noted that what works for young women in structuring health services include:

- Integrating HIV testing and services with family planning, maternal health care or within primary care facilities can increase uptake of HIV testing and other reproductive health services.
- Promoting contraceptives and family planning as part of routine HIV services can increase condom use, contraceptive use, and dual method use, thus averting unwanted pregnancies amongst HIV positive women.

- Providing VCT services together with other health services can increase the number of people accessing VCT.
- Scaling up PMTCT programmes increases the number of women who know their sero status and improves HIV knowledge.
- Training providers can reduce discrimination against people living with HIV and AIDS.
- Providing clinic services that are user friendly, conveniently located, affordable, confidential and non-judgemental can increase the use of clinic health services.

The literature review demonstrated that while there is significant evidence of what works, there are still many gaps relating to young women working in SMEs for which no evaluated interventions were found. In addition, many studies do not include sex-disaggregated data to begin the process to address the specific needs of young women. Evidence based interventions that have been shown to work must be scaled up with clear understanding of SME and gender contexts.

## **2.16 Theoretical framework**

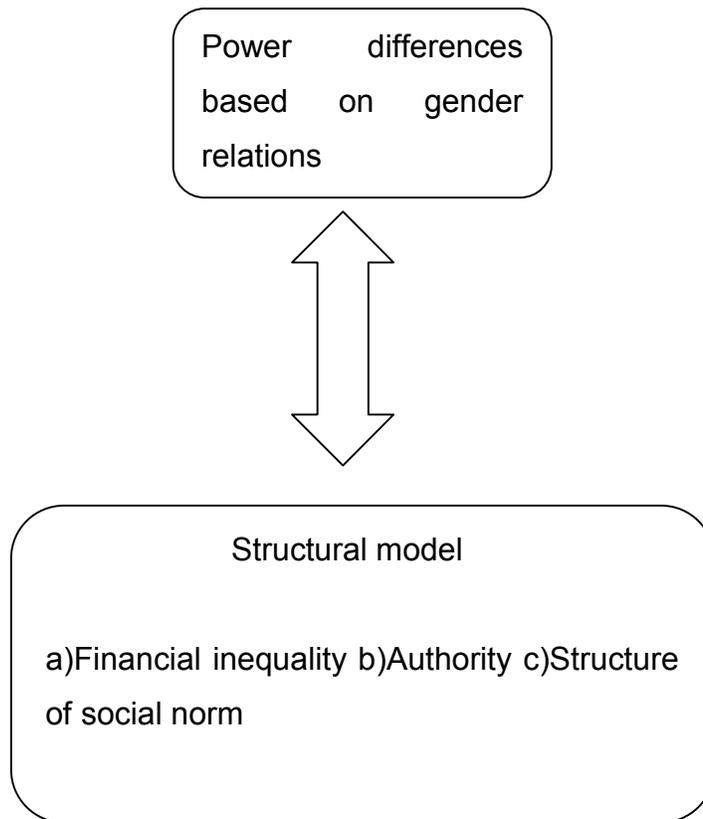
Workplaces may copy or duplicate the same social realities that are present outside the world of work. One's sex refers to physically acknowledged differences among men and women, including chromosomes, inner and outer sex organs, hormonal structure and secondary sex characteristics, such as breasts (Sprague, 2008). Gender, however, is a social construction. It includes the diverse behaviours, roles, expectations and responsibilities that women and men learn within the context of their culture or society. As a social category, gender (and the power relations associated with it) has the potential to confer upon men and women different societal, family, peer and even personal norms and expectations with regard to appropriate conduct. In this way, gender norms and ideals govern attitudes and behaviour and serve as an important mediating factor in sexual and reproductive experiences including HIV and AIDS issues. South African workplaces may not be gender-neutral. They may ignore sex-specific differences and realities surrounding health and HIV. They might simply replicate and reinforce some of the social norms. Nevertheless, if they mirror a society where gender

inequality is the norm, this would explain the level of SMEs attention to women and their health. Accordingly, the workplace would merely reflect existing social constructions of gender.

### **2.16.1 Gender and power theory and the major tenets**

The theory of gender and power will be applied in examining the social behavioural risk factors that increase women's vulnerability to acquiring HIV and AIDS. This is because employing the theory of gender and power among women brings new kinds of data, asks new and broader questions with regard to women and the risk to HIV and AIDS and most importantly creates new options for prevention (Connell, 1987; Diclemente and Wingood, 2000). This theory is important because it allows for an understanding of the complex interplay between gender and power beyond the individual perspective. A central emphasis of this theory is that the analysis of gender involves a three-part structural model involving sexual division of labour (e.g. financial inequality), sexual division of power (e.g. authority), and the structure of affective attachments (e.g. social norms). Furthermore, these structural models exist at different levels (e.g. family, societal and institutional) and are maintained by social mechanisms. Connell's theory of gender and power has been shown previously to explain the gender effects in the spread of HIV and AIDS infections. The diagram below shows the three part structural model from Connells' gender and power theory.

**Figure 2 Three part structural model**



**Source: Connell's theory of gender and power (1987)**

The three social structures are visible in society through segregation of power and ascribe social norms because of gender-determined roles. Men and women are assigned different duties as well as different entitlements. Tallis (2008) noted gender-based inequities and disparities in women's economic potential and women's control of resources, and that gender-based expectations of women's role in society are barriers to women realizing their full potential. These inequities and disparities all interact to increase women's vulnerability to diseases, including HIV. These major tenets of this theory are further discussed below.

### 2.16.1.1 The sexual division of labour

Male supremacy is achieved in what Connell calls hegemonic masculinity (Demetriou 2001). Hegemonic masculinity encapsulates the complex nature of femininities and masculinities and the power relationships between genders (Diclemente and Wingood, 2000). At societal level, labour is allocated differently to men and women (Diclemente and Wingood 2000). This division of labour results in women being allocated certain occupations that are less well paid, whereas men are allocated well-paid positions. Such organisation of women's work limits their economic potential and confines their career path (Diclemente and Wingood 2000). Moreover, women are allocated "unpaid nurturing work" such as childcare, domestic work or caring for the sick and the dying. This results in economic imbalances, making women economically vulnerable and dependent on men (Diclemente and Wingood 2000).

Additionally, Connell (1987) elaborates that "*hegemonic masculinity can be defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women*". Men's position in patriarchal societies gives them material advantages, such as higher incomes or easier access to education, something that Connell calls the "patriarchal dividend" (Demetriou 2001). This, in turn, gives rise to a range of economic vulnerabilities that underscore women's inability to challenge the *status quo* (Diclemente and Wingood 1998).

Sprague (2008) has found that in the context of poverty, women regard money as the driving force for relationship formation. For example, young schoolgirls have sexual relationships with older men for money so that they can buy food and clothing. It can be concluded that scarcity of resources might fuel risky behaviours that expose women to HIV infection. Furthermore, it should be kept in mind that poor women may be unable to afford prevention materials such as condoms, increasing their exposure to HIV infection. (Diclemente and Wingood, 2000; Abertyn, 2008).

### **2.16.1.2 The sexual division of power**

Power is defined as the ability to act or influence change in a desired way at the individual, interpersonal, institutional and community level (DiClemente and Wingood 2000). If one person has power over another it means that the “other” will be powerless. Wallerstein (1992) describes powerlessness as referring to alienation, victim-blaming, learned helplessness, internalised oppression or hidden injuries. The sexual division of power is maintained by the abuse of authority and control in relationships. According to DiClemente and Wingood (2000), the sexual division of power manifests as behavioural risks and inequities. Furthermore, DiClemente and Wingood (2000) argue that as the power between men and women increases in favour of men, women are more likely to experience adverse health outcomes.

### **2.16.1.3 The structure of cathexis**

DiClemente and Wingood (2000) refer to cathexis as the structure of affective attachments and social norms. The structure of cathexis prescribes sexual norms and defines how women should conduct themselves sexually. For example, a woman might be labelled as “immoral” if she had premarital sex. At the institutional level, women at risk of HIV infection include those who adhere strongly to conservative cultural norms and traditional beliefs. As such, they are less likely to negotiate safer sex with men. Sprague (2008) argues that women will wait for their male partners to suggest using a condom. Women who internalise such norms and beliefs often remain in relationships that are physically, psychologically and economically violent.

Biological and social factors continue to influence and shape determinants and patterns of the disease which are sex/gender specific (Sprague, 2008). The position of women in society provides social dynamics that increase their vulnerability to HIV and AIDS. Sprague (2008) included men’s dominance in sexual decisions amongst the range of accepted practices that aid women’s exposure to HIV. Shisana et al (2010) examined the relationships among sex, gender, age, HIV status, and socioeconomic characteristics, focusing on heads and non-heads of households. The research results recognized that the growing feminization of the HIV and AIDS epidemic reflects a

complex intersection of biological, socio-cultural, and economic factors. Shisana et al (2010) noted that there is a relationship between age, gender, poverty and HIV and AIDS in South Africa.

To improve the quality and efficiency of HIV management programmes, the importance of incorporating a gender dimension into workplace programmes and policies has been increasingly acknowledged. Feminization of HIV prevention in SMEs is appealing for several reasons. Firstly, the bulk of SME employees are young women. Secondly, in South Africa, the number of women with AIDS between 18 and 44 is 55%, more than any other group, making women the fastest growing sector of the population with AIDS. Globally, women account for 50% of the estimated 30.6 million adults infected with HIV. Thirdly, of the 15.4 million women living with HIV and AIDS globally, 77% live in Sub-Saharan Africa. Fourthly, because women infected with HIV are the major source of infection for infants, preventing the spread of HIV infection in women will reduce vertical transmission.

Two published reports have reviewed risk reduction interventions for women at risk of acquiring HIV. Armstrong (2007) studied mandatory testing for HIV in South Africa. The other study by Shisana et al (2010), focused on gender and poverty in South Africa in the era of HIV and AIDS. Both reviews suggest that the most successful HIV prevention programs for women (1) are guided by social psychological theories; (2) include only women; and (3) emphasize gender-related influences, such as gender based power imbalances, and sexual assertiveness. Both reviews suggest that future research needs to address conditions impeding women's ability to protect themselves against HIV.

### **2.16.2 Explaining young women's general vulnerabilities to HIV and AIDS using gender and power theory**

The aim of this section is to use a comprehensive version of the theory of gender and power to examine factors that increase young working women's vulnerabilities to HIV infections. This will help in better understanding the situation of young women for the purpose of developing strategies to help them.

Diclemente and Wingood (2000) hypothesized that social mechanisms produce gender-based inequities and disparities (for example, in women's economic potential, women's control of resources, and gender-based expectations of women's role in society). These inequities and disparities are noticeable in the public health, social and behavioural sciences and medical fields as exposures, risk factors, and biological properties. These exposures, risk factors, and biological properties all interact to increase women's vulnerability to diseases, including HIV.

Albertyn (2008) noted that it is these gender-based inequities and disparities in expectations that make the exposures, or acquired risks, and the risk factors that negatively influence women's health. He added that gender and power has direct relevance for understanding issues with regard to women's health. He articulated that exposures could be economic, physical, or social in nature. He also saw exposures as influencing the risk of disease among populations. Harrison, Xaba, Kunene, & Ntuli (2001) agree that vulnerability to HIV is driven by the overall conditions in which young women live in communities, including their workplaces.

According to UNGASS (2005), women's increased biological vulnerability is compounded by their subordinate social status. Limited access to economic opportunities denies women rights that prevent them from openly embracing ways to avoid infection with HIV. A woman is more likely to have sexual contact even though she does not want to because of her economic status. The study will seek to establish whether workplace interventions ameliorate young women's situation of subordination to

man. This may help in understanding the vulnerabilities to HIV infections of young working women in KwaZulu-Natal's SMEs.

UNGASS (2010) agrees that gender has a significant impact on the transmission of HIV. The organization added that the unequal social status of women is a disadvantage with respect to access to information about HIV and AIDS prevention, the ability to negotiate safe sexual encounters and access to treatment for AIDS once infected. If young women are employed, then when workplaces act as sources of HIV infection prevention information that information can become easily accessible to them. The research sought to establish whether SMEs increase chances of accessing HIV prevention information for young women through HIV programming.

Diclemente and Wingood (2000) cite living in poverty as an economic exposure. For UNGASS (2010) economically vulnerable women are less likely to terminate a potentially dangerous relationship, less likely to have access to information regarding HIV and AIDS, less likely to use condoms and more likely to resort to high-risk behaviours for either a source of income or to supplement their income. In economically desperate circumstances, women may exchange sex for money, food or other favours. Diclemente and Wingood (2000) demonstrated that having a lower income enhances women's exposure to HIV and AIDS. According to Ray and Madzimbamuto (2006), poverty makes people vulnerable to HIV infection, at the same time increasing the impact of HIV on communities. In this case it is demonstrated that the theory of gender and power can be used to explain young women's vulnerability to HIV infection.

Diclemente and Wingood (2000) agree with UNGASS (2005) that women's HIV risk behaviours should be considered in the context of other variables that shape vulnerabilities to HIV infection, such as other forms of inequality. According to Ray and Madzimbamuto (2006), inequalities that women and girls suffer because of HIV and AIDS serve as a barometer of their general status in society and the discrimination they encounter in all fields, including health, education and employment. He added that important variables that may further perpetuate inequalities include age, race, religion,

class, social and economic status and wealth, which interact with gender. Ray and Madzimbamuto (2006) cite that the main risk that young women face is their dependence on men for economic survival but also for the social status that comes with being 'a wife'. This reflects the broader HIV vulnerabilities that young women face due to societal expectations.

The sexual division of labour brings out how young women's vulnerability to HIV should be seen within the context of occupational sex segregation. For UNGASS (2005), some employed young women may still have to rely on their male partners economically because of gender disparity in earnings. Some women who are economically reliant on their husbands or other male partners have few alternatives but to engage in HIV risk behaviours enforced by those partners. This all increases vulnerability to HIV infection.

According to Ray and Madzimbamuto (2006), the influence of unequal gender relationships features throughout the story of HIV in southern African countries. He argues that sexual associations carry on as a buffer to socio-economic insecurity. Women often enter into sexual relationships to gain something or to escape from poverty. According to MacLachlan et al (2009), in a study conducted in Uganda, women who reported more missed meals had a higher prevalence of forced, coercive and survival sex.

Diclemente and Wingood (2000) concede that women without a roof over their head have high rates of many characteristics associated with HIV risk practices, including poverty and poor education. For Ray and Madzimbamuto (2006), women usually work in migratory and insecure employment. They are more likely to have poor and insecure housing tenure, especially if they are in informal affairs as girlfriends or mistresses of married men who pay their rent. Diclemente and Wingood (2000) accept that only after understanding the factors associated with homelessness among women can we ameliorate this situation and potentially increase young women's ability to practice safer sex.

According to Ray and Madzimbamuto (2006), women have a propensity to form relationships with men 5-10 years older than themselves who are potential marriage partners, whereas young men are inclined to have relationships with women of a similar age or slightly younger. If a husband make the first move for sex, his wife may not refuse him. This illustrates how safer sex practices may be influenced by imbalances of power in relationships. These imbalances of power in relationships are explained by the theory of gender and power in articulating young women's vulnerabilities to HIV infections.

Diclemente and Wingood (2000) agree that gender, or the social beliefs, customs and practices that define masculine and feminine attributes and behaviour, has an influence on the distribution of HIV infection. According to UNIFEM (2005), the rules governing sexual relationships differ for women and men, with men holding most of the decision-making power. This means that for many women, including those in marital unions, their male partners' sexual behaviour remains their most important risk factor for HIV infection. Diclemente and Wingood (2000) acknowledge that several studies have shown that women who adhere to traditional norms are more likely to engage in behaviours that increase their risk of HIV. In Southern Africa, there is a social acceptance that male partners define the timing for sex, giving young women little opportunity to discuss or practice safe sex. This all defines why the theory of gender and power is handy in explaining the young woman's vulnerabilities to HIV infections.

On the other hand, the impact of HIV and AIDS on young women is particularly acute. Whilst the theory of gender and power explains that young women are often economically, culturally and socially disadvantaged and will lack equal access to treatment, financial support and education, it has even been found that in a number of societies young women are mistakenly perceived as the main transmitters of sexually transmitted diseases. HIV positive women are treated very different from men in many developing countries: men are likely to be 'excused' for their behaviour that resulted in their infection, whereas women are not (HRSC, 2012).

## **2.17 Conclusion**

KwaZulu-Natal province has one of the highest HIV prevalence rates in the world. The literature review outlined the potential impact of HIV and AIDS on economic growth in KwaZulu-Natal and South Africa. The review indicated that HIV and AIDS undermine economic growth in South Africa. It lowers the GDP growth rate by 1.60 and 1.42 percentage points per year in KwaZulu-Natal and South Africa, respectively. Cumulatively, the losses mean that the KZN economy will be 43 percent smaller in 2025 than it would have been in the absence of HIV and AIDS. The literature review indicated that employing the theory of gender and power marshals new kinds of data, asks new and broader questions with regard to women's health, and creates new options for prevention and intervention. The review also noted that women's social risk for disease can be addressed through a variety of strategies, from education to policy. Interventions for women are destined to be less than optimally effective if they ignore the social environment.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

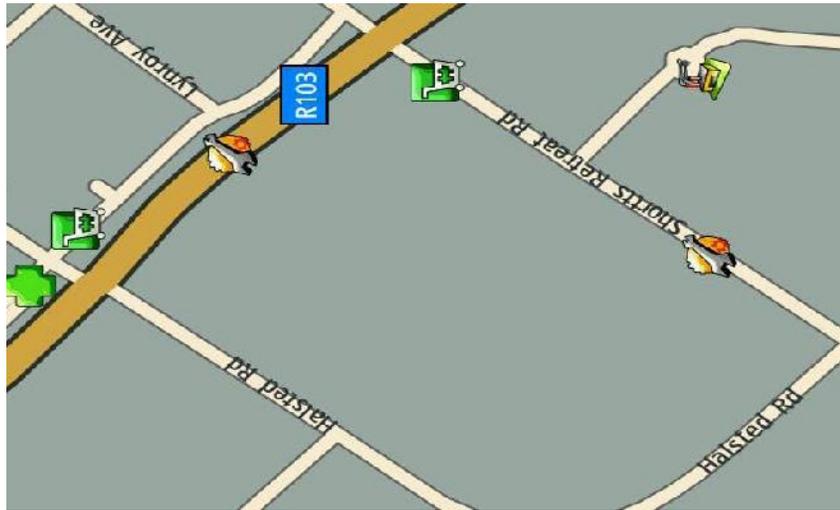
#### **3.1 Introduction**

In line with the focus of the research, this chapter discusses the research methods used in order to answer the research questions as detailed in Chapter 1. A brief description of the place where the research was carried out is included in this introduction. The next sections cover the research design, data collection method, sampling techniques and the demographics of the sample. The reflective role of the researcher, how the researcher guarded the auditability, credibility and appropriateness of the data, an explanation on how data were analysed and interpreted together with ethical considerations made, are all presented in this chapter. This chapter concludes with a discussion on the pilot study.

The study was conducted in Mkondeni, an area that has many social and economic disadvantages. The area is situated 10km to the south of the city of Pietermaritzburg. It houses most of the migrant population due to its proximity to an industrial area. The informal settlement where most of these young rural women in the study live has a high population density and is characterized by makeshift structures, some of which are self-made with boxes, polythene paper, iron sheets and mud. The homes are unhygienic, overcrowded, and lack privacy and security. Informal settlements experience inferior levels of health care and HIV prevention services to those received by the majority of urban populations. They also lack basic amenities including water, electricity, waste disposal and education facilities (UNAIDS, 2010).

In this area, there are no schools, clinics, roads, piped water or electricity. The nearest public clinic is 14 kilometres away. The SMEs are less than 300 metres away. The area provides labour to SMEs located in an industrial area of Pietermaritzburg in KwaZulu-Natal and the socio-economic circumstances explain the need for SMEs to respond to HIV and AIDS.

**Figure 3 Visual depiction of Mkondeni Area**



**Source: Samsung Wave II navigator (2010)**

### **3.2 The research design**

A qualitative phenomenological research design was chosen. For Leedy (2010), a phenomenological approach is a study that endeavours to understand peoples' perceptions, perspectives and understanding of a particular situation. The objective of phenomenological research is to describe a lived experience of a phenomenon. For Leedy (2010), the operational word in phenomenological research is 'describe'. The aim of the researcher is to describe as precisely as possible the phenomenon, abstaining from any pre-given framework, but remaining true to the facts. According to Welman, Kruger and Mitchel (2005), "the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved". A researcher applying phenomenology is concerned with the lived experiences of the people (Leedy, 2010). Phenomenological methods are able to bring out data on peoples' experiences, their feelings and emotions using flexible language (Leedy, 2010). Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and subjectivity, and emphasise the importance of personal perspective and interpretation.

Leedy (2010) states that researchers who use phenomenology are hesitant to set techniques. Phenomenological research designs do not adhere to rigid methodology as outlined in either the proposal or research method section, but allow for design flexibility. Makore-Rukuni (2001) agrees by stating that “there is an appropriate reluctance on the part of phenomenologists to focus too much on specific steps”. He goes on to say that, one cannot impose method on a phenomenon “since that would do a great injustice to the integrity of that phenomenon”. This means that within a study, methods and procedures were adapted to new experiences, with no set procedures as in quantitative designs where you preset your method before data collection (Makore-Rukuni, 2001). Patton (2002) states that too prescribed an approach when interviewing can be counter-productive and fails to acknowledge that qualitative interviewing is a descriptive process.

This study was about young womens’ experiences of HIV and AIDS programmes in SMEs. The researcher could ask questions about all the three domains - the affective, cognitive and behavioural. The researcher could probe, cajole and prod to enter the inner recesses of the individual. Following guidance from Leedy (2010) there were fewer restrictions on the data and the underlying theoretical models. Issues that cannot be quantified could be easily explored. It was easy to understand qualitative data, without the sweat from statistical analysis. The data collection was also not bound by a pre-existing hypothesis. There was also flexible sampling guided by the participants’ willingness to participate.

Now that phenomenology and the epistemology of the research has been explored, the following section outlines how the research unfolded. It starts with a synopsis of the data gathering method, then a description of the sampling techniques, followed by an explanation of data analysis and interpretation (comprising of several stages).

### **3.2.1 Data collection method**

In-depth interviews are an accepted data collection method for phenomenological studies as advocated by Leedy (2010). The advantages of interviews in phenomenological studies enables the researcher to do studies in depth and in detail. For Babbie and Mouton (2001), in-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation.

As the research problem seeks to understand the experiences and / or the perceptions of young women on the responses of SMEs to HIV and AIDS, in-depth interviews were held with these young women and managers. The benefit of this type of interview was that misunderstandings about either the questions or the responses were cleared up immediately (Patton, 2002). The participants had more freedom in responding in the interviews. Welman, Kruger and Mitchel (2005) advise that in-depth interviews be used when the topic is of a sensitive nature. Moreover, there maybe instances where additional information may be imparted for which there is not a specific question in the interview. This helped to show how these sets of voices and experiences worked together in creating the larger story emerging from the findings, thus optimizing the research outcome.

Interview guides were designed according to Welman, Kruger and Mitchel (2005) who recommend in-depth interviewing if the information to be probed relates to opinions and attitudes. Two different interview guides were developed to collect the data from the sample of young women and management. A sound criterion was considered in the development of the interview guides and the most important consideration was the applicability of questions to the participants. The interview guide for management was used to get a deeper understanding from management of their SME workplace programmes and policy on HIV and AIDS, especially on issues that young women are less knowledgeable about. The interview guide for young women was used to understand young women's experiences of the response of SMEs to HIV and AIDS. In

both interview guides, the questions were structured as open questions. In open-ended questions, respondents had to formulate the answers for themselves.

The interviewing process was conducted through one to one interviews with management or young women of the selected SMEs; the duration of interviews ranging from 60 and 70 minutes. Leedy (2010) advises that interviews for a phenomenological qualitative design should last between 60 and 120 minutes and the implementation is in the hands of the researcher as is in the hands of the participant. Welman, Kruger and Mitchel (2005) advise that interviews may be used when the topic is of a sensitive nature as is the case with HIV and AIDS.

### **3.2.2 Sampling techniques**

Purposive sampling is the selection of participants based on the researcher's knowledge of the population, its elements and the nature of the research aims (Babbie and Mouton, 2001). The researcher used purposive sampling in selecting participants for in-depth interviews. It normally targets a particular group of people. They are purposively selected because they meet a certain characteristic. Purposive sampling is very useful for situations where you need to reach a targeted sample quickly and where sampling for proportionality is not the main concern like in this research.

After getting permission from gatekeepers, the researcher spoke to various young women asking them if they were willing to participate in the study and their availability. At the same time, the researcher was looking for and speaking only to those people who met certain characteristics. In this case, the researcher was interested in the experiences of young women aged between 20 and 30 years old who work in SMEs. Purposive sampling technique is a type of non-probability sampling where the researcher consciously selects particular elements or subjects for addition in a study so as to make sure that the elements will have certain characteristics pertinent to the study (Babbie and Mouton, 2001). So the researcher was looking for and would seek interviews from only young women who looked like they possessed the needed characteristics. For management, the same procedure was adopted. One of the first things the researcher

did in this situation was verify that the respondent did in fact meet the characteristics or criteria for being included in the sample. If the interviewee did, the researcher then proceeded to make an appointment. If the interviewees did not meet the criteria, the researcher would leave him/her.

The following categories/levels were purposefully selected and included as respondents:

- at least two managers from each of the three SMEs.
- at least four young women from each of the three SMEs.

Inclusion criteria included:

- a willingness to participate in the study.

The criterion for the selection of SMEs was that the company had to:

- Employ 20 to 300 people in order to be classified as an SME.
- Be located in Mkondeni Pietermaritzburg within a radius of 10km of Polly Shorts Shopping Centre.

Below is the map of the area under discussion.



Figure 4 Map of Mkhondeni Industrial Area

Source: Samsung Wave 11 Navigator (2010)

The researcher personally visited the premises of the SMEs and sought audience with either young women or managers. Where an interviewee agreed to participate, either an appointment was then arranged, after hours or when interviewees were not busy. Interviewees, (6) managers and fifteen (15) young women, were directly visited and all appeals for interviews were successful. However, in almost all the cases the researcher had to exercise patience and persuasion due to the sensitivity of the study at hand.

### **3.2.3 Data analysis and interpretation**

The first principle of analysis of phenomenological data is to use an emergent strategy to allow the method of analysis to follow the nature of the data itself. The central task during data analysis is to identify common themes in descriptions and experiences (Leedy, 2010). For Leedy (2010) after transcribing the interviews, the researcher identifies statements that relates to the topic, group statements into units, seek divergent perspectives and then goes to construct a composite. The researcher followed a similar approach. Inductive analysis was used. By using inductive analysis, the researcher drew everything from the data.

The researcher audio-recorded all interviews using a cell-phone recorder. The data collected was linguistically based describing the participants' experiences in detail verbally. For Welman, Kruger and Mitchel (2005) data analysis entails converting notes into write offs. The audio records were transcribed through various replays by the researcher. Data from the audio records was analysed using qualitative techniques. The first analytical step, before coding, involved a close reading of the transcripts by the researcher. This close reading gives the researcher an initial sense of issues arising from the data (Dewet and Zimitri, 2005). For example, at this early stage it was already apparent that SMEs do not have HIV and AIDS policies. Reading the transcripts gave the researcher an opportunity to interact, in a relatively 'unmediated' way, with the data as a whole. It helped the researcher understand fragments of data in context, a practice central to qualitative data analysis. It gave the researcher an opportunity to listen to respondents' voices rather than simply hearing 'chords' as Dewet and Zimitri (2005) put it. It gave the researcher a sense of the 'spirit of the text' before imposing codes on it.

Furthermore, it helped the researcher to remain on the alert for unexpected responses. De Wet and Zimitri (2005) recommend that transcripts be read 'for regularly occurring phrases, and with an eye to surprising or counter intuitive material'. In line with this recommendation, the researcher read transcripts more than once so as not to lose alternative narratives to what emerged as the predominant experiences of young women and managers on SMEs' HIV and AIDS responses.

Coding involves assigning unique labels to text passages that contain references to particular categories of information (De Wet and Zimitri, 2005). This process of selecting a bit of data and assigning it to a category entails data fragmentation and contributes to data reduction (De Wet and Zimitri, 2005). Codes bring together selected data and identify emerging themes. De Wet and Zimitri (2005) note that coding helps one organize, manage, interpret and retrieve meaningful segments of data. They argue coding is not simply mechanical. Codes are partly analytical as they link various segments of text to a particular concept. De Wet and Zimitri (2005) talk about first-level coding, a process of naming and classifying data that results in a working set of codes. At this level codes are descriptive, but De Wet and Zimitri (2005) suggest they can also be interpretive. Second-level coding involved identifying clusters and hierarchies of information and a deeper level of analysis during which the researcher identified patterns and relationships in the data. This second step helped the researcher to produce the findings. The researcher examined this thematic cluster for further information by making new, fine first-level codes, thus implementing data reduction procedures.

The researcher made reports on each fine first-level code and produced summaries of the findings. Summaries reduce data and convert it into an easily retrievable form (De Wet and Zimitri, 2005). These summaries included evidence in the form of quotations from the data and a weighting of such evidence based on the number of occurrences across interviews of a single fine code (in other words, how many respondents said the same thing), on patterns of repetition among respondents when talking about a topic, on unusual disclosures and on consistent silences. The latter applied to both young women

and management respondents. The researcher was encouraged to check and verify data repeatedly. Repeated checking and verification helped the researcher to work towards rigorous analysis and so optimized the research outcome.

### **3.3 Reflecting on the role of the researcher**

According to Malacrida (2007), traditional reflective reporting is very important in ensuring the emotional safety of researchers. Given the researchers' gender and being a working colleague to some of the participants with whom interviews were conducted, personal and emotionally overwhelming issues were of concern. Babbie and Mouton (2001) point out that reactivity can occur in such studies, since research participants react to the characteristics of the researcher.

However, the researcher endeavoured not to allow his gender to interfere with his role as a researcher. The researcher ensured that he remained an investigator not the helper or counsellor. The researcher ensured that referral systems were in place. In research, the emotional response from the researcher in collecting, analysing and interpreting data can also shape the research process. As a male, hearing, typing, reading and coding the stories of the participants made the researcher feel sad.

However, due to the researchers' experience in such a process and his training as a counsellor, he had listening, counselling and communication skills. This also reduced the emotional impact of the research, as the researcher knew what he was doing could make a difference.

Mauther and Doucet (2003) drive qualitative researchers to develop a practical and visible process of reflectivity. They are of the belief that in this process an understanding of self in relation to the research and an accounting for ones' research choices can be achieved. Thus before analysing other peoples accounts of their lives, it was appropriate for the researcher to reflect on his own accounts.

The researchers' aim was to ensure that what was being investigated was clearly described and that the descriptions were interpreted as clearly as possible. How the researcher related to participants was crucial. For example, the researchers' gender had influence on how much the researcher could elicit from the participants. The researchers' language also affected how he could gauge the local intercommunication, patterns or cultural nuances that might escape his attention. Before the researcher set out to conduct qualitative research, he needed to know himself. Reflexivity means that the researcher needed to be extremely sensitive as to how and when he asks questions by placing himself in the participants' shoes. The researchers' ability to interpret data was his strongest asset in the research.

### **3.4 Demographic profile**

All of the respondents had reached at least matric and none had university qualifications. There were no indications as to whether they passed or failed matric. The results agree with literature reviewed which indicated that literacy does not seem to be a serious hitch for South African women and girls (UNDP, 2008). Most young women had worked for over two years in SMEs. The number of employees in the SMEs averaged 187. The gender distribution revealed that there were more females than males in the studied SMEs. Priscilla, a supervisor working in one of the studied SMEs said:

*"I stay in Mkondeni. I am a shift supervisor. I work with a lot of people. The majority are females. About 20% are males. The majority are between 21 and 40 years of age. They stay here in Mkondeni Saka and close by locations. Most people who are working here are coming from far afield so they stay in Saka".*

All the SMEs studied were in manufacturing. Casual and part-time employees were used infrequently due to the South African labour law, which requires permanent contracts for anyone employed for more than 24 hours per month (Department of Labour, 2002). The majority of young women were permanent workers. More than half of the employees working in the studied SMEs were young women aged below 30 years.

### **3.5 Auditability, credibility and appropriateness**

In qualitative research designs, the concern is with auditability, credibility and appropriateness. The auditability of qualitative studies requires the researcher to record in detail how raw data was collected. Another researcher should be able to understand what is going on and even replicate or give the same interpretations of the data later. For Babbie and Mouton (2001), the qualitative researcher is the main instrument in qualitative research, as opposed to for example, the questionnaire in quantitative research. Patton (2002) claims that qualitative researchers involve themselves as much as possible in the research process. The researcher was involved in the research and actively participated in interviewing participants. Therefore, the researcher had a mandate to make sure issues of trustworthiness and authenticity were not violated through his own participation in the process.

Ensuring that the appropriate participants were selected guarded the authenticity of the data. The interviews were done in IsiZulu or English. In cases where a participant did not understand IsiZulu, the researcher used English. The researcher ensured that the translation, re-translation, and interpretation were credible. The researcher developed an insight into research participants' personal experiences through in-depth interviews. The researcher adopted a non-judgmental attitude by demonstrating openness, sensitivity, respect, awareness and responsiveness. The interviews were conducted with the participants at different sites ranging from the workplace, homes, roadsides and even restaurants depending on the interviewees' choice of venue.

### **3.6 Ethical considerations**

Any study involving human beings has to be conducted with ethical considerations about the fairness and justice of the research process and its results. Heppner, Kivligan and Wampold (1992) discuss the principle of justice, which assumes that people are equal before the law. It would be unfair for the researcher to conduct a research in which issues of gender and diversity are ignored. All possible strategies were implemented to prevent any possible violation of the rights of the participants. To ensure that the rights of participants were protected, fair and non-coercive recruiting of

participants that honoured their dignity was done. Most importantly, only willing interviewees were involved in this study.

There are specific issues related to research that take place in a work-place setting. Elford (2010) mentioned that HIV and AIDS researchers in workplaces should take reasonable steps to avoid causing emotional or psychological distress for participants. Workers need to consent to participate in HIV and AIDS research and the participation in the study should not impact negatively on the workers. For Granillo (2010), HIV and AIDS researchers in the workplace should claim or imply professional qualifications actually completed and they should only use instruments for which they are trained and competent. For Bradley and Hendricks (2009), HIV and AIDS researchers in the workplace should report results accurately, should not plagiarize, must give full credit to whom it is due and must recognize copyright laws.

According to Heppner et al (1992) harm can be embarrassment, anger, irritation, physical and emotional stress, loss of self-esteem, exacerbation of stress, delay of treatment, sleep deprivation, loss of respect from others, negative labelling, invasion of privacy, damage to personal dignity, loss of employment and civil or criminal liability. As Makore-Rukuni (2001) observe, *'the most basic guideline to social scientists is that participants should not be harmed by participating in research'*. This clearly states that the ethical principle of non-maleficence, which states that research should be for the promotion of human welfare, for the promotion of the worth, dignity, potential, uniqueness of each individual, and thus to the service of the society. The avowed mission of the researcher was to ensure that the participants benefit from their interaction with the researcher. Research was conducted with the aim of maximally benefitting the participants. This is the ethical principle of beneficence. What this means was that the researcher strived to benefit the participants by being responsible in how he selected the research design and conducted the research itself. The researcher tried not to falsify information, nor exaggerate the results to suit pre-conceived ideas. The researcher did not claim results that were not of the study itself.

Confidentiality has to do with ensuring that what is discussed or shared during the research process must not be disclosed to any third party without the formal consent of the participants. This study was conducted in a sensitive and confidential manner. Suitable and safe venues that suited the preference of participants were secured for in-depth interviews. Pseudonyms are used to protect the identity of the participants. The limitations of confidentiality were discussed. All data collected was locked up at the researcher's home during the period of the research. The researcher undertook not to unnecessarily hold collected data. Necessary steps to destroy records or documents containing such information were put in place (Bradley et al, 2009). The names of the companies where the participants work were withheld to protect the identity of the companies involved. Transmission of such data was done through secure means such as a password locked laptop computer.

Informed consent refers to the aspect of voluntarily agreeing to participate in a study or procedure after a brief overview of the study objectives, methods, risks and benefits has been fully explained. Normally participants are asked to sign a consent form before participating. In this study, participants were informed about the purpose of the study, and what their participation in the research entails. An informed consent form was used to seek permission from the participants to participate in the research. Participants were provided with a brief background to the study prior to the interviews. The researcher verbally translated the consent form to the participants where they did not understand English, after which they were asked to sign if they agreed. The researcher avoided the misuse of any information discovered. There was a moral responsibility to protect the rights of people in the study as well as their privacy. The participants were not being forced to participate in the interviews. The opportunity to participate was open to all women at the chosen SME and involvement was voluntary. Participants were asked whether they wish to receive a summary of the interview or the findings of the study. Participants were also given contact details for the researcher in case they wished to request further information later.

### **3.7 Pre-test or pilot study**

Pope and Mays (2000) argues that a pilot study often provides the researcher with ideas, approaches and clues one may not have foreseen before conducting the study. Such ideas and clues increased the chances of getting clearer findings of the main study. A pilot study greatly reduced the number of unanticipated problems because of the opportunity to redesign parts of the study to overcome difficulties that the pilot study revealed. The researcher carried out a pilot study by interviewing two participants first, improved on problems revealed and then proceeded to do the rest. One young women and one member of management were interviewed. The pilot study indicated that responses from participants were mostly 'yes' or 'no' answers which did not yield the much needed 'voice' of the research participants. To counter these problems, the interviewer strived to be a good listener and a good questioner and made all the questions as open-ended as possible. The key to being a good interviewer is being a good listener and questioner. Tempting as it may be, it is not the role of the interviewer to put forth his or her opinions, perceptions, or feelings. Ideal interviewers should be individuals who are sensitive, empathetic, and able to establish a nonthreatening environment in which participants feel comfortable. Interviewers should have personal characteristics that will make them acceptable to the individuals being interviewed: age, sex, profession, race/ethnicity, and appearance may be key characteristics. Thorough training, including familiarization with the project and its goals, is important. Poor interviewing skills, poor phrasing of questions, or inadequate knowledge of the interviewee's culture or frame of reference may result in a collection that obtains little useful data. To counter these problems, open-ended questions were also used by the researcher in the main study.

### **3.8 Limitations**

Limitations were anticipated in this study. Welman, Kruger and Mitchel (2005) reckon that the language and cultural values of respondents must be taken into consideration. In certain African cultures, it is not culturally acceptable for young women to be in the company of a man either in private or in public for long lest the public infer that they are in a sexual relationship. Some young women might have declined the request for

interviews because of this connotation. Welman, Kruger and Mitchel (2005) caution that in certain cultures, certain topics should not be discussed at all and women generally feel uncomfortable discussing sensitive HIV and AIDS matters with men due to the way they are socialized. As a male who interviewed young women, they might have felt uncomfortable in answering questions or disclosing sensitive information. This was discussed prior to the interview-taking place. However, this might also have worked to the researcher's advantage. As an outsider, the researcher might have had an advantage since the respondents might have perceived the researcher to be a neutral person and stranger onto whom they can "off load" their burdens about how they experience their work environment.

### **3.9 Summary**

This chapter considered the research methodology, namely the research design, sampling techniques, data collection methods and instruments and data analysis and interpretation. Consequently, auditability, credibility and appropriateness, a reflection of the role of the researcher, ethical considerations and the pre-test or pilot study are discussed.

## **CHAPTER FOUR**

### **YOUNG WOMENS' PERCEPTIONS OF HIV POLICIES AND PROGRAMMES IN SMEs**

#### **4.0 Introduction**

In this chapter and the next one, the researcher presents the findings thereof. The data was generated through in-depth interviews that elicited narrations of lived experience. As such, this chapter is an interpretation of the stories of twenty-one women working in SMEs, who shared their experiences of the responses of SMEs to HIV and AIDS. Such an account is structured through a re-reading of the theoretical backdrop to the study as presented in Chapter 2 of the dissertation, a reflection on the objectives of the study and various cycles of data generation and interpretation. The chapter commences with general characteristics of participants, which is then followed by a presentation of the research findings and interpretation in terms of young women's experiences. The chapter concludes with a summary of the interpretations of the research findings. To protect the identities of the research participants, the researcher assigned pseudonyms to each woman. Moreover, the names of significant others in the young women's profiles have also been changed to protect the identities of such individuals.

#### **4.1 Characteristics of participants**

The researcher interviewed a total of twenty-one working women in SMEs. Fifteen of these women were young women between the ages of 18 and 30 years who shared their experiences of HIV and AIDS in SMEs. Most of them had at least reached matric. This agrees with the literature review which stated that literacy does not seem to be a serious hitch for South African women and girls. At the time of the study, six out of the twenty-one participants interviewed had been working in the SMEs as managers for 3-5 years, while 15 participants had been occupying lower position jobs for the past 2-5 years. This group consisted mainly of young women in lower positions. They belonged to what could be described as a lower-income group. They were IsiZulu speaking and were in the 18-30 years age bracket, while six of the participants (managers) could

speak either English, IsiZulu or both and were in the 35-45 years age bracket. Most of the participants were not married but claimed to have boyfriends.

#### **4.2 Young women's experiences of HIV policies or programmes in SMEs**

To gauge the experiences of young women employees regarding HIV and AIDS workplace policies in SMEs, in-depth interviews were undertaken. Two interview guides, one for young women and another for management, were used. Responses were audio recorded. Analysis of the audio-recorded transcripts of the in-depth interviews and their narratives led to the following emerging themes:

1. Non-implementation of HIV policies and programmes in SMEs.
2. Facilitation or provision of HIV and AIDS counselling and testing.
3. Appointment of HIV and AIDS Officer /Peer educators.
4. Supply of male and female condoms.
5. Provision of medical aid/ payment for the treatment of HIV and AIDS related illnesses.
6. HIV information distribution and Management support.
7. Protection of women from sexual exploitation.
8. Provision of resources for funerals.
9. Provision of any other assistance.
10. Factors hindering or promoting responses.

##### **4.2.1 Non-implementation of HIV policies and programmes in SMEs**

The non-implementation of HIV policies and programmes became a key theme emerging from the data which is in agreement with the research objectives. The majority of young women noted that SMEs were not implementing HIV policies and programmes. This finding is similar to the findings by Hawarden (2007) who stated that SMEs have not sufficiently shown a better understanding of the businesses role and responsibility in preventing HIV and AIDS and in mitigating the impact of the disease. Nombulelo stated that:

*“For sure, I do not have any knowledge about an HIV policy or programme.....”*

As alluded in a literature review by IFC (2011), one should not underestimate the significance of SMEs’ engagement on HIV and AIDS. The mere fact that employers have access to employees, i.e. an adult population, every day, is their strongest comparative advantage in the fight against HIV and AIDS, along with the other long-established actors such as NGOs, local or international health authorities. Unfortunately, Nonsikelelo’s revelations show that the studied SMEs do not have HIV policies or programmes. Asked about HIV policies and programmes, Nonsikelelo expressed her experience as follows:

*“There is a clinic where you go when you are sick. There is a sister who does first aid and if she cannot assist she will sent you to hospital”.*

The statement by Nonsikelelo revealed a partial response whereby an employee goes to a company nurse for first aid only. This shows that the SME in question is only concerned with injuries on duty. In other words they need to shepherd their workers through the medical process to safeguard the SME from paying hefty sums of money in lawsuits in case of the company being found liable for negligence. In fact they would like to make sure they have all the details of the injury for future justification in case of litigation or the need for compensation. Thus the motive behind provision of first aid, apart from the requirements of industrial safety requirements, is self-interest or the need for an SME to cover its back against being investigated by Government for failing to follow the occupational health and safety requirements. These requirements do not include HIV and AIDS; hence they are more concerned with injuries on duty than issues of HIV and AIDS. Nosisa mentioned that:

*“Yaa to prevent blood-to-blood transmission, they help but everything else there is nothing”.*

She was referring to the same approach that Nonsikelelo noted above where SMEs are more concerned with a partial response in the form of first aid in case of an injury on duty. Most participants agreed on one thing regarding the existence of the policy and programmes in SMEs. They acknowledged that assistance was provided when one was injured on duty. According to Nosisa's statement, the interpretation was that the concerned SMEs help by taking precautions against blood-to-blood transmission when someone has been injured on duty and is bleeding. In other words, the SMEs provide a partial response by avoiding endangering other employees when one of them is bleeding. Thembelihle had this to say:

*"We had them (i.e. programmes) when the company was still at the top (referring to the company's previous address). Now, there is nothing".*

She was referring to an attempt by one of the SMEs to introduce a mobile clinic three years prior to this study. However young women refused to participate and the company stopped the initiative. Muchaya had this to say:

*"It once had them (i.e. programmes) but workers are afraid to disclose that they are sick. They invited workers to come and get tested but workers did not want to participate. I am also one of those who refused. They then stopped".*

Muchayas' assertions add value to both Thembelihle and Nombulelos' sentiments. There are no HIV policies or programmes in the studied SMEs.

#### **4.2.2 Facilitation or provision of HIV and AIDS counselling and testing**

It is evident that the interviewees shared similar sentiments on the subject. Babekile revealed that voluntary counselling and testing was absent in the studied SMEs when she said:

*“Like what I mentioned earlier on that if I see that a co-worker is not healthy (showing signs of being sick) and is starting to look ill, then I can go advise that person to go and have tests. There is no one who is in charge of that at my workplace”.*

Nombulelo expressed herself like this:

*“If maybe people like counselors who can teach may come and teach, maybe people will know how HIV and AIDS is acquired. Maybe the company needs to ask those counselors to come. Workers will then know which behaviours put them at risk of contracting the disease. Maybe counselors must come and talk to workers and bring with them material that illustrate risk behaviours. However, for now this has not been done. This can help those without knowledge to get it”.*

She went on to add that:

*“You can get counselors from the clinic. They are not found here either. Like what I explained to you that they should allow counselors to visit the factory, then that will be a good thing. We do not have counselors from within or those that come from outside that explain what HIV and AIDS is”.*

Nosisa mentioned that:

*“There is nothing at work. You do not get it anywhere. There are no counselors”.*

Interviewees explained that individual employees sought health services on their own including HIV testing and counseling. They revealed that individuals pay to access these services on their own or they visit government hospitals or clinics.

### 4.2.3 Appointment of HIV and AIDS Officer /Peer educators

At the studied SME, young women indicated that there were no HIV and AIDS officers or assigned peer educators. Philile said this:

*“I think it is important that we do have an HIV officer. Then we can get help close by. I think we should have an HIV officer visiting. He/she can help both groups that are positive and negative. The HIV officer can inform everyone about the disease. There are lots of things workers can benefit from a HIV officer”.*

Interviewees still bemoaned the absence of an officially appointed HIV and AIDS officer or peer educator. Whilst SMEs in this research seem to be ignoring this intervention, peer education is widely understood as an effective tool in the response to HIV and AIDS. There are restrictions to peer education, but among its advantages is the ability to access people infected with HIV or vulnerable to infection. That is, the peer educators, as a result of their peer status, are an ordinary part of individuals' lives and know through shared experience what those individuals value, what they aspire to do, and what frustrates them. Peer educators also have the advantage of being able to communicate effectively because they understand the language and patterns of communication of those who they seek to influence. Thus, they can be seen as 'translators' who take technical information about HIV and AIDS and put it into forms that peers understand, making it clear how HIV and AIDS can affect them and their families. The workplace is a legal and open environment in which communication should not be a problem. However peer education is just as necessary in the workplace as it is in other environments because workplaces, and especially South African workplaces, are deeply divided by class, race, and language (Innes, Dickinson & Henwood, 2003). Nombulelo mentioned that:

*“I do not know how it can be done but the situation about HIV and AIDS is serious. You know what I can say is that there is no one who is written on her face that he or she is HIV positive. If someone wants to listen, it is her choice. If someone can come and educate people, obviously that can help. But if they do*

*not want to listen, they will continue their old ways even if they have been taught”.*

Nombulelos’ assertion reveals a serious limitation of whatever intervention or programme that might be put in place. She noted that the serious limitation is the individuals’ characteristics or behaviour. She reveals that whatever course of action is taken, its success will depend on the individuals’ attitude. She puts it straight that it is the individuals’ characteristics that matters, which is an interesting revelation. Interventions are successful when the participants take control of their own destiny. Thembie said:

*“If I remember, they tried before to bring a person that teaches workers about HIV and AIDS into the premises but the workers did not want to participate”.*

Whilst young women registered the absence of appointed HIV and AIDS officers in the studied SMEs, the presence of a health professional in an SME clearly provide an important resource for HIV and AIDS programmes. This could include assisting in monitoring and treatment of HIV-positive employees, identifying and counseling workers who showed symptoms that could be HIV-related, provision of VCT, assistance in wellness programmes, and general education and awareness on HIV and AIDS.

#### **4.2.4 Supply of male and female condoms**

Interviewees concurred that their employers did not provide free male condoms or female condoms. They went on to mention that they had been provided a long time back and have since been stopped. On how they were distributed, in one SME answers pointed to the fact that the condoms were personally handed over by the production manager on request. There was no regular supply and that stopped three years ago. Condoms were freely available in government clinics or hospitals and in tuck shops. Nosisas’ assertions confirm their concerns.

*“Yaa condoms should be placed in accessible areas because adults work here and they are not children. Condoms alone won’t help against HIV. Others can be given lessons about abstaining. Those who know that they do not sleep (have sexual intercourse) maybe supplied with prevention information. It must be made clear that those who need condoms may have them. Those who do engage in sexual intercourse may choose to or not to take the condoms but still be supported so that they continue doing well”.*

Young women’s assertions spelt out the need to stop the spread of HIV and AIDS. However, they noted that HIV and AIDS prevention included but was not limited to availability of condoms. Muchaya had this to say:

*“I never saw them give out condoms .....*”

UNAIDS (2010) noted that condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. It adds that the male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections. Whilst young women acknowledged that most people were sick due to HIV and AIDS, Maureen noted that condoms must be readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use:

*“Employers can make condoms available. Even now they should be available because we are really sick”.*

None of the SMEs had condom dispensers in place. However, the UN (2010) mentioned that male condoms can provide effective protection against HIV infection, and female condoms are agreed to increase women's empowerment. Female condoms are not readily available thus placing men somewhat in a position of power to decide whether or not to use a condom leaving young women continuing to be vulnerable. On the other hand, several issues impact upon the use of both male and female condoms

including power relations. Cost, availability and perceptions of risk are important factors. Power relations between men and women, including the relative social and economic status of partners influence the extent to which condom use can be successfully negotiated.

#### **4.2.5 Provision of medical aid/ Payment for the treatment of HIV and AIDS related illnesses**

Young women were asked whether the SMEs pay for the treatment of HIV and AIDS-related illnesses or provide medical aid. Provision of medical aid was unheard of in all the three SMEs, according to young women interviewees' responses. Nosisa's comments below do not need further elaboration:

*“Uuh medical aid helps because you access quality service compared to government clinics. It helps. .... you only get assistance when you are injured at work. I do not think that they help you when you talk about HIV and AIDS. What is the agreement between the company and Med Clinic? Oh it means it is their medical aid and not for workers. It does not help you with anything. You are only taken there to Med Clinic when you are injured at work and not when you are sick with other illnesses. What it means is that it is their medical aid and it's not for workers”.*

The assertions by young women showed that being ill whilst working in an SME was a challenge for young women. Cash is diverted to medical expenses because of the stringent requirements of a medical certificate by the employer. When they absent themselves from work for collection of ARVs, they are not paid and the employer deducts money for the time they are away. Babekile lamented that:

*“When you are sick you are not paid especially if your annual allocation of sick days is finished. You still pay the doctor with cash as employers do not accept sick letters from other sources except from the doctors”.*

Nombulelo mentioned the need for medical aid and its importance in SMEs:

*“I do not want to lie, I have never heard about medical aid. I think it is a good thing that medical aid is provided because it can happen that you are sick and you do not have money, and then you can use medical aid to access treatment and to get medication”.*

Amongst the SMEs the common thing was that the companies were catering for injuries on duty and not any other illness. Their concern was about compensating for injuries on duty hence they would take the person for treatment and monitor the healing process. She also registered that with the circumstances permitting, she would envisage having medical aid because of its advantages. Maureen added another dimension to the subject:

*“There is no medical aid. If you are sick you go to hospital except where you are injured at work. Where you are injured at work, they will take you to Med clinic on their own medical aid. You will see that it is important that a company should have a medical aid for its employees because we also need to be admitted at high-status hospitals like St Annes. I cannot be admitted there because there is no medical aid at this company”.*

In two of the SMEs, the majority were fortnightly paid workers. They were not members of any medical aid scheme. They were generally not members of the schemes because they could not afford the required monthly installments. At the same time, the employers did not have medical cover for its employees except for injuries on duty.

#### **4.2.6 HIV information distribution and management support**

The ILO explains that education and information are vital components of an AIDS prevention programme. Therefore, it is important to ensure that employees are informed on the prevention of the spread of disease through distribution of educational materials.

On display or distribution of educational materials (posters, brochures etc), all the young women interviewees reported that such a thing never happened in their SMEs. Muchaya had this to say:

*“I never saw them putting ..... or posters or any other thing. What I know is that they have encouraged people to check their status so that they can start treatment early where necessary”.*

Philile stated that:

*“They tried HIV educational sessions and few people attended. Eventually the employers advised workers to seek HIV services privately”.*

Nosisa noted that people gather for unions but they do not discuss anything about HIV and AIDS. What was important in her assertion was that she saw HIV and AIDS information dissemination as a right which young women should have access to. She also revealed that trade unions might have a role to play in issues of HIV and AIDS.

*“There are unions aaaaa, they are unions. No they speak about other rights at work, they talk about financial rights but they do not see HIV and AIDS issues as a right”.*

Interviewees reported that educational materials are only found at government clinics. At one SME they are provided with painkillers and bandages when they are injured at work. Nosisa mentioned that:

*“If you are positive there is information you require. If you are negative there is information you require”.*

Interviewees agree that there are no forums or HIV educational sessions that were held to promote exchange of HIV information.

#### **4.2.7 Protection of women from sexual exploitation**

SMEs need to make sure that the rights of young women are safeguarded by protecting them from sexual harassment. Interviewees were asked how the workplaces protect women from sexual exploitation and harassment and whether there was a policy. Respondents stated that a partial policy existed at their workplace in the form of rules for transgressions that are on display on the wall. Babekile stated that the onus is on young women to report such cases, which they seldom do. Only if such a case is reported can action be taken against the person. Philile had this to say:

*“People protect themselves. It is important to protect yourself through negotiating with a man”.*

Nosisa had this to say:

*“Uuuh, No there is nothing. If a guy makes and mistake and touches you and you tell him that you do not like it, he will quickly stop and apologize. Those who have sexual intercourse will be willing. Maybe sexual harassment happens to others but it has never happened to me. I think it cannot happen that a person takes advantage of you like that because you would have entered the workplace to work and whether he loves you or not does not mean anything”.*

Muchaya mentioned this:

*“No we enjoy establishing sexual relations with anyone without being forced”.*

On the other hand Nonsikelelo had this to say:

*“He would say he wants.....yes he was asking me to have a sexual relationship with him ...yes Phumulani would say he wants to take to take me out to Hlalanathi (a lodge) ..Yes he would say to me that Madhlamini I want to take you to Hlalanathi, buy you good food and have sexual intercourse with you. I do not know where this Hlalanathi is in town. Everyone ended up knowing that this supervisor loved young women and if you want work then you should first sleep with him. Other men knew it as well”.*

Young women expressed joy that they had the freedom to choose a sexual partner. This was echoed by another interviewee who said that young woman have all the right to chose a sexual partner. Her statement revealed how SMEs are protecting or safeguarding the rights of these young women against sexual harassment and sexual exploitation. However there appeared to be no policy on sexual exploitation in one of the studied SMEs.

#### **4.2.8 Provision of resources for funerals**

Some interviewees mentioned that their employer pays out money towards the funeral expenses of an employee. However, they stated that there was no funeral policy that employees contribute to. Surviving relatives are given R15000 for burial expenses. No time off is given to employees to attend funerals of colleagues and burials are done on weekends. Whilst some mentioned that they had not come across such programmes in SMEs, the general opinion was summarized by young women’s assertions stated below. Nombulelo said that:

*“What I can tell you about funeral assistance when someone has died at work is that in the past days the boss used to provide transport and we will then contribute money. By then the company gave no money. This has since changed. Now you pay for your own transport, but for sure, the company will pay money straight away to the relatives even if someone has passed away today”.*

This was confirmed by Maureen who mentioned that:

*“On transport, it depends on the distance. For going to Harding they can provide half and we pay half of transport costs but further than that they will not”.*

Nosisa complained about a goods vehicle that used to be provided by the employer to transport workers to the funeral and called it inhumane and degrading in the eyes of the community. Nosisa still thought that making them pay half of the transport cost was still unfair. She revealed that the new arrangement is a financial burden to young women who should seek for money before attending a friends' funeral. Her emotions were very profound. Nosisa's assertion summed up the situation in one of the SMEs when she said:

*“In the olden days, the employer was providing half the cost and we would pay the other half. When time went by, on long distances, the employer would pay half and we would pay the other half. When we intended to go to Durban, the other day, he said the payout had increased to R15000 from R10000. We paid our R40 for transport and we went to Durban and returned...no this thing is not enough because this R15000 is not paid to us but to his deceased workers family. What about us who need to go the funeral of our workmate? Even this thing of making us pay half was not fair. Initially he was taking us to the funeral with a truck. Travelling in a truck bin would undermine our social standing in the face of the community. When he saw that trucks were being arrested and fined on the road, he said he will pay half for the taxis. He stopped giving us the trucks when he noticed that we were now getting used to paying for taxis on our own. This thing affects us badly because you see that a fellow workmate has passed away and you do want to attend the funeral but you have no money for transport. This is very painful, this is very painful”.*

Nosisas' frustration did not go unnoticed. Morale can be severely affected by the loss of a colleague. Affective attachments built up over longer time frames which are critical for

a more efficient, effective and ultimately productive workforces, are threatened. While these factors may be essentially invisible in nature and difficult to calculate, their impact on productivity levels is nonetheless enormous. But for Nonsikelelo the situation was different. The narration below by Nonsikelelo provides a sad reality of her employers' attitude towards HIV and AIDS issues.

*“There was a young woman who was working with us who passed away last year. She had worked for 10 years. She started by being sick. For two years, she was sick. The employer was not giving her anything. She was HIV positive. Every time she would go to work with a medical certificate and the owner would tell her to come when she was fit. He would give her no assistance. He never gave her anything - transport, money for treatment or money for the funeral”.*

Despite the fact the SME referred to by Nonsikelelo did not provide any form of assistance to a sick worker let alone any funeral assistance after her death, the general consensus was that SMEs provide some form of assistance towards funerals of workers. The assistance included transport and money paid to relatives.

#### **4.2.9 Provision of any other assistance**

The majority of the young women believed that SMEs do not do much for employees who are sick. Most of the interviewees acknowledged that employers keep sick employees' jobs vacant until they are fit. In other words, even if an employee is sick, he or she retains her job despite the fact that it is unpaid during the period of absence. However, some interviewees revealed that they are allowed to collect their medical prescriptions during working hours every month but on condition of the no work no pay situation. Nombulelo had this to say:

*“What I know is that if you are sick and you tell the employer the nature of your problem (that I can explain because I have done it myself), they have no problem as long as you tell them the truth about your illness. They will never say no as*

*long as you bring the medical report from hospital. What they need to know is exactly what you are sick of. If you need to stay at home, they do not have a problem, they will wait until you get well and return to work. When you return to work and need time to go and collect medication, they will allow you to do so”.*

Nonsikelelo provided another dimension on what she thought employers could provide as a form of assistance. Nonsikelelo commented that:

*“Maybe SMEs should give out handouts of good and nice food. A company that I was working for before this one by the name Flow pack used to give out fruits on Fridays”.*

Nonsikelelo's assertion shows that she values nutritional food as it mitigates the effects of HIV and AIDS. Literature reviewed showed that the progression of HIV can be affected by poor diet. Nutrition is the pivotal interface between food security and health security. An individual's susceptibility to any disease depends on the strength of the immune system, which among other factors is affected by nutrition, stress, and the presence of other infections and parasites.

#### **4.2.10 Factors hindering or promoting SME responses**

Young women respondents thought that SMEs do not have a policy or programme for several reasons. Firstly, they thought it is expensive to implement an HIV and AIDS policy because employers have too many workers to take care of, hence it will become expensive for them to do so. Nombulelo mentioned that:

*“As it stands if something beneficial is offered to the workers, then at the end maybe the all employees will need that service and the company will require huge resources to take care of everyone. Everyone might come open about his her status if there are benefits that come through doing so”.*

Nombulelo mentions that young women see no benefit in revealing their status but if the employer avails a programme that benefits HIV positive individuals then the numbers of

those coming out might be overwhelming. The company might later find it expensive because of the high number of individuals wanting to benefit from the service or programme. She reveals that the employer might be afraid of the cost. Babekile said an almost a similar but different assertion:

*“We are so many. He cannot provide an HIV programme to everyone. What he did only was to avail a provident fund. If someone passes away, there is something that the relatives can get. At times employers have that attitude that it’s not their responsibility”.*

Young women thought that implementation of an HIV policy might cost a lot of money to their employers and that could be the reason why they are not taking any action. Her fear was that it would be expensive for the employer to provide HIV and AIDS policies or programmes given the high number of HIV positive employees. Instead she thought provision of a provident fund was a better option. Nonsikelelo offered another perspective:

*“The owner is very selfish. He listens to no-one. No one can tell him anything. I remember we went on strike in July wanting more money. We never got anything. We ended up returning to work without getting the increase”.*

Nonsikelelo revealed that she thinks her employer was just arrogant and will not listen to anyone. To stress her point that her employer would not do anything extra to try and help his workers, she spoke about an incident in which they were seeking for a wage increase through an industrial action. Even after protracted industrial action this was not granted and they ended up going back to work. Some participants thought that SMEs were not to blame for not implementing policies or programmes. They saw their employers as helpful but the problem was that no-one had sought assistance. Nosisa mentioned that:

*“I do not think that the employer does not want to involve himself with HIV and AIDS issues. It’s the people who do not want to come out open about their status. What I know is that there is not a single person who has come out open and sought for assistance. There is not even a single person that has been sick and gone to the employer to seek assistance and said he got nothing. Nobody has ever tried. Nobody has gone to the employer and came back complaining saying he got nothing. So I do not want to lie against the employer”.*

Nombulelo agreed with Nosisa when she said:

*“I think the reason why it is not being done is that nobody spoke to the boss about it. I think if someone makes a proposal to the boss, I think he will take it aboard. I will never think they do not care, but the way it is, no one has made a strong proposal to the boss that bringing in counselors will benefit the company and the boss will take it aboard. I do not think the companies do not care. Everyone cares for everyone. Nobody has made a serious proposal and placed it on the table. I do not think they do not care.....”*

Nombulelo thought there are no people who have brought this to the attention of her employer. Her assertion shows that if employers are advised of the merits then they might implement policy. Some interviewees thought that their managers have not thought about implementing policy and they do not see it as important. Philile mentioned that:

*“I think it’s because of our leaders who have not thought about it. ....I do not know what I can say, but I think our leaders are not worried about things that do not involve work especially those that affect workers. I think they are worried about things that are directly connected to work only”.*

Philile revealed that managers were not concerned about the welfare of workers but they were only concerned with work related issues only. They do not see HIV and AIDS

as a work place issue. Nosisa had a different view-point and thought the workers were to blame when she said:

*“People obviously do not want to disclose their status. May be if people were disclosing then the company was going to assist here and there”.*

A climate of employer-worker poor relationship leaves workers more vulnerable to infection and less able to cope with AIDS because it makes it difficult for them to seek voluntary testing, counseling, treatment or support; they will also not be in a position to take part in advocacy and prevention campaigns. Moreover, individuals who suffer discrimination and lack of respect for their human rights are both more vulnerable to becoming infected and less able to cope with the burdens of HIV and AIDS. Maureen reiterated Nosisas' viewpoint but added more details when she said:

*“Our employer invited young women to come and check their status but they did not. I am one of those who refused. Our employer then stopped inviting the mobile health care workers to the premises. Young women said they were comfortable checking their own status at their own time at preferred clinics or hospitals. Like what I said earlier on that we refused. If we had agreed in the first place, then we should be having those policies and programmes. The employer brought forward something like that. As for now it's something that can help an individual thus it rests upon the person to go and check his/her status. There is no doctor who will just come to you and say I want to see your status. HIV and AIDS is a disease that can cause stigma. We are dying because we do not want people to know our status and we prefer to go and check on our own. It's not easy”.*

Maureen explained that her employer once allowed a government mobile unit into the premises. The mobile unit would do periodic visits and they invited young women to do HIV and AIDS testing. The mobile unit also did HIV and AIDS counseling and testing. However the uptake of the service was poor and both the employer and the provider

saw no reason in continuing. Young women did not trust that the provider was going to respect confidentiality and keep the test results secret. As the mobile unit was coming to the premises through the employer, young women were not sure whether confidentiality was going to be respected. As a safety precaution young women ignored the mobile unit and sought HIV and AIDS counseling and testing services privately. Young women feared the stigma associated with HIV and AIDS. They were afraid that other workers would draw conclusions about their status if they were seen visiting the mobile unit each time it visited their premises. Manase commented that:

*“It is so cheap to replace labour because there are many people waiting at the gate looking for jobs”.*

Some young women interviewed agreed that whilst management understands that HIV is an issue that affects workers, which in turn affects business, they will not take it as a motivator to implement policy. Instead they will use the high rate of unemployment as an advantage to seek replacement of sick workers. They are not worried about training/replacement costs as these are regarded as low level jobs that are easy to learn.

#### **4.2.11 Summative conclusion**

The salient deductions from the study are reported below whilst observations and statements that are not relevant were omitted. Some young women explained that employers absolve themselves from responsibility hence they are not worried about young women’s vulnerability to HIV and AIDS. Young women expressed their desire of having a doctor or a company nurse that can visit and explain HIV and AIDS to them. They also thought that they might learn about what they can do when they are positive and what they can do when they are negative from HIV officers if they are employed by SMEs or if they are allowed to visit. This can also save them travel money and time. They visit clinics and private doctors on their own and pay for it themselves. Babekile said:

*“Employers must urge young women to check status and seek treatment. They must be encouraged to eat healthy food, use condoms, given love and encouragement and spell out that it’s not the end of life”.*

Babekile’s assertion summarizes the suggestions from young women. These words point to the need for HIV and AIDS programmes in SMEs. It also links to the need for HIV and AIDS education, the need for condom distribution and the need for the provision of counseling and testing in SMEs. Most of the time, young women's voices point to the lack of HIV and AIDS programming in SMEs which they think is necessary.

## **CHAPTER FIVE**

### **MANAGEMENTS' PERCEPTIONS OF HIV AND AIDS ISSUES IN SMEs**

#### **5.0 Introduction**

In order to have an overview of the effects of HIV and AIDS on SMEs under study, managers were interviewed to assess their experiences of HIV and AIDS on various aspects. This was done to complement young women's experiences and to provide answers to those aspects that young women were less knowledgeable about. The researcher saw this as enriching the research and enhancing the credibility of young women's assertions. The aspects are outlined below.

#### **5.1 Perceptions on the causes of HIV and AIDs infections**

Managers were interviewed with regard to their experiences on the causes of HIV infections amongst young women. Nombu had this to say;

*"They use sex for the sake of economic survival. In our company they do not get a lot of money. Therefore, they need something to boost their income to be able to live a better life. If a man says no to the condom, they cannot say no to sex. As females they need money and it's not easy to say no to men because men have power over them and they need to respect men even where the men is not right".*

Nombu's assertions revealed the situation of young women in terms of their economic status, lower wage levels and gender and power issues in SMEs. Her experiences show that young women in SMEs are vulnerable to HIV and AIDS. Nombu perceived power inequalities between men and women to play a key role in putting women at risk of HIV infection. Carlos' assertions do not differ from Nombu's as they point to the need to increase their income as the main cause of HIV infections.

*“Economic hardships, need for many children in order to get government grants, alcohol and culture were causing high levels of HIV infections in SMEs”.*

Nosihle perceived financial inequalities between men and women as playing a big role in putting women at risk of HIV infection. In this regard, Nosihle perceived financial inequalities skewing sexual and decision-making powers in men's favour. She sees financial inequalities as decreasing the likelihood of the use of protection and increasing young women's risk of HIV infections. Her experiences clearly reflected how gender and power imbalances constrain young women in negotiating safer sex when she said:

*“They like to be provided with for example money, free transport and that is the danger. Usually they are given money and they lose all the power to bargain for safe sex even if they see that the relationship is not realistic or ideal. For others it is not even necessary for them to ask boyfriends to check their status because HIV has been around for a long time now. One can easily see or suspect that maybe this person is sick but you will see people continuing to have relations with such people because they will be looking for money”.*

Nosihle's experience of the effect that financial inequalities had on health was similar to what DiClemente and Wingood (2000) found. They found that as power between men and women increases and favours men, women will be more likely to experience adverse health outcomes. Meaning that men's control over women's sexuality - for example, men deciding when, where and with whom to have sex - greatly contributes to the spread of HIV.

Behavioural practices continue to drive the probability curve that a worker may acquire the infection upwards. These include unprotected sexual relationships with partners, whose HIV status is not known, lack of adherence to infection-control warnings and cultural norms and values. Priscilla saw concurrent relationships as the cause of HIV infections.

*“Where I am working for example there are few men and lots of ladies. You find that lots of girls will go for the same man. More than five ladies going for the same man. What about if that man is HIV positive? That’s what is spreading the disease. The same girl will go to the other man. Five men will go past the same girl. Also the same thing, one girl with more than five men in the same surrounding. One guy will have ten girls, this month it’s another one, next month it’s another one or three of them at the same time”.*

One of the serious revelations was that young women are not afraid to share one boyfriend, especially a rich one. The revelations show that one of the major issues in SMEs is multiple or concurrent partnerships and poor partner selection. This is brought about because those already affected would want to infect as many people as possible in revenge for having got the disease from some other people. This phenomenon was mentioned as common amongst both young women and men. Hester added value to Priscilla’s assertions when she said:

*“There are people who I can say are careless or I do not have a proper term to describe them. These people will know that they are already positive and they will continue to have sex with so many young women in the factory. We on-lookers feel the pain when we see such a person having many young women sexual partners and knowing that he does not use protection”.*

Nosihle also gave a conflicting account of HIV infections amongst young women:

*“The money that they earn is too little. But we can not make it a reason because it’s not everyone who is doing that. Others fail to budget their money and look for money at wrong places. It’s those who need material things. I also see that these people are not afraid of HIV and AIDS. Maybe they have a treatment they are using. What I have also noticed with people who take anti-retroviral drugs is that*

*they love to drink alcohol irresponsibly. When you ask them as to why they are doing it they tell you that they want everything in their body to be drunk”.*

Nosihle said that what was surprising was that these young women earn the same salary. You will still find some who are decent who do not indulge in risky behaviours. Priscilla also said the issue of money was debatable when she said:

*“I really do not understand. I always find myself asking the same question. It’s not money. Like where I am working you will find one or two guys with money. But the rest are normal guys. There are a lot of young girls there. I think they will be under pressure to have a boyfriend. I do not really understand. They know that the boy is in a relationship with someone else and they also go for the same guy. I always ask myself, what is so special about this guy? There may be one or two guys who we might say are being paid much but still we do have normal guys but you will still find girls going for them”.*

## **5.2 Absenteeism in SMEs**

To establish if HIV and AIDS was affecting SMEs, managers were asked about worker absenteeism and its causes. Managers’ assertions agree with the literature reviewed. The BER (2006) survey revealed that HIV and AIDS has reduced labour productivity and has increased absenteeism in SMEs, resulting in less profitable organizations. The economic effect has been noticed in terms of an increase in labour turnover rates, loss of experience and skills and increased recruitment and training costs. Managers perceived that employees were absent from work due to several reasons, including HIV and AIDS. Nosihle had this to say:

*“Yes there is problem of absenteeism although it does not occur frequently. What happens is that someone who has known that she is HIV positive, may accept her situation and she will know that every month she will have a day that she will not be available at work so that she may go and collect medication. Those who do not want to accept their condition and are not on treatment are always sick*

*and will take sick leave now and then. I won't say they would not have accepted or what. Probably they would not have thought about the possibility of them being infected. What is disturbing is that when they go to collect medication, the dates of collection are almost the same for everybody. You then get reports from a number of people all seeking to go the hospital at the same time".*

According to the UN (2010), a link exists between HIV and AIDS and declining productivity and profits. The bottom line is that declining levels of productivity could lead to declining profits especially when production costs are not declining at an equal or higher rate, as is usually the case when the prevalence rate of HIV and AIDS is high among the productive segment of the population. Carlos mentioned that:

*"They don't come to work on Friday night shift and also Mondays because of hangover. They are not willing to work. They only care about pay. For ladies it is because also of alcohol, lack of interest, because night shift is much colder and family problems".*

Carlos' assertions were different. He thought absenteeism was as a result of alcohol, lack of interest, family problems and because nights are much colder. Priscilla gave a similar account of Carlos' viewpoint when she said:

*"It's a lot, it's a lot like you will find on Monday they do not come to work. On Friday if you are on night shift, they also do not want to come to work. Especially the pay week, we have a higher percentage of absenteeism. I think people like to party. We are working with youngsters. Obviously Friday they will have money. Come Monday morning they cannot come to work because of hangover. None of them will bring and report that they were sick or something. It's obvious it's because of parties".*

Thembe saw HIV and AIDS affecting SMEs through absenteeism.

*“I think for others they will be pregnant, for others they will be sick and they need to go to the doctor or to collect their medication”.*

Her assertions points towards HIV and AIDS when she included the collection of medication. This was interpreted by the researcher as referring to the collection of anti-retroviral drugs, which falls under the broad terminology of HIV and AIDS.

### **5.3 Ill-health retirement in SMEs**

Asked about her experience of ill-health retirement, Priscilla noted that young women do not necessarily retire but they go on off sick where they will return to work once they have recovered. Priscilla had this to say:

*“Aaah, not really the people who we have are off sick. It’s like they no longer have sick leave. They will come back only after they have recovered. They rarely come back. Out of the people who were on sick off only a few came back. Most of them would have passed away”.*

However, her assertions speak volumes on how HIV and AIDS are impacting on SMEs. On the same subject, Nosihle gave almost a similar account:

*“Even where someone is getting better, the factory environment is not conducive for HIV positive individuals. We tend to believe that HIV and AIDS is associated with tuberculosis. Now things like flavor and dust are the problem. Now the person would have sat at home and getting better. When she comes to work and is exposed to the dusty environment, she will get worse again. This forces her to choose between life and the job. Then she chooses life and leaves the job. This affects them, shame”.*

Nombu had this to say:

*“I think because we are dealing with eeh chips, we use flavor, which affects other peoples’ health. If you are not healthy especially nowadays of HIV and AIDS, it is not a safe place to work as it can worsen your situation”.*

Nombu thought chemicals that are contained in flavor are harmful to people with a weak immune system. The situation of those infected with HIV and AIDS can worsen if they are exposed to such environments. Priscilla thought that most of these people are absent for long periods from work because of HIV and AIDS.

*“You will find that most of these people who are absent for long periods are positive. There are those sicknesses like meningitis. Like one of the girls I am working with, she had a problem with meningitis but it’s linked to HIV and AIDS. Like now on my shift there is one girl who is off sick. She is recovering from meningitis. She has been sick for 6 months already. They say its tuberculosis or meningitis. No one will tell you I am sick of this, you need to figure it out yourselves. Just a few people will come out and say I am sick because of this”.*

Managers agree that young women do not necessarily go on ill-health retirement. They are absent for long periods until they are fit to partake in work activities again. However it is evident that HIV and AIDS also increase organizational disruption within the workforce due to high rates of absenteeism. Usually making prompt and adequate adjustments to the erratic rate of staff turnover coupled with the loss of skills and tacit knowledge can be very difficult.

#### **5.4 HIV and AIDS related deaths in SMEs**

Interviewees were asked if they were aware of any HIV and AIDS related death in the company. Evidence from the in-depth interviews with Nosihle and Nombu revealed that HIV and AIDS related death were occurring in SMEs. Nosihle said:

*“Not really because they do not disclose. We just assume. A person will point to the head and to the leg but you will say that it’s better that this person points*

*at the correct thing. There are people who die but they do not tell the truth through their mouth but we know the symptoms. The person would have pointed to the leg and head but we will know that he/she has pointed to the leg and head but this was not true”.*

Nombu had this to say:

*“Sometimes pneumonia, TB, its different illnesses, a lot are dying of illnesses that are related to HIV and AIDS. E-he-e those who were dying, were not involved in a car accident. Everybody was sick”.*

Priscilla said:

*“Like every year one worker passes away. This year we had one. Each and every year we have more than one”.*

The interviewees assertion agrees with literature reviewed. Hawarden (2007) mentioned that attrition due to AIDS differed according to skill level, with unqualified workers much more likely to leave the workforce due to AIDS than skilled workers or managers.

## **5.5 Effect of HIV and AIDS on workplaces**

The UN (2010) noted that the world of work is coming under constant threat as a result of the epidemic in two aspects: financial consequences and the basic rights of the infected and affected worker. Nosihle said:

*“It’s painful because one may end up dying. That person will be having children and a family and who will support it? Nobody will support the family. That will definitely affect. And also that when this person dies she would have been with us for long, she/he would not have been with us from yesterday. The company will be forced to hire a new person. The new person does not know much. All this is a serious draw-back”.*

Workers have to meet increasing costs of treatment at the expense of other life sustaining and direct family needs. With respect to the first, both the worker and the enterprise feel the impact. Earnings are reduced and enterprises are obliged to incur huge costs through declining productivity, increasing labour replacement and training interventions. On further probing Nosihle explained further:

*“It affects a lot of things. The company is forced to commit itself to pay money after the death of an employee. The more people die the more money the company pays. The company is affected in that sense in addition to loss of skill. The company is also affected when workers go to collect medication from Hospital. Let us say five people have gone to hospital and are coming late, what are you are going to do without five people. What it means you will not be able to use five packing machines. Even if you are to try to use them, you will not use them as if all the people are around. Then you are forced to adjust other things. Your days’ total production will be less due to those people who would have gone to collect medication”.*

Priscilla had this to say:

*“It does like when a person wants to go for medication. It does affect production.”*

Interviewees assertions agree with literature reviewed. Thurlow et al (2010) argued that the impact of HIV and AIDS in SMEs is reflected through loss of production and leads to financial strain. Most SMEs are disrupted by the consequences of HIV and AIDS. Once an employee is absent or too sick to perform duties, the production cycle is disrupted. The only viable option to the SME is to recruit another employee to perform the same duty. For the most part, organizations lose the skills that were possessed by the sick employee and need to recruit new or temporary staff members in order to keep the companies functioning. More money is then spent on recruiting and training the newly hired employees. Moreover, HIV and AIDS affect SME budgets. Some SMEs do not

have an efficient system for coping with expected absences of staff, like sick leave, let alone unexpected staff shortages (Holden, 2003).

## **5.6 Measures taken to respond to HIV and AIDS**

According to managers' perceptions, responses from SMEs were partial or incomplete. Priscilla mentioned this:

*"They wanted to but the workers discouraged them because the workers wanted nothing to do with that. Maybe if the workers had shown a positive attitude towards the programmes, the company will be doing something about it. The workers were very angry about it and were questioning what their status had to do with the company. I remember one thing that out of three shifts it was only one shift that went for the HIV counselor meeting. Even on that shift only 20 percent attended. Workers were asking too many questions".*

All respondents agreed that stigma had a hand in drawing back some SMEs from implementing policy. Hawarden (2007) agreed with Nosihles' assertions when he said companies that believed they have workers living with HIV were much more likely to provide HIV and AIDS services than other companies. In his research, he found out that nearly half of respondents from firms not providing HIV and AIDS services stated that they would be motivated to offer such services only if they knew that any of their employees had HIV and AIDS or if more of their employees had HIV and AIDS. Nosihle said:

*"There is not much because they do not disclose their status. If they were disclosing the company would do something. Now the company thought everyone is healthy. We cannot blame the company. People are afraid of stigma".*

Nosihle also noted that stigma is responsible for peoples' failure to disclose their status. Goffman (1963) defines stigma, in broad sense, as an unwanted or discrediting

characteristic that an individual possesses that reduces an individual's status in the eyes of society. Stigma can result from a particular characteristic, such as a physical deformity, or it can stem from negative attitudes toward the behaviour of a group. UNAIDS (2011) bring us closer to our topic of discussion when they define AIDS-related stigma as prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or being infected with HIV and at the individuals, groups and communities with which they are associated. In a related aspect, managers revealed that some of the young women die due to HIV and AIDS because they are not prepared to take HIV and AIDS tests. Carlos had a case in point:

*“A lot of people are infected but are not willing to be tested because of stigma around HIV and AIDS”.*

For UNAIDS (2011), 'stigma' is derived from the Greek, meaning a mark or a stain. UNAIDS (2011) further described stigma as a powerful method of devaluation that extensively discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as shameful or contemptible. UNAIDS (2011) took note that when stigma is acted upon, the result is prejudice that may take the form of actions or omissions. Discrimination is described by UNAIDS (2011) as any form of arbitrary distinction, segregation, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group. SMEs that believed they have workers living with HIV are much more likely to provide HIV and AIDS services than other companies. In fact, where the problem has not been adequately highlighted, SMEs see no reason for action.

## **5.7 Conclusion**

The assertions of managers of three SMEs, all of which are experiencing the effects of HIV and AIDS, provide a snapshot of their response. What is clear is that these SMEs have limited ability to measure the current or future impact of the disease on their operations. The current level of their response was largely a reaction to attributed AIDS-related deaths and absenteeism. The primary fear of managers is the loss of skilled workers and the higher rates of absenteeism that AIDS will bring. It is the driving force in the current response which centered mostly on the provision of funeral assistance. Greater certainty on the part of management as to actual prevalence rates of HIV among workers could well have a major effect on whether or not these efforts will go beyond what they are currently providing.

All results reported above in chapter 4 and 5 are further discussed in the following chapter.

## **CHAPTER SIX**

### **DISCUSSION OF RESULTS**

#### **6.0 Introduction**

This chapter discusses the research findings. In the first instance, it sets out to present the theory that is relevant in the explanation of vulnerability to HIV and AIDS of young women working in SMEs. In an attempt to explain the risks factors for HIV and AIDS infections, I employ the gender and power theory to examine socio-cultural factors that expose young women to HIV and AIDS. This chapter will argue that at the very heart of HIV and AIDS infections of young women in SMEs, there is the logic of the theory of gender and power, which in itself draws sustenance from the patriarchal social structure of the broader South African society. The chapter also recognises the young women's powerlessness by virtue of their being thrust into a relatively low social status through their gendered roles and incomes in SMEs. This reinforces how dominant patriarchal societies put male and female relations in privileged and less-privileged roles. This chapter will also argue that young women's subordinate status with regard to men is a critical factor influencing their greater risk for infection, placing gender issues at the centre of the HIV prevention challenge. Gender and power theory thus is a strong reality in the shaping of the lives of young women in SMEs.

Intervention strategies relevant to vulnerable young women infected or affected by HIV and AIDS who are currently employed in SMEs, as captured in the narratives, are discussed in this chapter. Implicit in this is the observation that SMEs would want to stick to their core business and would as much as possible want to follow all legal requirements. Anything outside this scope is paid lip service or elicits a partial response from SMEs. Whilst applauding what SMEs have to offer in terms of assistance, young women as a progressive group have refused to remain passive but have clung onto the conviction that young women's health is not, and should never be, dependent on someone else other than oneself. While taking charge and control of ones' own health requirements is an overarching idea for young women in the narratives, there was also some evidence that young women still applaud SMEs that partially respond to the

epidemic. This is highlighted along with the view that young women should not be viewed as subjects who can dance according to the SMEs' tune but they can also act as agents of change with or without the response of SMEs to HIV and AIDS. Throughout this analysis, the researcher made cross reference to relevant theory and literature where appropriate.

### **6.1 Theory of gender and power**

The findings exposed gender and power aspects through the lens of HIV and AIDS in the studied SMEs. Although gender and power relations have remained part of the daily rhetoric in modern KwaZulu-Natal, this research found out that this has not triggered HIV and AIDS policies and programmes that recognise young women's unique health needs in the studied SMEs. Whilst HIV and AIDS provide a different way of addressing gender and power problems in KwaZulu-Natal, it is distressing to note that most narratives captured under this theme reported limited or non-existent HIV policies and programmes in the studied SMEs. The studied SMEs have paid less attention to the importance of promoting young women's health. They failed to influence change on the patriarchal norms that continue to hold young women in positions of inequality, powerlessness and subordination. An analysis of the narratives reveals how gender inequalities have fuelled the epidemic. It also reveals the complex nature of gender and power theory by highlighting the multiple and intersecting levels of sexual, cultural and economic inequality that structure the HIV and AIDS vulnerability of young women working in the studied SMEs. Available literature shows that where a comprehensive HIV policy or programme is available, the vulnerability of employees to HIV infections is reduced, the adverse impacts of HIV and AIDS are mitigated, and stigma and discrimination against employees infected and affected by HIV and AIDS is lessened (IFC and GBC, 2008).

### **6.2 Intervention strategies in SMEs**

Gender influences the effects of HIV and AIDS prognosis and treatment medically and socially for young women. Young women face a number of barriers to HIV prevention, testing and counseling. These include embarrassment, fear of rejection and stigma,

partner's objection to testing, and lack of access to financial resources, reliable, accessible information, time and transportation. These obstacles deter young women from taking preventive measures, accurately assessing their own risks and from seeking early diagnosis and treatment for HIV. Additionally, stereotypes associated with high-risk groups, in particular young women, contribute to blaming young women for the spread of HIV. As such this can explain the interviewees' assertions that one SME attempted to facilitate or provide HIV and AIDS counselling and testing but the uptake was very low.

Voluntary HIV testing and counselling should be part of the HIV response for young women (Institute for futures research, 2011). Narratives from young women reveal that counseling and testing is available at public hospitals only. Knowing ones' HIV status is a crucial step in managing the disease. In fact, HIV counselling and testing is considered to be a bridge between prevention and care that allows HIV positive individuals to gain access to a continuum of care that may include proactive prevention of opportunistic infections, access to information and supplements and anti-retroviral therapy. Testing also provides an opportunity to reinforce prevention messages, whether individuals test positive or not. By providing access to HIV testing services, an SME can encourage employees to take charge of their health (IFC against AIDS and SABCOHA, 2011). ILO (2007) reiterated that workers make up a distinct audience for HIV counselling and testing. An overview of the main literature review does suggest that change is possible through counselling for young women working in SMEs. Open Society Institute (2010) detailed STI counselling, diagnosis and treatment as important access points for women at high risk of HIV infection, particularly in the early stages of the epidemic.

In promoting HIV and AIDS policies or programmes acceptance, peer education could be very effective in SME settings. ILO (2007) outlined that SMEs are communities - places where people congregate, discuss and learn from each other. The Open Society Institute (2010) mentioned that peer education could increase protective behaviours. IFC (2011) reveals that HIV and AIDS programmes and policies need to incorporate

peers in order to have a positive influence on young women's lives. ILO (2007) hailed peer education as one of the most effective ways of inspiring behaviour change and conducting HIV and AIDS education in the workplace. Peer education is based on the idea that individuals are most likely to change their behaviour if people they know and trust persuade them to do so. It helps break barriers by allowing people to discuss sensitive matters without fear. Narrative number three on theme 3 captures how young women have organised themselves against powerlessness. They recognised the role of the individual in bringing change. The research found out that young women are not helpless victims but active participants in the search to protect themselves sexually. In fact, unknown to the SMEs concerned they act as peer educators.

Whereas interviewees saw the introduction of peer educators, an HIV officer and policies and programmes in SMEs as important, none of the interviewees experienced it happening in the SMEs under study. However, there seems to be a contradiction on young women's assertions. They claim that there was low uptake of services when the employer attempted to provide them. At the same time, they grieve that they need policies or programmes, an HIV Officer or peer educator in the SMEs. No theory or literature seems to support this contradiction. The differences in the periods might have caused this contradiction. In this instance, they refused to participate three years ago. Since then, a lot has happened in the advancement of HIV issues. HIV and AIDS knowledge seems to have increased substantially hence, they now recognise they made a mistake of not participating in the services.

The young women's contradicting assertions can also be explained by managements' own actions. In a social environment where gender is an unmistakable hallmark of every decision, an impression may have been created that management do not want to be associated with HIV and AIDS matters especially those pertaining to young women. Whilst they need the services, they might still not trust the employer. An overview of the narratives shows that a lack of open communication and management support led young women to suspect sinister motives on the part of the employers when they attempted to initiate HIV programmes or policies. Management support is essential. HIV

policies and programmes may fail to take off because the leaders fail to provide effective and open communication. Leadership is critical to the success of the programme. The HIV and AIDS response in an SME should be led and championed by senior management or it will not be taken seriously. Inclusive participation and transparent decision-making are key factors towards building trust. A major desired outcome of management support is the increased acceptance of the programme itself and the generation of opportunities for open dialogue both top-down and bottom-up.

If risk reduction associated with correct consistent condom use is about 90% (Trussel, Warner, & Hatcher, 1992) it makes sense that promotion of condoms should be a foremost mode of intervention. In the absence of an effective vaccine, use of condoms and complemented by voluntary counseling and testing (VTC) may have to remain important prevention efforts. The male latex condom is currently the only widely available form of contraception, which also protects against HIV and other STIs. The distribution of power between men and women, their ability to negotiate and their respect for one another's freedom will influence the supply and utilization of any protective technology. However, both men and women present challenges to the use of the male condom. Demotts (2008) have shown that both sexes associate intimacy and trust with unprotected sex, and may perceive the use of condoms as an accusation of infidelity. Insisting on the use of the condom may be interpreted as a challenge of male power and integrity, suggesting that he is not trusted or loved. Moreover, both men and women see the condom as interfering with their physical enjoyment of sex as well as their emotional rapport. In some cases, women opt to have unprotected sex in order to maintain a feeling of closeness with their partners. Prevention efforts, which rely solely on use of the male condom, are only partially effective, because women are not always free to negotiate condom use with their male partners.

Data from this research have shown that short term and intermittent relationships frequently involve exchange of sexual favours for shelter or some other economic security. With gender and power issues underlying these relations, sex is often unsafe. If women insist on safe sex, they risk losing economic support, a gamble that they might

not be prepared to take. Literature reviewed showed that partnership type strongly influences condom use, with condoms generally viewed as less acceptable or desirable in long-term partnerships based on love and trust but more acceptable in casual relationships. Various obstacles to condom use include negative beliefs about and attitudes toward condoms that are often grounded in gender and power issues. Some studies have found that young persons may also associate condom use with promiscuity and sexually transmitted infections, including HIV infection and AIDS. Despite comparable efficacy rates between male and female condoms and high acceptability levels, limited access to female condoms have limited uptake and use of female condoms and, thus, an opportunity to reduce the prevalence of HIV infection among women through a women-initiated method.

IFC against AIDS and SABCOHA (2011) supports the provision of condoms by SMEs by mentioning that an important element of any HIV and AIDS prevention program is a reliable supply of free, affordable and high quality condoms. Ensuring availability of condoms in the workplace addresses a primary limiting factor of their use, namely stigma or simple embarrassment associated with purchasing them. Condoms can be offered in SMEs' clinics or through self-service dispensers in bathrooms and clinic waiting rooms. Open Society Institute (2010) summarized what works for young women in HIV prevention and seems to agree with young women's assertions. The society noted that male and female condoms, partner reduction and treating STIs are all important components of prevention efforts. Prevention efforts are also strengthened by addressing gender norms, income and education.

All the young women (that is those in the sample) reported that the studied SMEs do not provide medical aid or treatment to their employees. They alluded that whenever they visited the clinic or hospital they bore a triple burden. Their employers require a letter from a medical practitioner and not from a clinic, thus they have to pay exorbitant consultation fees. Secondly, during the time they are away, they are not paid if their sick leave days have been exhausted. Thirdly, scheduled hospital visits for ARV collection or

other services invoke unfair comments from fellow workers and attracts stigma as they become sceptical about one's absence from work during a particular day of the month.

(UNAIDS (2010) noted that where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work. This explains the greater use of a contracted health provider (Med Clinic) by some of the SMEs as noted in the narratives. Whilst this circumvents the need for a permanently employed HIV officer, it also bare out the mistrust between the employer and young women that may lead to low uptake when HIV services are provided. However, the absence of an HIV officer in an SME clearly robs young women of an important resource for HIV and AIDS programmes. This could include assisting in monitoring and treatment of HIV-positive employees, identifying and counselling workers who showed symptoms that could be HIV-related, provision of VCT, and assistance in wellness.

Open Society Institute (2010) noted that providing medical services that are young women friendly, conveniently located, affordable and non-judgmental could increase the use of health services. IFC against AIDS and SABCOHA (2011) noted that the availability of health services through employment relations is an important factor in a context where access to health services is uneven across the population. There are studies suggesting that provision of health services does yield immediate financial benefits to SMEs when they extend it to their employees. Connelly and Rosen (2006) find that providing health services saves money for all categories of employees (managers, skilled workers, and unskilled workers) for a number of SMEs, although this may not hold for labor-intensive, low-technology industries where the costs of labor attrition are relatively low.

A majority of the companies in Africa have recognized that productivity can be affected when workers have to become caregivers for ill relatives (GBC, 2008). Most of the international companies in the GBC survey ensured that their workers have access to

HIV treatment via health insurance, cost sharing or other mechanisms. The majority of African companies in the same survey provided treatment and these companies extended their programmes to include treatment for spouses and all registered dependents. Companies in Africa have said that they cannot afford not to provide treatment for HIV. One company in the GBC survey found that most of their employees on ARV's are able to carry on working normally. In addition, they found that in the short-term, the costs of ARV are more than covered by savings achieved through a reduction in absenteeism, the reduction in healthcare costs and retention of skilled staff, as well as improved productivity (GBC, 2008). Therefore provision of medical aid saves SMEs money.

Most tellingly, however, as has been demonstrated in the data, is that at least some of the women in the sample were engaging in either short-term or long term sexual exchange partnerships with men in which sexual exploitation was absent. The researcher argues that the practice of sexual relations between young women and older men, a common pattern of sexual networking in the area under study, may increase the risk of HIV infection among young women. The reason for this is that male partners are most likely to already be HIV infected or may engage in concurrent or multiple partnership patterns that increase their own and their partners' risk of HIV infection. Such sexual conduct is an important contributing factor to the higher prevalence of HIV infection among young adult women UNAIDS (2010). Young persons with multiple or concurrent sex partners are also known to have an increased risk of HIV infection, although sex and other factors strongly influence this association. The narratives tell a story of concurrent sexual relations by young women. The researcher reiterates that it is important to appreciate the critical importance of how gendered income levels influence risk of HIV infection, particularly the role of sex and how it impacts HIV acquisition in women. Because of the social and economic constraints that limit young women's access to resources in the area under study, sex becomes a commodity to ensure survival. In such a context, the definition of sex work becomes wide open, because

there are many transactions that it can encompass, which may include sporadic or occasional exchange of sex for transportation, money and accommodation.

To expose the phenomena of HIV and AIDS in SMEs, narratives revealed how young women in SMEs become victims of power imbalances, and as a result, they become infected by HIV. Interviewees mentioned that because young women earn little, they would love to boost their income through sexual relationships with men. They added that young women are not prepared to say no to men due to unequal power relations even if they are aware about the undesirable consequences of HIV infections. Young women's low income causes low self-efficacy and lack of power and control in intimate relationships, contributing to them being less likely to negotiate safer sex with their partners. The findings strengthen the applicability of the theoretical framework of gender and power. The perceived lack of sexual and decision-making powers in women's intimate relationship is constraining because it decreases the likelihood of consistent condom use and increases young women's risk of becoming infected with HIV. Managers' perceptions clearly reflected gender power imbalances, which are similar to the findings by several other researchers. Diclemente and Wingood (1997) suggested that gender power imbalances constrain women in negotiating safer sex.

The researcher will argue that young women's reputation, as proper and reproductive women must be secured if their status within the community is to be maintained. To date, there is no method for women to protect themselves from HIV if they desire to have a child. Because of the powerful cultural values attached to "womanhood", HIV risk is only one factor that women have to weigh when engaging in sexual behaviour. Indeed, young women are continually making trade-offs between HIV risk and their social status (derived from culture).

Gendered income inequality combined with cultural norms that make it difficult for young women to resist sexual advances of older men, deepen young women's vulnerability. Whilst sexual harassment was forbidden in two SMEs' through normal laws that govern the work environment, its confirmed presence in one SME was a tip of the ice-berg. It

shows that in the absence of a policy on sexual harassment, SMEs can be a potential haven of sexual harassment that can increase young women's vulnerability to HIV and AIDS. Young women's assertions also validate Sprague's (2008) assertion that in the context of poverty, women regard money as the driving force for relationship formation. For example, in one narrative a male was trying to use his financial muscle to lure young women into a sexual relationship with him. It can be concluded that scarcity of resources might fuel risky behaviour that exposes women to HIV infection.

### **6.3 Limited services provided by SMEs**

As alluded in the narratives, HIV and AIDS is a leading cause of death in South Africa and presents an additional burden to the affected families with the strain on family members that cares for these individuals and the drain on family finances due to health care expenses and /or burial expenses. HIV and AIDS causes great long term damage to families because the disease diverts resources to healthcare and often robs children of a proper education. There is a ripple effect from the individual to firstly, households, secondly businesses and communities and lastly, the welfare system.

Narratives acknowledged provision of resources for funerals in two of the SMEs. Although theory and reviewed literature does not that support this notion, this was interpreted to reveal the employers' acknowledgement of the impact of HIV and AIDS and deaths, or the employers' apprehension about lack of affordability of funerals due to workers low income, hence they will be helped a great deal if the employer provides assistance for funerals. This could have been a reaction to their experiences over the years of noticing workers die without adequate funeral cover. Most likely, requests for transport were overwhelming in an area where hiring for funerals is prohibitively expensive. As a consequence, the SMEs had to balance the use of their vehicles for work with funeral needs when the request comes from a worker, to whom they could not say no.

Antiretroviral therapy (ART) has greatly reduced HIV and AIDS-related mortality and morbidity in industrialized countries (Baggaley, Garnett & Ferguson 2006). Narratives

from interviewees revealed that employers allow young to collect their ARVs from public hospitals during working hours. Because it reduces a patient's viral load, it is also believed to reduce infectiousness, and so has been suggested as a prevention tool in its own right, as well as a treatment. In order to maximize the benefit of ART to young women, sick employees are allowed to take time off and recover before coming back to work. This could be an important response from SMEs. Literature reviewed confirms that a higher number of women receiving treatment may be due to greater access to HIV screening and care through antenatal services, as well as a difference in health seeking behaviour (ASSA, 2008). This reveals a new dimension of gendered access to health which favours women.

#### **6.4 Expectations of young women in respect of SMEs' responses to HIV and AIDS**

Interviewees added a voice on what they expected from SMEs. Gender and power literature defines power as the ability to act so that change happens in a desired direction. If one person has power over another it means that the "other" will be powerless (Connell, 1987). For example, because of many societal expectations that men have control over women in all aspects of relationships, women become powerless. The researcher argues that male power involves decision-making on when and how women will have sexual relations, and on when and how many children women will have. This type of male power is condoned by tradition and social norms. They mentioned that they see it as the responsibility of SMEs to teach and empower young women who are positive to look after themselves, live a positive life, practice safe sex and help those who are negative to stay negative. However, there appears to be a point of contradiction. Whilst they see it as the responsibility of SMEs to empower young women, it is the same young women who refused to participate when attempts to provide policies and programmes were made in one of the SMEs. In fact they refused to be empowered. Open Society Institute (2010) accepted that comprehensive HIV programs include components such as peer education, medical services and support groups which are all a form of empowerment. The assertions complement suggestions given by young women.

An understanding of how gender issues affect young women in their daily lives, particularly in the workplace, is essential in designing an appropriate and effective plan to manage HIV and AIDS (IFC against AIDS and SABCOHA, 2011). A starting point is to appreciate the gender-differentiated vulnerabilities and risks that the results of this research have highlighted. These include traditional norms of femininity and masculinity, physical vulnerabilities of young women, societal notions and certain risk behaviours such as multiple partners. Introducing activities that can tackle gender disparities and bias can help mitigate the increasing bias of HIV toward women (IFC against AIDS and SABCOHA, 2011). SMEs can target efforts to ensure non-discriminatory practices and equitable access to legal, medical and social benefits and services (IFC against AIDS and SABCOHA, 2011).

### **6.5 Factors hindering or promoting SME responses to HIV and AIDS**

Bureau for Economic Research (2005) says that HIV and AIDS has been recognized as a major challenge by large companies in South Africa and this is evident from the large number of companies who have formal HIV and AIDS policies. SMEs play an increasingly important role in the South African economy. Given this significance, SMEs are well placed to help young women through the implementation of HIV and AIDS policies and programmes. Narratives captures why SMEs are responding in the manner they are. For these SMEs, considerations of the impact on financial and operational costs are some of the factors that are driving their actions. (Whiteside & Sunter, 2000) noted that while large companies may have the resources to manage the impact of HIV and AIDS on their workforces, the SMEs generally lack such resources, making them act in the manner they are.

Dickson (2004) supports the assertion by interviewees that for SMEs who have not instigated policies, it is because it is cheaper to replace labour than to implement policy. The researcher will argue that SMEs feel that they are less important than large organizations, and they should learn from larger organizations. The phenomenon appears to be true within the studied SMEs. However an unacceptable explanation from literature for the actions of SMEs is that the SME workplace is not associated with high-

risk behaviours that lead to the transmission of HIV. Thus according to literature reviewed, little attention has been given in explaining the behavioural intention of SMEs in implementing an HIV and AIDS policy and programme in the workplace.

Some interviewees raised the theme that employees are not interested. Participants spoke about attempts by some SMEs to introduce HIV and AIDS programmes and employees' refusal to partake in those activities. The key theme coming out of this divergent view is that of denial, which links back to stigma. Hawarden's (2007) study on SMEs supports this, indicating that employees generally fear the process of HIV testing and the results. From the interviewee's responses, sources of stigma included fear of illness, fear of contagion, and fear of death. Fear of illness and fear of contagion was a common assertion amongst interviewees. The participants noted that stigma is one means of coping with the fear that contact with a member of an affected group will result in contracting the disease. The way in which individuals discover and disclose their HIV status to others, as well as how they cope with their HIV status, was found to be influenced by cultural and community beliefs and values regarding causes of illness, learned patterns of response to illness, social and economic contexts, and social norms. However, whatever the form of stigmatization, it inflicted suffering on young women and interfered with attempts to respond to the AIDS epidemic in SMEs.

## **6.6 Impact of HIV and AIDS on SMEs**

Narratives on the causes of sickness among employees indicate a perceived higher prevalence of HIV and AIDS. Parallel with this result, Hawarden (2007) reports that on average 75% of adult AIDS-related illnesses are pronounced as due to TB and lower respiratory infections. Thus, while the impact of HIV and AIDS may not be obvious, the prevalence of AIDS-related illnesses confirms that there is an impact of HIV and AIDS on the SMEs under review. The increasing visibility of HIV and AIDS – notably in the deaths of employees – appears to be bringing about significant changes in the responses of all three SMEs. As described in the previous chapter, a new method of response in the form of provision of funeral assistance was being implemented. Prior to this, activity around HIV and AIDS had been too limited.

Although HIV and AIDS were not credited with being solely responsible for the bulk of absenteeism, it was recognized that the disease was particularly taxing in this regard. The results confirm that young women absent themselves from SMEs due to HIV and AIDS or related illnesses. Young women absent themselves from work in order to have adequate time to nurse themselves whilst sick, to collect medication or put simply due to illness. Whilst it is uncertain whether all of this is attributable to HIV and AIDS, the majority of interviewees supported that this was the case although they added other issues too. However, within an increasingly competitive economy requiring higher levels of productivity and 'leaner' operations, any factor adding to absenteeism is a problem (BER, 2005). A number of narratives outlined a now familiar absence pattern, in which individuals would take increasing amounts of leave, exhaust sickness leave and eventually die of AIDS-related illness. This is disruptive to production.

All three SMEs found absenteeism to be a problem. These SMEs relied less on substitutable low-skilled labour, which could be easily and quickly drawn from the unemployed waiting outside the factory gates in the hope of casual employment. For these SMEs, absenteeism was a major problem, despite the fact that one of them offered a flexible scheme for collection of medication from hospital. Faulk and Usunier (2009) who attribute increased absenteeism and funeral costs to HIV and AIDS, further support this. One study in South Africa found that workers with AIDS take over 27 more sick days than an average worker (Dickinson, 2005).

Narratives captured higher attrition rates of employees at the three SMEs under review. A number of employees have been absent from the SMEs either on medical grounds or due to death in service. Management advised that of those cases, some were due to HIV and AIDS. Some cases were due to TB, pneumonia and respiratory problems. As all of these illnesses are closely linked to HIV and AIDS (Hawarden, 2007) and due to stigma surrounding HIV and AIDS, AIDS is not often stated as a cause of death. The researcher experienced a problem as to whether cause of death was directly related to HIV and AIDS or not as these assertions were based on interviewee's judgments and perceptions. Nevertheless, it can in all likelihood be concluded that the attrition rate due

to HIV and AIDS appears to have increased and appears to be rising all the time, illustrating the impact the epidemic is having on organizations.

In conclusion, the above findings corroborate that the data obtained validates the literature from several sources, which asserts that SMEs do experience the impact of HIV and AIDS. Studied SMEs in KwaZulu-Natal are experiencing the impact of the epidemic in the following ways:

- an increase in the number of AIDS-related sicknesses
- an increase in absenteeism levels and rates of attrition
- indirect or to a lesser degree direct costs being experienced
- growing awareness by both management and young women of HIV infection rates

## **6.7 Summary**

The research established that none of the SME manufacturers has responded to the epidemic by implementing complete HIV and AIDS policies in their companies. This assertion is also confirmed by the Bureau for Economic Research (2005) which established that none of the SMEs surveyed has implemented policies. The data gleaned from this research established that two out of three of SMEs are providing limited service. The data shows that some of the SMEs are providing condoms and funeral assistance. These findings do not support the literature reviewed which stated that services being provided were usually limited to education and awareness.

The provision of employee benefits is another area illustrating how firms are responding to the HIV and AIDS epidemic. The majority of young women report that none of the SMEs is providing medical aid membership for employees, a result which does not support the reviewed literature. Thus, the provision of medical benefits is not a conclusive tool to determine how SME manufacturers are responding to the epidemic.

The above discussion has thus confirmed that studied SMEs are not responding to the epidemic or are responding by providing a limited HIV and AIDS response, which is not ideal.

## **CHAPTER SEVEN**

### **CONCLUSION**

Chapter 7 consolidates the findings of the research, offers recommendations for the stakeholders involved and then put forward future research ideas emerging from the present undertaking.

#### **7.1 Introduction**

When scrutinising the findings of each of the four research questions and then addressing them as a whole by pulling themes together, it appears there is a difference between impact and response. There appears to be synchronicity between SME management and young women in their suggestions for similar intervention strategies. However, there is no harmony between the impact of the disease on SMEs and how SMEs are responding. With regards to policies and programmes on HIV and AIDS in SMEs narratives show that none of the SMEs had implemented a complete policy or programme. Earlier studies by Hawarden (2007) and Dickson (2004) resonate the same limited response to HIV and AIDS by SMEs. Surprisingly, this study's narratives do point out that where SMEs took an initiative to respond the young women themselves were not eager to partake in the policies or programmes.

One of the objectives was to have a deeper understanding of the impact of HIV and AIDS on SMEs in KwaZulu-Natal. The narratives revealed that HIV and AIDS was most likely causing absenteeism and deaths in SMEs. However, it was brought to the fore that those that were sick would not state the precise cause of their illness due to fear of stigma associated with the disease. The same reason of stigma or a reason of gaps between management and workers in terms of race, class and gender may not be overlooked as reasons why young women did not want to play a part where a programme or something similar has been initiated or offered. A full understanding of young women's experiences of the SME response to HIV and AIDS therefore becomes complex and requires further dissection.

## **7.2 Limitations**

### **7.2.1 Study site**

The study site was restricted to a specific industrial area namely Mkondeni in Pietermaritzburg. The results in this study can therefore not be fully representative of all KwaZulu-Natal SMEs nor of other SMEs in the country or elsewhere.

### **7.2.2 Gender**

Most of the research participants were young women. Men were not part of the study and the interpretation of these findings should be limited to young women. The researcher has included only young women working in SMEs.

### **7.2.3 The Sample size**

The sample size was small, as only fifteen young women and six managers were interviewed. Low recruitment rates are well-reported disadvantages of qualitative research. The study deeply relied on data from in-depth interviews. The selected sample could only represent a limited number of the total population of SME population in KwaZulu-Natal. This implies that the findings of this study should be interpreted with caution, because the general SME population was not fully represented.

## **7.3 HIV and AIDS and access to health**

The division of health provision is even sharper, as better paid employees (who are predominantly male) are members of medical aid schemes, while lower paid employees can generally not afford to be in a medical aid scheme and rely on limited primary health care offered through the public sector health care system. This research exposed this gender-based income difference in access to health.

## **7.4 Recommendations for SMEs**

As with any serious medical condition, it is important to outline the principles that an SME needs to follow towards employees who are infected with HIV. An official AIDS policy informs employees of their rights and responsibilities, articulates company management commitment, clarifies company obligations and in certain cases protects

companies from liability. The HIV and AIDS policy is the first document that is used internally to brief people on HIV and AIDS matters. Creation and implementation of such a policy should be the first step that SMEs should take.

Dedicating a budget for the implementation of an HIV and AIDS programme will be a good investment in the end. SMEs operate in diverse environments and need to consider the various subsets of populations they draw their workforce from, including women. An understanding of how gender issues affect people's daily lives, particularly in the workplace, is essential in designing an appropriate action plan to manage HIV and AIDS. A starting point is to appreciate the gendered differences to vulnerability to HIV and AIDS. These include the traditional norms that affect femininity and masculinity, greater physiological vulnerabilities, violence against women and other issues.

SMEs can be powerful role players in this endeavour because of their access to young women and proximity to communities. Insights gained from this study underline the proposal that SMEs consider the following recommendations:

**(i) Prevention**

Workplace initiatives on prevention can focus on information dissemination, education, promotion, and distribution of condoms. Information can be disseminated through posters, printed material and drama, and workplace prevention programs making use of peer education and voluntary counselling and testing. It is generally accepted that HIV and AIDS awareness can increase because of workplace HIV and AIDS prevention programs. In the area of behaviour change, however, prevention programs may bear fruit.

**(ii) Treatment and Care**

The issue of treatment is critical for the management and control of HIV and AIDS at the workplace. Whilst there is no law that compels SMEs to provide health care to their employees or assist them to access health care, SMEs may, however, be encouraged to do so. Providing health care to employees makes it easier to treat and control opportunistic infections. Contracting a medical doctor to provide health care to workers free of charge may help. A supportive work environment includes appropriate health

benefits package, which can help SMEs see reduced employee turnover and increased respect from employees.

The provision of anti-retroviral drugs is an important component of the treatment and care component. Whilst the government is able to provide free anti-retroviral drugs, SMEs may assist their workers to access anti-retroviral drugs through allowing them time off or leave.

### **(iii) Compensation**

The issue of compensation in the context of HIV and AIDS is critical for the wellbeing of workers and their families. Thus, recommendations are made that workers who contract the disease in the course of their duties be considered for compensation.

## **7.5 Future research ideas**

A major factor emerging from this research is that while SMEs are experiencing the direct impact of the epidemic, they are not responding specifically to the needs of young women. While this research has focussed on young women, it has also included management in their providing answers to the research questions. A possible future research option would be to design research that would get responses only from young women, without including their managers.

A second possible research alternative would be to identify the components of a cost benefit analysis so that SME organizations can determine the significance of responding or not.

Finally, a third alternative would be to examine and write case studies of best practices around South African SMEs' responses to the HIV and AIDS crisis.

## **7.6 Summary**

This chapter consolidated the findings of the research; offered recommendations and then put forward future research ideas emerging from the present undertaking. The

limitations of the study, suggestions for future research as well as recommendations for policies and practices were discussed. In this study it was argued that power imbalances have existed for decades, and have been perpetuated and sustained by the belief that men should have power and control over women. Literature review and narratives from participants reported gendered income inequality combined with cultural norms that put young women at increased risk to HIV infection in their intimate relationships. In an attempt to successfully address the problems of gendered inequality the researcher advocated for community and societal transformations which challenge cultures that condone male dominant norms of gender relations. However in conclusion, the researcher would like to end this dissertation with remarks made by the United Nations former Secretary-General Mr. Kofi Annan who stated that empowerment of young women must be made a priority focus area for HIV prevention ... (UNAIDS, 2005).

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## APPENDICES

### APPENDIX 1

#### INTERVIEW GUIDE FOR MANAGEMENT

### APPENDIX 2

#### INTERVIEW GUIDE FOR YOUNG WOMEN

## **APPENDIX 1 INTERVIEW GUIDE FOR MANAGEMENT**

### **CONSENT FORM**

Good day, my name is Pheyiye Mapungwana and I am studying for a Masters of Arts in Social Behaviour Studies in HIV and AIDS degree in the Department of Sociology at UNISA. Young women are particularly vulnerable to HIV and AIDS. I am conducting a study on young women workers' experiences of the response of Small and Medium Enterprises to HIV and AIDS in KwaZulu-Natal. I am interviewing management in order to develop a deeper understanding of the impact of HIV and AIDS on small and medium enterprises and how they are responding to HIV and AIDS from a management perspective. As part of management in an SME, I would like to interview you in order to hear your ideas, feelings and thoughts on this topic.

Participation in the study is voluntary and the choice of whether to participate or not is yours alone. There are no repercussions for you should you decide not to take part in the study. If you do agree to participate, you may stop the interview at any time with no penalties and you will not be prejudiced in any way.

The interview will last between 60 – 70 minutes. I will ask questions and request that you answer them as openly and honestly as possible. There is no right or wrong answer; I am interested in your personal experiences and understanding.

The interviews are anonymous and your name will not be linked to your responses. As the researcher, I am the only person who will have access to your identity and I am governed by a code of ethics and thus professionally obliged to protect your identity. I may approach you with some follow up questions after the interview to seek clarity or to enhance my understanding on the topic only.

I want to ask your permission to record our conversation by using this audio tape recorder. It will assist me in recording our conversation so that I can refer to it once we are finished. The tapes will also be treated with utmost confidentiality and kept under lock and key. Once the research is completed, they will be destroyed. Please can I confirm your willingness to participate? I request you to speak loudly and clearly so that the recorder will easily capture your voice. If you have any further inquiries, do not hesitate to contact me.

Pheyiye Mapungwana Cell phone number 0715826181

## **CONSENT FORM**

I hereby agree to participate in a research study regarding young women workers' experiences of the response of Small and Medium enterprises to HIV and AIDS in KwaZulu-Natal. I understand that I am participating freely and without being coerced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project whose purpose is not necessarily to benefit me personally. I understand that this information will be treated with utmost confidentiality and I will be kept anonymous unless I provide written consent. I understand the consent form will not be linked to the questions.

Signature of Participant .....Date.....

## **INTERVIEW GUIDE**

All information will remain confidential.

- 1 Tell me about yourself?
- 2 Will you tell me more about your work-place and the work force composition?
- 3 What you think are the causes of HIV infections amongst female employees?
- 4 Compared to previous years, please tell me about changes in the level of absenteeism amongst employees if there are any? What do you think the cause could be?
- 5 Have you ever come across workers who have retired on medical grounds or due to ill- health? What do you think has been the cause of ill-heath retirement?
- 6 Are you aware of any AIDS-related death in the company?
- 7 What do you think HIV and AIDS has affected at your workplace?
- 8 How would you find the current impact of HIV and AIDS on your company?
- 9 What measures has your company taken to respond to HIV and AIDS?
- 10 What sort of medical assistance or programmes does your company provide for its employees?
- 11 Why do you think your business has implemented or not implemented an HIV policy or programme?

12 Is there anything else you would like to tell me about HIV and AIDS in general at your workplace?

## **APPENDIX 2 INTERVIEW GUIDE FOR YOUNG WOMEN.**

### **CONSENT FORM**

Good day, my name is Pheyiye Mapungwana and I am studying for a Masters of Arts in Social Behaviour Studies in HIV and AIDS degree in the Department of Sociology at UNISA. Young women are particularly vulnerable to HIV and AIDS. I am conducting a study on young women workers' experiences of the response of small and medium enterprises to HIV and AIDS in KwaZulu-Natal. I am interviewing young women (18-30 years old) who work in small to medium enterprises, and the management, about their understanding and experiences of workplace programmes and policy on HIV and AIDS. As a young women working in an SME, I would like to interview you in order to understand your experiences, ideas, feelings and thoughts on this topic.

Participation in the study is voluntary and the choice of whether to participate or not is yours alone. There are no repercussions for you should you decide not to take part in the study. If you do agree to participate, you may stop the interview at any time with no penalties and you will not be prejudiced in any way.

The interview will last between 60 to 70 minutes. I will ask questions and request that you answer them as openly and honestly as possible. Some questions may be of a personal and/or sensitive nature. You may indicate if they make you uncomfortable and you may choose not to answer them. There is no right or wrong answer; I am interested in your personal experiences and understanding.

The interviews are anonymous and your name will not be linked to your responses. As the researcher, I am the only person who will have access to your identity and I am governed by a code of ethics, and thus I am professionally obliged to protect your identity. I may approach you with some follow up questions after the interview to seek clarity or to enhance my understanding on the topic only.

I want to ask your permission to record our conversation by using this audio tape recorder. It will assist me in recording our conversation so that I can refer to it once we are finished. The tapes will be treated with utmost confidentiality, and will be kept under lock and key. Once the research is completed, they will be destroyed. Please can I confirm your willingness to participate? I request you to speak loudly and clearly so that

the recorder will easily capture your voice. If you have any further inquiries, do not hesitate to contact me.

Pheyiye Mapungwana Cell phone number 0715826181

### **CONSENT FORM**

I hereby agree to participate in a research study regarding young women workers' experiences of the response of Small and Medium enterprises to HIV and AIDS in KwaZulu-Natal. I understand that I am participating freely and without being coerced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not affect me negatively in any way. I understand that this is a research project whose purpose is not necessarily to benefit me personally. I understand that this information will be treated with utmost confidentiality and I will be kept anonymous unless I provide written consent. I understand the consent form will not be linked to the questions.

Signature of Participant .....Date.....

### **INTERVIEW GUIDE**

All information will remain confidential.

#### **SECTION 1**

##### **Personal information**

1 Tell me about yourself?

##### **Experiences of workplace policies and programmes**

2 Tell me about your company's general involvement in HIV and AIDS policies and programmes.

3 What accomplishments are you particularly proud of that your company has been doing to protect workers like yourself from being infected with HIV and AIDS?

4 Will you be able to tell me in general what the procedure is at your workplace when one is sick of an HIV and AIDS related illness or needs to collect medication from hospital?

- 5 What is the current scenario and the most ideal scenario in terms of medical aid membership provision by your employer for you and other workmates?
- 6 Where and how often do you access peer educators, lay counsellors or forums that promote exchange of HIV and AIDS information with others?
- 7 Tell me about your concerns about sexual exploitation and harassment at work if any?
- 8 According to your experience, who provides assistance (either financial or transport) when there is a funeral of a fellow worker and what is your opinion on the adequacy of this provision?
- 9 Could you tell me the reasons as to why your employer does have or does not have an HIV policy or programme?
- 10 Is there anything else you would like to tell me about HIV and AIDS in general at your workplace?
- 11 What do you think a company like yours can do for young women living with HIV? What can they do for women who are HIV negative?