AN INVESTIGATION OF THE IMPACT OF HIV/AIDS ON SMALL BUSINESS IN THE VAAL REGION

by

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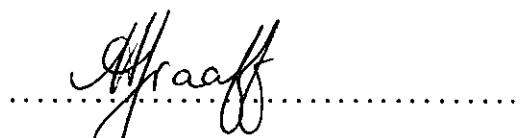

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DECLARATION

I declare that:

"AN INVESTIGATION OF THE IMPACT OF HIV/AIDS ON SMALL BUSINESS IN THE VAAL REGION"

Is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this thesis was not previously submitted by me for a degree at another university.

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T. D. MNGOMEZULU

October 2002

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EXECUTIVE SUMMARY

One of the dangerous things about HIV/AIDS is that people do not want to know about it. It is a frightening disease for which there is no vaccine and no cure. It is also sex-related and therefore treated with embarrassment by many people.

Many of us are scared by what is happening. Family members, relatives, friends and work mates are falling ill and dying, often when they are quite young. Husbands, wives and infants are being struck down. People do not like to talk about the cause of death. It seems mysterious and shameful (Asmal, in Jewkes, 1999).

Today it is common to hear about employers who require job applicants to prove that they are not HIV-positive before offering them work.

Some business privately acknowledged the likely long-term effects of HIV/AIDS were one reason for the trend away from labour – intensive processes and towards increased mechanisation and higher capital investment. Unfortunately even production processes dominated by robotics can not entirely remove the human factors. People are needed to maintain, repair and re-programme the robots.

Many employers and employees have already been significantly influenced by the impact of the HIV-positive condition of an employee or full-blown AIDS. This is hardly surprising, given the ever-growing number of HIV-infection (Healy, 1999).

The workplace is precisely an arena where education and awareness programmes can be beneficial. Employers can contribute to employee education by providing training and educational programmes, which focus on awareness and prevention.

The main objective of this research was to identify the business activities and procedures used to deal with the impact of HIV/AIDS on Small Business. Previous studies has shown that the number of people in Small Businesses who have AIDS or are infected with HIV, is increasing steadily (Myslik, 2001). HIV/AIDS is seen by many businesses as such an overwhelming issue that they take the easy way out by ignoring it, or giving it minimal attention.

The thesis is divided into three main sections. Firstly, a literature study of the subject is undertaken. Secondly, an empirical study is conducted by means of data collected from Small Businesses in the Vaal Region. The data is analysed and reported on. Thirdly, a number of conclusions are drawn from the analysis of the data and a number of recommendations are made.

This thesis serves as an introduction on investigating the impact of HIV/AIDS on Small Business in the Vaal Region and further research in this field, using this study as a basis, is recommended.

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CHAPTER 1

OBJECTIVES AND SCOPE OF THE STUDY

Chapter 1 is an introduction to the whole thesis. Discussion in this chapter is focused on matters such as the reasons of the study, objectives, demarcation of the field of study, research methodology, hypotheses and contents of the study.

1.1 INTRODUCTION

Chilling news from an AIDS-survey is that Vaal Region AIDS figures appear to be higher than the national average. That is the conclusion drawn from an anonymous AIDS-survey of the Vaal Region, which had grim results, in spite of being confined to antenatal clinics, and clinics in which sexually transmitted diseases (STDs) are treated (Sebakela, 2001).

One of the dangerous things about HIV/AIDS is that people do not want to know about it. It is a frightening disease for which there is no vaccine and no cure. It is also sex-related and therefore treated with embarrassment by many people.

Many employers and employees have already been significantly influenced by the impact of the HIV-positive condition of an employee or full-blown AIDS. This is hardly surprising, given the ever-growing number of HIV-infections.

It has been estimated that there are in the region of 3,6 million HIV-positive South Africans, of which 90 percent are unaware of such

infections (Healy, 1999). It follows that this has the potential to have a very major negative impact on South African society at large, including the workplace.

Many of us are scared by what is happening. Family members, relatives, friends and colleagues are falling ill and dying, often when they are quite young. Husbands, wives and infants are being struck down. People do not like to talk about the cause of death. It seems mysterious and shameful as stated by Asmal (Jewkes, 1999).

The term HIV/AIDS would not have been found in any medical dictionary and would certainly have caused blank looks on the faces of health workers and development economists. Today the epidemic is one of the most serious problems facing Southern Africa. Although the disease has to be seen in context, given these is much health and other problems facing the countries of the region, there are characteristics, which make it unique. Firstly it is far more than a health problem and secondly, the region is woefully unprepared for the consequences of the epidemic (Whiteside, 1998:13).

The advent of HIV/AIDS forces reappraisal: There is barely a field of science or care provision that will not be touched and will not be changed in the process. Just as the individual has to work through mixed reactions to the discovery of HIV-status, so the scientific world, care providers and the general public must come to terms with the existence of the Human Immune Deficiency Virus and must also consider the various positive and negative impacts from the arrival of HIV. Not only is it incumbent upon us to undertake a fundamental re-examination of our attitudes and

behaviour regarding this disease and drug use, but we must also conduct these without the luxury of adequate time. The re-examination must be conducted against the background of a ticking clock and the changing dynamics of the HIV-epidemic (Strang, et al. 1990:3).

In this regard, Piot (2001) assert that it is a tale of globalisation: of the global spread of a predominantly sexually transmitted virus; of global inequities in health care services and of the need for a global response and solution. It is a tale that is still in its opening chapters.

According to Webb (1997:1) the emergence of the disease now known as Acquired Immune Deficiency Syndrome (AIDS) in the early 1980's coincided with a period of social transition in Southern Africa, characterised by rapid political and structural change. Why this disease has captured the attention of academics, politicians, business organisations and the general public at large is related to its potential for massive social and economic disturbance.

The Walala-Wasala (you snooze you lose) festival, which was held at Dickinson Park and organised by Gauteng Department of Health, was a success as many Kwaito lovers turned up. The aim of the festival was to raise funds for the HIV/AIDS programme. Most of the artists are associated with African Musicians Against HIV/AIDS (AMAHA) and have been performing at these kinds of festivals for several years (Sebakela, 2001).

Togni (1997:25) predicted that 5,2 million South Africans will be HIV-positive by the year 2000, with about 667 000 people having died of AIDS. Despite this horrendous possibility, life seems to move casually on in

South Africa, with most people thinking it will not happen to them. This is a regrettable attitude, for soon, if the transmission rate is not checked, a very large number of families will directly or indirectly be involved with someone who has the disease.

Togni (1997) further points out that the official AIDS story in South Africa began when two men said to be homosexuals, died of the disease. By December 1990, more than 600 cases of AIDS were reported. In the same year (1990) 270 AIDS-related deaths and 0,76 percent HIV among pregnant women were confirmed. Should the rates of infection continue, by the year 2005, about 7,5 million people in South Africa may be infected by the deadly HIV virus and 2,9 million may have died of the disease.

At the start of the new century, South Africa probably had the largest number of HIV-infected people of any country in the world. The only nation that comes close is India with a population of one billion people compared to our figure of 42 million. The tragedy is that this did not have to happen. South Africa was aware of the dangers posed by AIDS as early as 1985. In 1991, the national survey of women attending antenatal clinics found that only 0,8 percent were infected. In 1994, when the new government took power, the figure was still comparatively low at 7,6 percent. The 1999 figure, which has been published, was 22,4 percent (Whiteside, et al. 2000:1).

Thom (2000) points out that while the government made preparations to host the final meeting of President Mbeki's international AIDS panel, tasked with discussing the link between HIV/AIDS and anti-HIV-

therapies, UN-AIDS revealed that South Africa has the largest number of people with HIV/AIDS (4,2 million).

According to the report the effects of the epidemic are becoming increasingly visible in the hardest hit region, Sub-Sahara Africa, where HIV is now deadlier than war.

South Africa has the highest number of people living with AIDS. Eventually China and India will surpass South Africa, but the epidemic is only just starting there (Delate, 2001).

The reasons for this study are based on an investigation of the impact of HIV/AIDS on Small Business, because previous studies has shown that the number of people in Small Business who have AIDS or are infected with HIV, is increasing steadily (Myslik, 2001).

Hunan trauma, clearly one of the many consequences of HIV/AIDS, also brings severely negative consequences to the workplace. The negative impact, which occurs within organisations, present employers with increased labour turnover, reduced productivity and heightened absenteeism. In addition, increased strain is put on the cost associated with employee benefits (Healy, 1999).

How to effectively deal with employees affected by HIV/AIDS is a topic seldom discussed in work situation. Yet, with the rapidly increasing number of affected workers, it is imperative that managers in Small Businesses learn how to deal with the challenges of HIV/AIDS in the work situation.

According to Kohl, et al. (1997) managers, in particular, must be prepared to deal effectively with workers who have AIDS or HIV. The managers need to know how HIV is transmitted, stages of the disease, how to prevent discrimination against employees who have AIDS or are infected with HIV, and what accommodations must be provided for such workers. The managers also need to learn how to manage the psychological climate of work groups that have employees with AIDS or HIV to prevent work place disruptions, and how to use employee assistance programmes to provide support and information for their organisation's workforce.

HIV/AIDS has become a significant threat to South African business with Small Businesses already having to deal with a sizeable part of their workforce functioning at a much-reduced level of productivity, but there are ways to reduce the impact of the disease. It is expensive, but ignoring the epidemic will cost more (Harebottle, 1999).

This study focuses mainly on an investigation of the impact of HIV/AIDS on Small Business with special reference to the understanding of HIV/AIDS, business attitudes about HIV/AIDS, to evaluate costs to business, the economic and social impact of HIV/AIDS, the intervention programmes for employees with HIV/AIDS and the key legal issues when drawing up HIV/AIDS policy.

Businesses that do not provide their employees with HIV/AIDS education fail to reduce the prejudice and discrimination against people with the disease. These businesses are at great risk of workplace disruptions and

violence when it is discovered that an employee has AIDS or is infected with HIV (Miller, et al. 1997:78-86).

In workplaces, attention would be focused on the dissemination of information about AIDS and the reduction of fear among employees, particularly those who have to work with employees suffering from AIDS. Training in the workplace must disseminate information regarding the nature, symptoms and transmission of the illness, and prepare employees for the emotional problems they may experience when a fellow worker contracts this fatal disease.

According to Gerber, et al. (1998:247) the vast majority of workers tested HIV positive or with AIDS is of working age, between 22 and 45 years. This is unlike other illnesses such as Alzheimer's or heart diseases, which usually strike relatively late in the working life of employees. Direct costs as a result of AIDS will impact on small businesses in the following manner. Medical aids premiums will increase to cover the employee against AIDS, medical costs will increase because of AIDS-victims who do not have medical insurance and the medical aid burden will increase. The indirect costs will also affect the bottom line in organisations. AIDS-patients will contribute towards lost work time, with others having to do their work while they are unavailable. Productivity will suffer if co-workers refuse to work with HIV-infected employees. Finally it is obvious that recruitment costs will increase as it is generally accepted that AIDS is a lethal disease at this stage.

According to Kramer (2001) the AIDS-epidemic should teach South African business one thing: The value of being proactive rather than act

responsive. The difference will essentially decide who wins the battle. An estimated 5.6 million new HIV-infections occurred worldwide in 1999 about 15 000 each day with more than 70 percent of them in Sub-Sahara Africa.

Based on current trends, it is estimated that 40 million people were infected with HIV as we entered the new millennium.

Kramer (2001) further points out that the AIDS-epidemic will claim some of the best business leaders and managers and a great number of workers at all levels of the production system

By claiming a large part of the urban population with disposable income and by impoverishing families and communities, it also affects the market base of African business.

1.2 OBJECTIVES OF THE STUDY

1.2.1 PRIMARY OBJECTIVE

The primary objective of the study is to investigate the socio-economic impact of HIV/AIDS on Small Business.

1.2.2 SECONDARY OBJECTIVES

To help achieve the main objective of the study, the secondary objectives of this study are:

- To provide an understanding of HIV/AIDS.

- To investigate business attitudes about HIV/AIDS and evaluate costs of HIV/AIDS to business.

- To determine the economic and social impact of HIV/AIDS.

- To establish intervention programmes for employees with HIV/AIDS.

- To highlight some of the key legal issues when drawing up HIV/AIDS policy.

1.3 DEMARCATION OF THE FIELD OF STUDY

This is a study in Business Management with its focus on the investigation of the impact of HIV/AIDS on Small Business. The area of research is the Vaal Region (see Annexure A); since Small Business in the Vaal Region will also be directly affected through greater absenteeism, lower productivity by affected workers and a high labour turnover rate. No area in the Vaal Region can be called AIDS-free and the existence of an AIDS-epidemic is no longer in question (Van der Walt, 1994). Therefore there is also a need for Small Business in the Vaal Region to deal with this problem in their environment.

1.4 RESEARCH METHODOLOGY

Two methods of research are used, namely a literature study and empirical research.

1.4.1 THE LITERATURE STUDY

Primary and secondary sources are used. Secondary research is used to obtain information about the study. The major sources of information are textbooks, journals, articles in the newspapers and previous studies on the subject.

Information not obtainable from publication and which was relevant to the specific study purpose was gathered through the use of questionnaires and personal interviews directed at the target group of this study.

1.4.2 EMPIRICAL RESEARCH

The empirical data was collected in two stages. The first stage was devoted to the analysis of the impact of HIV/AIDS through structured interviews and the second stage was also devoted to the analysis of the impact of HIV/AIDS through structured, self-completion questionnaires.

(i) First stage of empirical study

This stage was directed at managers or owners of foodstuff business to give their personal opinions regarding the impact of HIV/AIDS in the workplace. They are the first to take action when an employee shows the first sign of illness, because of the hygienic and social nature of their businesses. The sample was selected from the first 40 foodstuff businesses that appeared on the list of registered Small Businesses (refer Annexure D) and they were contacted and invited to take part on a structured interview basis, but only 20 foodstuff businesses were prepared to be interviewed (refer Personal Inter-

views on p.183 and p.184). The results of this stage are discussed in Chapter 7.

(ii) Second stage of empirical study

The second stage of the empirical study was directed at managers or owners of other forms of Small Business (manufacturing, repairs, etc).

The data were collected through structured, self-completion questionnaires. The questionnaire variables were captured, and then subjected to detailed frequency analysis and correlations with the various categories of business.

- **Pilot Study of the Questionnaire**

A pilot study of the questionnaire was done to carefully select and adjust the questions, in order to eliminate ambiguous questions and improve the clarity of unclear questions. Every precaution was taken to ensure that these questions were understood, no biased questions have been included and good quality answers were obtained.

- **Population and sample**

Small Business enjoys a tradition of infinite variety and solid achievement. It thrives everywhere. Few parts of our economy could survive without its products and services.

From the definitions of a Small Business, the following characteristics can be made:

- The owners are directly involved in the management of the enterprise.
- There are fewer than 100 employees.
- The annual turnover of the enterprise is less than R5 million.
- The total capacity assets of the business amount to less than R1 million.
- There are no more than five units (or branches) of industry.

In the Vaal Region 1 000 Small Businesses (see Annexure C) are registered (Town Council, 2000), for this study we have made use of the random sampling method, where we targeted every tenth Small Business for participation. Hundred (100) questionnaires were distributed personally but only seventy (70) responded.

1.5 HYPOTHESES IN RESPECT OF THE RESEARCH ISSUES

In an effort to provide an empirical window on the state of the preparedness of Vaal Region Small Business on dealing with HIV/AIDS problem, the following hypotheses were formulated:

H1: All the managers or owners of Small Business in the Vaal Region are aware of the socio-economic impact of HIV/AIDS in the workplace.

H2: All the managers or owners of Small Business in the Vaal Region have a formal business policy dealing with HIV/AIDS issues in the workplace.

It is assumed that the nature and size of these Small Businesses are such that the results can be interpreted as being a measure of the relevant situation in the Vaal Region.

1.6 CONTENTS OF THE STUDY

The contents of the study are classified as follows:

Chapter 1: An introductory chapter of the whole thesis. Discussion in this chapter is focused on matters such as reasons of the study, objectives, demarcation of the field of study, research methodology, hypothesis and contents of the study.

Chapter 2: This chapter serves to provide an understanding of HIV/AIDS.

Chapter 3: In this chapter business attitudes and the costs of HIV/AIDS are investigated.

Chapter 4: This chapter explores the economic and social impact of HIV/AIDS on Small Business.

Chapter 5: This chapter focuses on the intervention programmes for employees with HIV/AIDS.

Chapter 6: Discussion in this chapter is based on the key legal issues when drawing up HIV/AIDS policy.

Chapter 7: An empirical analysis of an investigation of the impact of HIV/AIDS on Small Business in the Vaal Region is discussed.

Chapter 8: This is the final chapter in which conclusions are reached and recommendations made where necessary.

1.7 GLOSSARY

The following terms and acronyms are found in this thesis and are explained as follows:

Acquired	Not inherited in the genes from one's parents, but coming from the environment.
AIDS	Acquired Immune Deficiency Syndrome, which means that the body loses the ability to fight against infections because the immune system is weakened by the AIDS-virus.
Anal sex	Sexual act in which the penis is inserted in the partner's anus.
Anonymous testing	HIV-testing in which no names are used, and no HIV-status is written down anywhere.
Antibiotic	A substance produce by or derived from a micro-organism and able in solution to inhibit or kill another micro-organism; used to combat infection caused by micro-organisms.
Antibody	One of several types of substances produced by the body to combat bacteria, virus, or other foreign substance.

Antigen	A bacteria, virus, or other foreign substance that causes the body to form an antibody.
ARC	AIDS-related complex; not officially defined, a lesser disease response to the AIDS-virus; people with ARC may develop some of the symptoms typical of AIDS but not the life-threatening ones.
Auto-antibody	An antibody that reacts against a person's own healthy tissue
B cells	White blood cells of the immune system produced in bone marrow and involved in the production of antibodies.
Bacteria	Unicellular organisms that lack a distinct nuclear membrane; some cause diseases that can be treated with antibiotics such as penicillin.
Bisexual	An individual who directs sexual desire towards members of both sexes.
Bone marrow	Soft tissue found in the hollow centre of bones. Bone marrow is the site where all blood cells, red and white, are produced.
Candida	A yeast-like fungus that causes infection in moist areas of the body such as the skin folds, mouth, respiratory tract, and vagina; an infection that often affects those with AIDS.
CDC	Centres for Disease Control; a government-run medical and scientific centre in Atlanta charged with tracking down the areas of origin, geographic and social, of disease outbreaks: CDC distributes literature and information on AIDS, runs a national AIDS hot line, and is monitoring the spread of AIDS in the population.
Chromosome	Microscopic, threadlike structures that are found in the nucleus of each plant or animal cell. They contain DNA, the basic material of heredity.

CMV infection	An infection caused by a cytomegalovirus, a virus in the herpes family; severe infections can result in hepatitis, mononucleosis, or pneumonia; in those with normal immune systems these infections are usually mild but can be much more serious in those with AIDS; Kaposi's sarcoma is caused by a CMV.
Condom	Covering for the penis, which should be made of latex to protect against HIV.
Confidential testing	Testing for HIV done in a clinic or private office, where health-care workers are aware of your HIV-status.
Dementia	A gradual loss of mental function due to an organic cause.
Disease	A group of physical problems usually caused by an organism.
DNA (deoxyribonucleic acid)	The long, twisted molecule in a cell's chromosomes that contains the genetic information that is passed from parents to their young.
Drug abusers	People who use drugs to change the way they feel, not to make themselves well.
Elisa test	A blood test for antibodies to HIV; the test shows whether a subject's blood has been infected, regardless of whether or not the subject exhibits symptoms of AIDS.
Enzymes	Proteins that help or drive chemical reactions in the body.
Factor VIII	A preparation used by haemophiliacs; composed of a blood-clotting element prepared from blood donated by non-haemophiliacs, it was responsible for the spread of AIDS to haemophiliacs early in the disease's course; now all blood donations are tested, so there is little danger of contracting AIDS from this preparation.
False negative result	A negative tests result although the person being tested has, in fact, been infected.
False positive result	A positive tests result although the person being tested has not, in fact, been infected.

Gay	Homosexual.
Gene	A segment of DNA that is the basic unit of heredity. Each gene provides coded instructions for one or more hereditary traits.
GM-CSF	Human granulocyte-macrophage colony-stimulating factor; a body chemical that is still being researched but may be useful as an anti-AIDS drug; it raises production of white blood cells in people with AIDS.
Gonorrhoea	Bacterially caused venereal disease that affects the genital mucous membranes; if treated early in the course of the disease, antibiotics can be effective; if left untreated, serious complications may occur.
Gp160	One component of HIV, being considered by the United States for use as a possible vaccine against AIDS; gp 160 is a protein found on the outside of HIV; it does not include any of the virus itself so there is little chance it will cause AIDS; however, it may have other side effects.
Haemophilia	An inherited disease mainly striking men in which an individual lacks adequate quantities of the element that enables blood to clot.
Helper T cells	T4 cells. They help control immune system function by sending other cells or chemicals to fight an invader.
Hepatitis	An inflammation of the liver usually caused by a virus; spread by contaminated food, drink, and needles; may cause the skin and eyes to take on a yellow colour (jaundice).
Herpes virus	A family of viruses that contain large amounts of DNA; they include herpes simplex, which causes painful scores on the mouth (simplex I) or anus and genitals (simplex II), herpes zoster, cytomegalovirus, and Epstein-Barr virus; in people with AIDS, these infections may involve greater areas and be more persistent.
Heterosexual	Someone who chooses members of the opposite sex for romantic or sexual relationships.

HIV	Human immunodeficiency virus; the virus believed to cause AIDS; identical to HTLV-III and LAV; this name was decided upon by an international commission of scientists as a compromise between the French "LAV" and the American "HTLV-III".
HIV-2	A virus isolated in West Africans; causes AIDS-like disease but is not identical to HIV.
Homosexual	A person who directs sexual desire toward another of the same sex.
Hospice	A place specialising in treatment, both psychological and physical, of people with terminal illnesses.
Host cell	A cell on which a parasite preys.
HPA-23	The first promising drug against HIV: it may help prevent replication of HIV in the body but has a number of serious side effects.
HTLV	The first virus believed to cause AIDS; isolated by Dr. Gallo; identical to LAV; now referred to as HIV.
Immune system	A system of organs, cells – especially white blood cells and chemicals that work together to fight disease.
Informed consent	Knowing what it means to be tested for HIV or to have medical treatment, and agreeing to it.
Injecting drug use	Using drugs that are injected (inserted with needles) either into the veins or under the skin.
Institute for Immunological Disorders	A Houston hospital founded in 1986 solely for the treatment of people with AIDS; within the first year it was R8 million in debt, revealing the immense problem of paying for AIDS care.
IV (intravenous) drugs	Drugs taken by injecting them into one's veins; heroin is probably the most common illegal IV drug; people who abuse drugs intravenously may contract AIDS through shared needles.

Kaposi's sarcoma	Normally rate type of cancer which starts as pink or dark, flat or raised marks on the skin which gradually spread, and internal organs may later become infected, it is a quite common problem with AIDS, and occurs in a mild form in some elderly people.
Latency	Ability of a virus to enter the body and then lie dormant for a period of time before it causes the clinical illness; AIDS has a latency period that may be as long as eight years, although more often it ranges from three to five years.
LAV	Lymphadenopathy-associated virus; virus believed to cause AIDS: isolated by the French; identical to HTLV-III; now referred to as HIV.
Lentivirus	Slow acting virus: this includes HIV.
Lethargy	Extreme tiredness.
Lymph	A clear fluid that batches the body's tissues.
Lymph glands	As a filter for harmful substances, and so help fight against disease.
Lymph nodes	Glands located in various parts of the body that filter micro-organisms out of lymph and produce lymphocytes.
Lymph system	A network of small vessels, much like blood vessels, that carries lymph throughout the body. Immune system cells, such as lymphocytes and macrophages, move through the lymph system as well as through the blood.
Lymphadenopathy	Swollen lymph nodes or glands, felt as bumps in neck, armpit and groin and elsewhere.
Lymphocyte	A variety of white blood cells involved in immunity; includes B-lymphocytes and T-lymphocytes.
Lymphoma	General term for tumours in lymphoid tissue.
Macrophage	From the Greek work meaning "big eater," white blood cells that form part of the first line of defence, attacking all foreign invaders and carrying parts of the invader back to the T cells. Macrophages also help clean up after the invaders are destroyed.

Marker disease	Disease associate with a particular infection, in the case HIV. Someone developing a marker disease would be suspected of having HIV, unless proved clear by a blood test.
Meningitis	Inflammation of the meninges, the membranes covering the brain.
Microbes	Living organisms that are invisible except under a microscope.
Monogamous	Having only one sexual partner (also refers to marriage between one man and one woman).
Neutralising antibody	An antibody that coats a virus's surface and prevents it from entering cells; people infected with HIV do not produce neutralising antibodies against it.
NIH	National Institutes of Health; a federal research institution involved with much of the AIDS research being done in the United States; it was in an NIH lab that Dr. Gallo first isolated HTLV, then thought to be the virus causing AIDS.
Nonoxynol-9	Chemical in spermicides that is thought to kill HIV.
Notifiable	A legal requirement to inform the health authorities of the name of any individual developing a given transmissible disease and to identify contacts who are at risk.
Opportunistic infection	An infection that takes advantage of a weakened immune system.
Oral sex	Sex act involving one person's mouth on another person's penis or vagina.
Oral thrush	The term used to refer to an infection caused by the Candida virus when it occurs in the mouth; characterised by white patches on the tongue or inside the cheeks.
Organism	Living creature, including everything, from humans to minute single-celled animals and plants such as viruses and bacteria; many tiny organisms cause disease.
Pandemic	A global or very widespread epidemic such as that of AIDS.

Parasite	An organism that relies on something else for its existence or support without providing anything useful or adequate in return; often harmful to its host, as in the case of viruses.
Penetrative sex	Sexual intercourse, involving the penis entering the vagina (or anus or mouth) of a partner.
Persistence	Term used to describe the length of time an infectious agent remain in the body once the disease has begun; in the case of AIDS, the infectious agent seems to remain for the rest of the person's lifetime.
Persistent generalised Lymphadenopathy	The lymph glands around the body are swollen over a long period of time (at least three months); this is often a sign of HIV-infection, but other long-lasting infections can also cause this symptom, and many people with HIV do not have swollen glands.
Pessary	Tablet placed in the vagina; some types are used for contraception.
Pneumocystis carinii pneumonia	Often called PCP, this type of pneumonia, or inflammation of the lung, often affects people with AIDS: pneumonia is usually caused by bacteria but PCP is the leading cause of death in AIDS-patients.
Pneumocystist carn (pneumonia)	Virus that causes a type of pneumonia often seen in people with AIDS, the disease may be called PCPs.
Pneumonia	Serious lung infection causing coughing and breathing difficulties; there are different types of pneumonia; it can arise if another infection is not properly treated.
Prevalence	The level of existing infection in a population.
Prognosis	Predicted result of a disease.
Protease inhibitors	Medicines that stop the work of the enzyme protease.
Proteins	Very important, complex group of chemicals found in living matter, antibodies are proteins.
Reportable	A legal requirement to report the occurrence of a disease without naming infected individuals or tracing contacts.
Retroviral	Drug such as AZT used to slow the growth of HIV.

Retrovirus	Unusual, recently identified group of viruses including HIV, which reproduces in a different way from most other viruses.
RNA	Ribonucleic acid; genetic material composed of paired nitrogenous bases like DNA but structurally is a single stand; the bases of RNA "mirror" those in DNA, enabling RNA to replicate its analogous DNA strand.
Safer sex	Sex using a latex condom.
Screening for HIV	Analysing the blood of whole populations or of groups within a population to see if they are infected with HIV.
Secretion	Body fluid.
Semen	Sperm-carrying fluid released through the penis at the climax of sexual activity.
Seroconversion	When the blood starts producing antibodies in response to infection by the virus.
Seropositive	Having antibodies in HIV.
Seroprevalence survey for HIV	Study of how widespread HIV-infection is in a population by testing people's blood for antibodies to HIV.
Sex fluids	The genital secretions or juices released during sex; in a man this is semen and in a woman, cervical and vaginal secretions.
Sexual intercourse	Sex act in which the penis penetrates the vagina.
Shingles	Painful inflammation of nerve ending (herpes zoster) with a bleeding skin rash. Shingles usually occurs when the immune system is impaired, and it is increasingly common with HIV-infection.
Side effects	The action or effect of a drug other than that which is desired. The term usually refers to negative or undesirable effects, such as headache, nausea, or rash.
Sperm	Short for spermatozoa, the male sex cells for making a baby.

Spermicide	A cream, gel, foam or pessary that kills sperm and so works as a contraceptive. Used with a condom it helps provide good protection against HIV also.
STDs	Sexually transmitted diseases, e.g. syphilis, gonorrhoea, chanroid and AIDS, infections passed from one person to another during sexual intercourse.
Sterilised	Thoroughly cleaned of all dirt and disease-causing organisms, e.g. by using bleach or boiling water.
Sub-clinical infection	Infection that does not cause observable disease symptoms.
Suppresser cells	T cells that help control immune system function by holding back immune units from fighting an invader, keeping a balance with the helper T cells.
Symptom	Perceived sign of disease or another problem.
Syndrome	Range of different diseases and symptoms, not just one.
T cells	White blood cells processed in the thymus. They produce lymphokines and are responsible, in large part, for carrying out the immune response.
Testing for HIV	Finding out if an individual has HIV, normally by a test for anti-bodies.
T-helper lymphocyte	T4; a type of cell with a specialised function in the body's immune system; it appears that they are primary targets of the virus HIV because AIDS-patients show a strikingly low quantity of these cells in their blood.
Thrush	An infection caused by a fungus which can be very severe in people with AIDS, causing a heavy white coating in the mouth and throat, in the gut or on the lining of the genitals (Candida).
Toxoplasma	Parasitic organisms that live within the cells of a host; in AIDS-patients these parasites may attack the brain cells.
Transfusion	A transfer of a liquid usually bloods, into the bloodstream.

Transmission	The process of spreading a germ and the infection caused by that germ.
Unprotected sex	Full sexual intercourse where an exchange of sex fluids take place with no barrier such as a condom; it can also be called unsafe sex, and means that someone with an STD including HIV can spread it to other person; it is risky.
Vaccine	Weakened or killed virus that creates immunity in the person getting the vaccine by stimulating the production of antibodies against that specific virus.
Vaginal secretion	The normal liquid produced by the vagina.
Vein	A part of the body through which blood flows.
Virus	The smallest and simplest of all life forms.
Western blot	Blood test for antibodies to HIV; this is more specific but also more expensive than the ELISA test; performed to confirm a positive result of an ELISA test.
White blood cells	Part of the immune system that protects the body against foreign substances, such as disease-producing micro-organisms.
Who	World Health Organisation; an agency of the United Nations, set up in 1948 to co-ordinate international efforts in the health field; WHO, in co-operation with member nations, works to train health care workers, combat disease, and improve health; WHO has been active in the fight against AIDS.

1.8 GENERAL

- Annexures are provided at the back of the thesis.

- The Harvard method of referencing is used.

- Where no sources are mentioned, it refers to own research.

- If reference is made only to the year, emphasis is placed on the general impression of the author.

- Tables and figures are placed on, or immediately following, the relevant pages in the thesis.

- A copy of an interview guide is provided.

- A copy of the questionnaire is provided.

- To maintain the anonymity of the original source of the empirical data, the designation of the person interviewed is used in the text reference and bibliography.

CHAPTER 2

UNDERSTANDING HIV/AIDS

This chapter serves to provide an understanding of HIV/AIDS. The purpose is to clear misconceptions about HIV/AIDS on Small Business.

2.1 INTRODUCTION

One of the dangerous things about HIV/AIDS is that people do not want to know about it. It is a frightening disease for which there is no vaccine and no cure. It is also sex-related and therefore treated with embarrassment by many people.

Today it is common to hear about employers who require job applicants to prove that they are not HIV-positive before offering them work.

AIDS is one of the most important strategic issues facing business in the 21st Century.

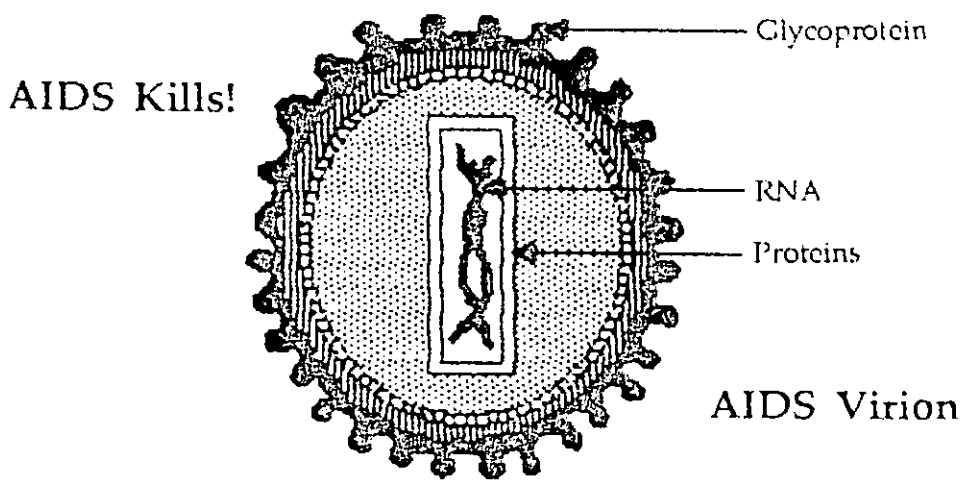
One may hear different rumours about HIV/AIDS, some of which contradict each other. So one might wonder, what exactly is this disease?

2.2 WHAT IS HIV/AIDS VIRUS?

The AIDS virus, sometimes called Human Immunodeficiency Virus (HIV), Human T-Cell Lymphotropic Virus III (HTLV-III), or Lymph-adenopathy

Virus (LAV) is an incredibly small organism, roughly 1 000 angstrom units (one ten-thousandth of a millimetre) across – just a little larger than the wavelength of red light (refer Figure 2.1 below). Neither plant nor animal, the virus particle (virion) is covered by two layers of fatty material that are stolen from the outer covering of the human host cell (T4 Lymphocyte – a white blood cell). Studying the AIDS retrovirus's surface, much like straight pins protruding from a pincushion, are 'glycoproteins' – proteins with sugar molecule chains attached. Each glycoprotein has two components: Glycoprotein – 41 (gp-41) – the body of the example of the example pin – spans the spherical surface of the virus, and glycoprotein – 120 (gp-120) – the head of the example pin – extends beyond the spherical surface placed at the end of glycoprotein-41 (gp-41). The spherical surface covers a core made up of proteins designated protein – 24 (gp-24) and protein – 18 (gp-18) (Lee, 1987:5).

FIGURE 2.1: THE AIDS VIRUS PARTICLE IS A SPHERE THAT IS ABOUT 1 000 ANGSTROM ACROSS. THE VIRAL RNA AND THE ENZYME REVERSE TRANSCRIPTASE ARE CARRIED IN THE VIRUS'S CORE



Source: Lee, 1987:5

Kelly (1995:1) points out that AIDS is the end stage consequence of HIV-infection. A formal diagnosis of AIDS is usually made after an individual with HIV-infection develops any of a number of life-threatening opportunistic illnesses that include Pneumocystic carinii pneumonia, Kaposi's sarcoma, lymphomas and other cancers, or a host of other potentially fatal bacterial, viral, fungal, or parasitic infections. These illnesses or secondary infections are considered "opportunistic" because they occur and are aggressively virulent in persons whose immune system is compromised.

AIDS is also diagnosed in some persons who do not yet have a clear-cut AIDS-defining opportunistic illness but whose immune system functioning is so impaired that the individual is imminently vulnerable to life-threatening illness. The specific point when a formal AIDS diagnosis is made (and the specific illnesses that constitute full-blown AIDS) are somewhat arbitrary and have occasionally changed as knowledge has evolved concerning the clinical manifestations of the syndrome (Kelly, 1995:1).

Tonks (1996:36-39) states that the term "AIDS" stands for Acquired Immune Deficiency Syndrome. Each of these words has a meaning that helps explain what AIDS is and how it works. Acquired refers to something that people get from outside themselves. They have somehow acquired anything that people have that they were not born with. Since people are only born with their bodies, their hands, feet, eyes, noses, mouths and every other part of their body are natural and are not acquired. Some diseases, such as diabetes, are hereditary and are passed through families, from parents to children before birth and are therefore not

acquired. AIDS is not hereditary, but it is transmitted from one person to another through various means.

The definition of the word immune is invulnerable or protected. If something is immune, then it cannot be hurt or defeated. The body has an immune system that fights off diseases such as the flu, colds and other illnesses. If the body's immune system is working properly, a person may get ill with some sort of sickness but will later get better. The immune system battles disease by creating antibodies to fight the source of the disease and ultimately to get rid of it entirely. Our immune system is what keeps us from getting sick all the time from invading germs and viruses.

Unfortunately, the next word in AIDS is deficiency. Deficiency means not enough of something, a shortage. If a student fails a test, that means he or she has a deficiency, a lack of knowledge on the subject. In the term "AIDS", deficiency is teamed up with immune, meaning that the body does not have enough immunity to fight off germs and diseases effectively. Viruses invade the body from the outside and under normal circumstances the immune system is strong enough to fight most of them off completely. We come into contact with a number of germs and viruses every day and the reason that we are not sick all the time is that our immune system keeps us healthy. If that immune system is not as strong as it should be, if it is deficient, then our bodies become like an open door to any number of dangerous invaders.

The final word, Syndrome, refers to a group of symptoms that combine to demonstrate a particular condition or disease. In the case of AIDS, these

symptoms include the presence of HIV in the body and the deficient immune system discussed above, as well as a number of opportunistic infections, such as Kaposi's sarcoma, pneumocystis carinii pneumonia (PCP) and lymphoma, that take advantage of the body's weak state to get a foothold. When enough of these symptoms get together in one body, the diagnosis of AIDS is made.

The term "AIDS", all of these words – Acquired Immune Deficiency Syndrome – together, refers to a group of symptoms that people get from somewhere outside themselves and that weaken the body's ability to defend itself against diseases. With this kind of explanation, it is obvious why AIDS is such a dangerous and deadly matter.

Tonks (1996) further points out that AIDS does not infect people, but HIV does. HIV stands for Human Immunodeficiency Virus. Human, obviously, means that this is a virus that affects humans, or people. It does not infect animals, although there are some similar but not identical viruses that do infect animals. HIV does not infect dogs, cats, fish, hamsters, mosquitoes or any other animal one can think of. Therefore, HIV-positive people have acquired HIV only from other people. The second word, immunodeficiency, combines two of the words used in "AIDS", and means a weak defence system for the body. Virus, of course, is the name for a microscopic agent that causes disease.

According to Togni (1997:3) the acquired immunodeficiency syndrome or AIDS disease as it is commonly called, is the result of infection with the human immunodeficiency virus (HIV). The virus severely damages the immune system of the body, which normally protects it from any number

of viral and other attacks. A person infected with HIV may develop full-blown AIDS, thus making the individual susceptible to a wide range of other infections and diseases.

HIV enters the bloodstream and circulates through the body. HIV attacks and damages the immune system, which heals and protects the body. The key T4 help cells also called the CD4 cells form a critical controlling and regulating component of the immune system and are the cells mostly affected and destroyed by the virus. Without sufficient normally functioning CD4 cells, the body's immune system is unable to defend itself adequately against infections and the development of specific cancers. In addition, the HIV can impair the functioning of nerve and muscle cells, resulting in weakness, wasting away and impaired mental functioning (Toms, in Togni, 1997:12-13).

Webb (1997:3) argues that the cause of AIDS, identified in 1983, is a retrovirus, which since 1986, has been known as the human immunodeficiency virus (HIV). The retrovirus group includes the Simian Immunodeficiency Virus (SIV) and the Human T-cell Lymphotropic Virus (HTLV), which was identified in 1980. The virus, once within the blood stream, targets the CD4 T-lymphocyte cells, which constitute a vital component in the immune system, as they co-ordinate antibody production and all immune responses. HIV viral RNA is transcribed to DNA within the T-cell cytoplasm. The viral DNA is then incorporated into the host's nuclear DNA. Replication of the cell results also in viral replication, possibly concentrated within the lymph nodes.

Webb (1997:3) further points out that the human immunodeficiency virus (HIV) belongs to a family of viruses called retroviruses. The virus causes infected cells to translate the viral genetic material Ribonucleic Acid (RNA), into another form, Deoxyribonucleic Acid (DNA), which it uses to infect new cells. HIV attacks mainly white cells in the body called T-Lymphocytes, a key part of the immune response. Of the two main types of HIV, the most common, HIV-1, is thought to be transmitted about three times more readily than HIV-2 (which also causes AIDS and has been seen mainly in West Africa and Mozambique).

With the destruction of the immune system cells the body becomes increasingly unable to resist other infections giving rise to the opportunistic infections characteristic of AIDS. As the body's defence system weakens, one or multiple symptoms might appear. They include: Chronic fatigue or weakness, diarrhoea, minor skin infections, respiratory problems, sustained weight loss, persistent swelling of the lymph nodes, deterioration of the central nervous system. As the immune system weakens, more severe diseases manifest themselves, such as cryptococcal meningitis, tuberculosis, pneumocystis pneumonia and cancers such as Kaposi's sarcoma. This more severe phase can continue for up to two years before death, with progressively longer periods of illness that may be interspersed with periods of remission. The median time from infection to development of AIDS in industrialised countries is 10 to 11 years, while in Sub-Saharan African it is estimated to be 5 to 10 years (Whiteside, 1998:13-14).

Granich and Mermin (1999:5-6) stated that HIV stands for "Human Immunodeficiency Virus". "Human" because the virus causes disease

only in people. "Immunodeficiency" because the immune system, which normally protects a person from disease, becomes weak. "Virus" because like all viruses, HIV is a small organism that infects living things and uses them to make copies of itself. HIV causes AIDS (Acquired Immune Deficiency Syndrome). AIDS is a group of diseases that occur when HIV damages a person's immune system. Most people with HIV feel healthy for the first few years after getting the virus, but later they become sick with AIDS.

According to Taylor (1998:9-11) AIDS is caused by HIV, or Human Immunodeficiency Virus. A virus is a tiny semi-living organism that can be seen only under a high-powered microscope. Semi-living means half-alive; that is a virus is simply tissue when it is outside a body and is alive only when it is inside the body.

A virus grows best inside a living cell. Once the virus enters a body and finds a cell, it enters the cell and lives on that cell's protein. Eventually, as the virus grows and reproduces, the cell is destroyed. The virus then enters new cells. When this happens, the body starts to come down with a disease. Viruses cause diseases such as colds, mumps and measles. The immune system often kills viruses even before they make you feel sick.

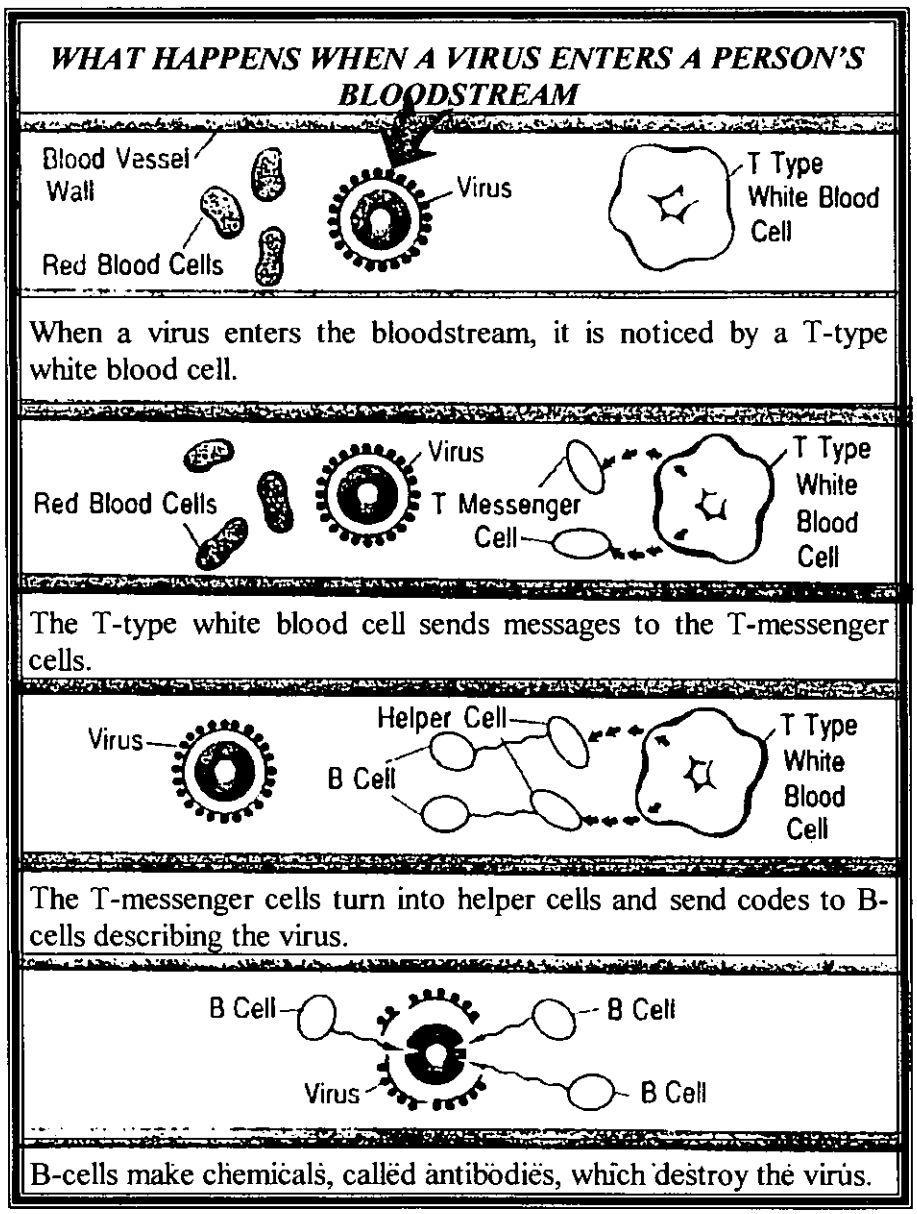
Taylor further points out that the human immune system usually works so well that we don't even notice it working. It points to viruses, bacteria, and even splinters that enter the body. Once an invader has been discovered, the system identifies it and then figures out how to defeat it.

The immune system consists mostly of blood cells. There are three kinds of blood cells: Red blood cells, which carry oxygen in the blood; platelets, which make clots and scabs when you get a cut and white blood cells. Only white blood cells help in the immune system process. The white cells come in many different forms. The two most important are T-cells and B-cells.

The T-cells are a kind of alarm system. They sense attacks from bacteria and viruses and send out a warning to the rest of the immune system. The T-helper cells pick up the alarm and identify the intruder. They pass this information on to the B-cells. The B-cells hunt down the infection. When they find it, they make a chemical called an antibody to destroy it. Each infection requires a different antibody to defeat it. The immune system keeps track of which antibody fights which infection. That's why you can get certain infections only once, like chicken pox. The first time you get the infection, the B-cells learn which antibody kills the chicken pox infection, so that the next time you are exposed to it the immune system can kill the infection before it makes you sick (refer Figure 2.2).

Figure 2.2 follows on p.35.

FIGURE 2.2: THE VIRUS IN ACTION



Source: Taylor, 1998:11

2.3 THE ORIGIN OF HIV/AIDS

AIDS, according to most observers and epidemiologists, originated in the central region of Africa, probably on the shores of Lake Victoria, about a decade ago. The striking similarity between SIV, a Simian Virus infecting

the green monkeys that live near the lake and HIV the virus that causes AIDS in man gave rise to the theory. SIV does not cause AIDS but somehow the SIV virus crossed over to man and mutated into the deadly HIV-virus.

Maybe a hunter or cook came into contact with an infected monkey, since these monkeys are cooked and eaten.

Another theory is that AIDS has been present in remote regions of Africa for generations. Many residents on the western shores of Lake Victoria claim that AIDS, which they call "slim disease" because of its wasting symptoms, did not exist before 1979 when the Tanzanian army invaded Uganda (Informa, 1989).

Viljoen (1990:1) states that in June 1981 the Centre for Disease Control (CDC) in Atlanta in the United States of America, received a report that within the previous eight months there were five cases which needed the remedy known as pentamedien isetionaat. The report described these five cases as five, young, previously healthy, homosexuals who had been treated in Los Angeles.

At the same time the CDC also received reports of an extremely rare type of cancer, known as Kaposi's Sarcoma (KS) with young homosexuals as the victims. In the course of the following three years a French researcher, Dr. Luc Montagnier, identified a new virus, later to be known as "human immunodeficiency virus". Subsequent research described its epidermiology and designed a blood test to identify bearers. A new disease, AIDS, had arrived on the scene.

According to Kelly and Lawrence (1988:1) in the spring of 1981, investigators at the UCLA Medical Centre recorded five cases of Pneumocystis carinii pneumonia, a virulent form of pneumonia uncommon in the United States (Centres for Disease Control). Within a few months, clinical researchers in New York, San Francisco and Los Angeles discovered 25 cases of Kaposi's sarcoma, an exceedingly unusual cancer among young and otherwise healthy persons in this country. None of the patients suffered from any underlying illness that would account for the development of these often fatal and unusual diseases, but each patient exhibited severe immune system impairment for unknown reasons and each was a young homosexual male. The syndrome accounting for these first few cases were not yet named but would shortly be identified as acquired immune deficiency syndrome (AIDS). Within just a few years, it would be considered the most serious infectious disease epidemic of modern times and be designated as the nation's primary medical priority by the National Institutes of Health.

Scientists believe HIV, which has infected nearly 40 million people worldwide, began after an ape and monkey version known as simian immunodeficiency virus (SIV) jumped from chimpanzees to human beings in Western Central Africa. The US Centres for Disease Control and Prevention (CDC) says it probably occurred during the slaughter of chimpanzees as early as the 1930's (Reuters, 2000).

Achmat, et al. (1997:10) points out that the first signs of a fatal new illness that later became known as AIDS were seen in the United States of America in 1981. It was several years before scientists were able to point

to a particular virus, which they called HIV, as the common factor in all people with these illnesses.

At first these illnesses were seen mainly in gay men. This led to the misunderstanding that AIDS is a gay person's disease and a new wave of prejudice and discrimination emerged against gay men and lesbians.

Today, scientists still do not know why HIV suddenly appeared in the 1980's. They do know what kind of practices lead to HIV-infection.

According to Whiteside and Sunter (2000:4-6) it is now believed by scientists that HIV is a virus that crossed the species barrier into humans. It is related to a number of Simian (monkey) Immunodeficiency Viruses (SIVs) found in Africa. If the evolution of the virus is traced through a "family tree", HIV-1 is closely related to Chimpanzee SIV and HIV-2 to Macaque SIV. Both are more distantly related to the African Green Monkey SIV.

How did HIV enter the human population? An important point to note is that the spread of diseases from animals to man is not unique to HIV. Congo fever, which occurs sporadically in South Africa, is a tick-borne disease, which does not kill its animal hosts, but is extremely serious when people are infected. The influenza virus, for example, evolves in birds – waterfowl to be exact. The latter are what virologists call "reservoirs" for influenza. They carry nearly all known types of influenza, with no ill effects and spread them to the rest of the animal kingdom through their faeces. Hence, many kinds of animals can get flu – horses, ferrets, seals, pigs, among others – as well as human beings.

Whiteside (1998:14) states that by comparison with other viruses, HIV is a simple virus. At some point in time, it entered the blood of humans and then spread through sexual contact from person to person. It has been suggested that the current HIV-epidemic had its origin in an infection across the species barrier in the 1930's. Interestingly, the transfer of the virus from an animal into a human may have happened on a number of previous occasions. However, because on those occasions each infected person did not in turn infect more than one other person, the potential epidemic petered out. There could have been a pool (or pools) of infected but isolated people, in some parts of Africa for many years. What was different about the crossing of the species barriers in the 1930's (and the subsequent pattern of the epidemic) was the environment into which the virus was introduced. The upheavals of the colonial and postcolonial periods and development of a modern transport infrastructure allowed HIV to spread out into the global community very quickly.

Whiteside (1998:14) further points out that their important features of HIV/AIDS that call for mobilisation of a broad response to the epidemic.

Key Characteristics of HIV/AIDS:

- AIDS is a new epidemic. It was first recognised as a specific condition only in 1981 and it was not until 1984 that the cause (and a test to detect it) was identified.

- It has a long incubation period. Persons who are infected by the virus may have many years of normal productive life, although they can infect others during this period.

- The prognosis for people infected with HIV is currently bleak.

- The scale of the epidemic is also different from most other diseases. In some urban settings more than 30 percent of antenatal clinic attendees are infected.

- The disease is found mainly in two specific age groups, infants and adults aged between 20 to 40 years. In the developing world, slightly more females than males are infected and women are infected and develop the disease at a younger age than men.

- HIV interacts with other diseases, both in terms of causing HIV/AIDS to spread (for example other sexually transmitted diseases increase the rate of HIV-transmission ten-fold) and arising from HIV-infection (for example significant increases in tuberculosis cases are directly related to HIV). This implies that HIV will not only be a public health burden in itself, but is directly linked to the burden of other significant public health problems.

- In general the epidemic is still spreading. In some Southern Africa countries it may have peaked in urban centres, but it continues to spread in the rural areas.

The official AIDS story in South Africa began in 1982 when two men, said to be homosexuals, died of the disease. By December 1990 more than 600 cases of AIDS were reported. In the same year (1990) 270 AIDS-related deaths and 0,76 percent HIV among pregnant women were confirmed. Should the rates of infection continue by the year 2005, about 7,5 million people in South Africa may be infected by the deadly HIV-virus and 2,9 million may have died of the disease (Togni, 1997:25).

2.4 HOW IS HIV/AIDS CONTRACTED?

HIV-transmission occurs when the virus from an infected individual's body fluids, primarily blood or semen, gains entry to the bloodstream of another person. Among some AIDS risk groups, the reasons for increased HIV susceptibility are readily apparent. Haemophiliacs and transfusion recipients were directly exposed to the virus if they received blood or blood products contaminated with HIV. The likelihood of developing HIV-infection if one received contaminated blood is high in light of follow-up studies of transfusion recipients (Ward, in Kelly, et al. 1988:19).

According to Inforna (1989), whatever the truth, once the disease gained a foothold, it spread rapidly among Africans mainly through sex with multiple partners, although blood transfusions of HIV-contaminated blood, use of contaminated needles, ritual incisions and other cultural practices involving blood, also transmit AIDS. Another Third World condition that may promote the disease is the presence of faeces in drinking water.

HIV is a fluid-borne virus. Because it is carried only in fluids rather than dispersed through air, HIV is not transmissible by sneezing, coughing or

similar routes that permit the transmission of other more common viruses such as influenza or the rhinoviruses that cause colds. No cases of HIV-transmission have ever been linked to casual or social contact and even family members who care for persons with AIDS and have daily close physical and touching contact, are not at risk for contracting the disease provided they are not sexual partners and do not have direct blood exposure (Friedland, et al. in Kelly, 1995:8).

Kelly (1995:8-9) points out that HIV is present in only certain body fluids of an infected person at concentrations sufficient to permit practical risk of transmission. These fluids are blood, semen, vaginal secretions and probably breast milk. For viral transmission to occur, one of these fluids of an infected individual must gain direct access to the blood stream of another person. The virus can also enter the body through direct contact with mucous membranes. HIV is a fragile virus that dies quickly if dried or exposed to disinfecting agents such as bleach and it does not penetrate unbroken skin. It also appears that there is a threshold concentration of HIV needed to infect another person. This probably accounts for why body fluids that may contain HIV at very low levels if at all – such as tears or saliva – are not salient sectors for transmission. Because of these characteristics, risk for contracting HIV is limited to several routes that collectively account for virtually all cases of infection (refer Table 2.1 below).

Table 2.1 follows on p.43.

TABLE 2.1: KEY BEHAVIOUR PRACTICES THAT CONFER RISK FOR HIV-INFECTION AND BEHAVIOUR CHANGES THAT SERVE TO LESSEN RISK

Population	Risk behaviour/risk reduction changes
Homosexual active men	*High-risk behaviour:* Unprotected anal intercourse is the practice most strongly predictive of contracting or transmitting HIV-infection. Other practices that permit entry or exchange of sexual fluid or exposure to blood also confer risk *Risk reduction changes:* If sexually active, refraining from all anal intercourse or consistently using latex condoms with water-based lubricant containing the spermicide nonoxynol-9 during intercourse. Avoiding other sexual practices that permit sexual fluid exchange or entry. Adopting only sexual practices that do not involve penetration (such as mutual masturbation or frottage).
Heterosexual men and women	*High-risk behaviour:* Unprotected vaginal or anal intercourse permits transmission of HIV from male to female or female to male. Oral sex may confer some level of risk if sexual fluids are exchanged. *Risk reduction changes:* If sexually active, consistently using latex condoms containing the spermicide nonoxynol-9 during intercourse. Alternatively, adopting only sexual practices that do not involve penetration (such as mutual masturbation or frottage).
IDUs	*High-risk behaviours:* Sharing syringes or injecting with needles that may have been used by someone else. Engaging in unprotected intercourse. *Risk reduction changes:* Injection risk behaviour: Ceasing injection drug used through drug treatment or maintenance programmes. If still injecting, (1) using new syringes for each injection; (2) using only one's own syringe and not borrowing or exchanging apparatus; or (3) carefully cleaning any used syringe with full-strength bleach solution leaving bleach in the syringe for at least 60 seconds, tapping the syringe to dislodge any dried blood fragments; repeating the bleach pull-up again for another minute, and then flushing with water. Sexual risk behaviour: Same changes as described above.

Source: Kelly, 1995:9

According to Tonks (1996:39) transmission of HIV is both very easy and very difficult. It is easy because there are very specific avenues through which HIV can be passed. HIV lives and thrives in human bodily fluids and when these fluids are passed from one person to another, HIV can be passed right along with them. The four bodily fluids that carry HIV is a high enough concentration to infect others are blood, semen, which includes pre-ejaculatory fluid, the male secretion that precedes semen and is also sometimes known as pre-come, vaginal fluids and breast milk. Trace amounts of HIV can be found in other bodily fluids, such as tears or saliva as well, but doctors have never recorded a large enough amount of the virus in such fluids to successfully make it infectious to another person.

Two types of HIV have been identified, namely HIV-1 and HIV-2. Recent reports of a third type of HIV discovered in the Cameroon point to the possible existence of many more variants and a high mutation rate. In recent years these variants have been classified further, with varying degrees of transmissability and virulence (Hu, et al. in Webb, 1997:4-5).

According to Webb (1997:5-6) HIV-1 and HIV-2 are both transmitted in the same way, which involve the mixing of body fluids:

- Heterosexual or homosexual intercourse (horizontal transmission). The virus is found in blood, seminal and vaginal fluids. The presence of venereal infection, particularly those, which cause ulceration or lesions, such as syphilis and genital ulcer disease (GUD), increase the likelihood of transmission by up to a factor of four (Laga, et al. in Webb, 1997:5).

- From mother to child (vertical transmission), causing paediatric AIDS. The World Health Organisation (WHO) estimates that approximately one third of children born to zero-positive mothers will themselves be HIV-positive and separate studies in Africa suggest that vertical transmission occurs in roughly 20 to 40 percent of zero-positive pregnant women. The causal factors behind parental transmission are not fully understood.

- Through infected blood or blood products. Blood infected with HIV can be transfused into a patient if it is not screened for HIV.

- Intravenous drug use (IVDU). The sharing of infected needles has accounted for an estimated 7 percent of infections worldwide (Mann, et al. in Webb, 1997:6).

- Other means of transmission are far less frequent, such as parental infection (needle stick injury or re-use of an infected needle in a medical setting) and through the use of infected blades in circumcision rituals, sacrification and traditional medicine. Biting insects, such as mosquitoes and bedbugs, are not vectors of the virus. HIV has been detected in human saliva, but this is not responsible for transmission during deep kissing.

Taylor (1998:16-17) states that AIDS is a preventable disease. If one takes the right precautions, one will not be at risk for contracting HIV, the virus that causes AIDS.

In order to protect oneself, it is important to know the major ways in which HIV is spread:

- Infected blood enters the body through intravenous (IV) drug use.

- During unprotected sex (sex without using a latex condom) infected semen or vaginal fluids enter the body through mucous membranes in the mouth or genitals.

- An infant is infected from his or her mother either before or during birth or from breast milk.

- Infected blood enters the body through a blood transfusion given before 1985 (hospitals and blood centres started testing blood for HIV-antibodies in 1985).

Taylor (1998:17) further points out that HIV can't be transmitted through normal contact with a person: Hugging, kissing, holding hands or sharing eating utensils. It is not transmitted through mosquito bites or through the air. One will not contract it by donating the blood or going to the dentist or doctor.

In most cases, people have become infected with HIV by having sex. However, there are other ways that HIV can be spread: By dirty needles and instruments, by transfusion of HIV-infected blood and from a mother to her baby (Granich and Mermin, 1999:57).

According to Whiteside and Sunter (2000:10) HIV is not a very strong virus. Every disease has a reproduction number (Ro), which is the number of other people each infected person would normally infect. In the case of HIV, Ro is around five; i.e. each HIV-positive person is likely to infect five others during his or her lifetime. The Ro for malaria, by comparison, is 100, which is the reason why it can spread so explosively. The challenge is to reduce the Ro of HIV to less than unity so that the disease goes into decline.

HIV is also hard to transmit. In order for a person to be infected, the virus has to enter the body in sufficient quantities. It must pass through an entry point in the skin and/or mucous membranes into the bloodstream. The main modes of transmission, in order of importance, are:

- Unsafe sex.

- Transmission from infected mother to child.

- Intravenous drug use with contaminated needles.

- Use of infected blood or blood products.

- Other modes of transmission involving blood including bodily contact involving open bleeding wounds.

Mbuya (2000:26) states that the virus is found in significant amounts in semen and vaginal secretions and in very small amounts in saliva and breast milk. If there are traces of blood in urine, faeces or vomit, then

these may also contain the virus and therefore they are considered a problem in the transmission of HIV.

A distinction therefore must be made between substances that have been shown to contain some virus and those substances that contain sufficient virus to spread it to other people (this is illustrated in Table 2.2 below). Only the first three substances shown in the table contains sufficient virus to be a serious health hazard to others, even though the virus or antibodies to it, have been identified in various other body fluids. It is estimated, for example, that roughly two to three litres of saliva would be needed to risk spreading HIV. Saliva, faeces, urine and vomit are only thought to be a risk if they contain blood. In this case, the blood in them could possibly transmit the virus if it reaches open sores or cuts on someone else's skin. However, the chance of the virus spreading in this way is small.

TABLE 2.2: BODY SUBSTANCES AND THE RISK OF TRANSMISSION OF HIV

Substance:	Shown to contain known to be linked Virus or antibodies to spread of HIV	
Blood	YES	
Semen	YES	Yes, high risk
Vaginal/cervical secretion	YES	
Saliva	YES	
Urine	YES	No definite case, but
Faeces	YES	Possibly some risk
Cerebrospinal fluid	YES	Risk only to surgeons
Breast milk	YES	Very low risk
Tears	YES	No known risk
Sweat	YES	
Skin	NO	
Hair	NO	
Nails	NO	No risk
Breath	NO	
Coughs	NO	
Sneezes	NO	

Source: Mbuya, 2000:26

Mbuya (2000:27) further points out that to be infected with the virus, people must have close contact with the blood, semen or vaginal fluid of an infected person. This can be through:

- Full sexual intercourse.

- An infected mother to her baby, in the uterus or at birth.

- Blood transfusion with infected blood or infected blood product or tissue and organ transplants.

- A contaminated needle or cutting object.

- Close physical contact with an infected person's blood, for instance if someone is bleeding from an injury.

2.5 CONCLUDING REMARKS

HIV/AIDS is not restricted to marginalised persons and groups like gay persons and intravenous drug abusers, specific cultural groups and sex workers. HIV/AIDS is a disease of all sexual orientations – homosexual as well as heterosexual.

Small Business is no less affected and cannot remain complacent about the HIV/AIDS-infection rate. The vast majority of workers tested HIV-positive or with AIDS is of working age, between 22 and 45 years (Kruger, in Gerber, et al. 1998:247).

In business attention should be focused on the dissemination of information about HIV/AIDS and the reduction of fear among employees, particularly those who have to work with employees suffering from HIV/AIDS. It is just as important for employers and employees to understand how HIV/AIDS is not spread in ordinary daily life, as to understand how it is spread through sex and blood contact.

In the next chapter business attitudes and the costs of HIV/AIDS are discussed.

CHAPTER 3

BUSINESS ATTITUDES AND THE COSTS OF HIV/AIDS

In this chapter business attitudes and the costs of HIV/AIDS are investigated.

3.1 INTRODUCTION

While South Africa was focusing on the apparent lack of concrete action by the government in the fight against HIV/AIDS, little attention had been paid to the inactivity of the country's businesses in responding to the challenges of the virus in the work situation.

How to effectively deal with employees affected by HIV/AIDS is a topic seldom discussed in work situation. Yet, with the rapidly increasing number of affected workers, it is imperative that managers in Small Businesses learn how to deal with the challenges of HIV/AIDS in the work situation.

AIDS is the single most important strategic issue facing Vaal Region Small Businesses as they enter the 21st Century. What makes this even more significant is that the impact on their global competitors will be very different, with all other Provinces hardest hit by the epidemic. AIDS will have very little impact on the highly developed countries and those where levels of education are high.

3.2 BUSINESS ATTITUDES TOWARDS HIV/AIDS

According to Laverack (2001) HIV/AIDS-epidemic in South Africa is at its most severe among the productive population in the workplace. Unlike any other epidemic that has hit the human race through the centuries, the majority of infections in this epidemic are among people in the 15 to 40 year age group.

HIV/AIDS is seen by many businesses as such an overwhelming issue that they take the easy way out – by ignoring it or giving it minimal attention.

HIV/AIDS has become a significant threat to South African business with Small Businesses already having to deal with a sizeable part of their workforce functioning at a much-reduced level of productivity.

There are ways to reduce the impact of the disease. It is expensive, but ignoring the epidemic will cost more (Harebottle, 1999).

Venter (2000) states that while business is staring straight down the barrel of significant direct and indirect costs as a result of HIV/AIDS in the workplace, most South African Small Businesses turn their blind eyes to it.

It is understandable that most businesses might feel they are exempt from the impact of the pandemic, but in reality, to ignore the facts now simply set you up to pay the damage later (Van Bassen, in Venter, 2000).

Strugnell (2000) points out that any Small Business director or manager who doubts the coming tidal wave effect of AIDS on the balance sheet

should debate the matter with friends involved in the management of labour-intensive businesses in KwaZulu-Natal, the province at the forefront of HIV experience in the country.

According to Kramer (2001) the research confirmed suspicions that South African business was either not planning for the epidemic at all nor making token attempts to create awareness about it. The survey found that most Small Businesses saw AIDS as either a health problem or a problem of poverty and not one endemic to themselves. In fact, most Small Businesses were in a state of denial about the epidemic.

Ramaube (in Cullinan, 1999) points out that Small Business, depend more on their individual employees and many may collapse when a key manager, or even the owner, succumbs to the disease. In addition, many Small Businesses are completely unprepared for the AIDS crisis. Even the big businesses are ignoring the full extent of the problem.

Businesses are not doing well when it comes to funding AIDS research to help fight the disease itself, or negotiating medical policies with insurance companies to keep their workers healthy longer. Many Small Businesses locked in AIDS-denial still trumpet their ambitions to become global players.

There is a mismatch in many Small Businesses between global ambitions and local realities. They are on a mission to become globally competitive yet are reluctant to undertake studies of their cost structures which will enable proper forward planning to take place.

Small Businesses rightly see rigid labour legislation as an impediment to global competitiveness because this increases the cost of labour. They fail to follow through and look at other impacts on the cost of employment. If they did, they would see that AIDS could be as big a threat to low unit costs as union-friendly labour laws. For instance, there will be a 54 percent increase in the cost of employment in the next five years if benefits remain the same. This was just one area where cost pressures were felt. It ignored issues like highly training and retraining costs, recruitment, productivity losses, the cost of higher absenteeism and leave entitlements (Myslik, 2001).

Myslik (2001) further points out that some managers privately acknowledged the likely long-term effects of AIDS were one reason for the trend away from labour-intensive processes and towards increased mechanisation and higher investment in systems.

Unfortunately, even production processes dominated by robotics cannot entirely remove the human factor. People are needed to maintain, repair and re-programme the robots. In effect, one finds one self reliant on fewer, but higher qualified and better trained people. The cost implications then become even more severe should these staff contract AIDS.

3.3 THE COSTS OF HIV/AIDS

Many employers and employees have already been significantly influenced by the impact of the HIV-positive condition of an employee or full-blown AIDS. This is hardly surprising, given the ever-growing number of HIV-infections.

It has been estimated that there are in the region of 3,6 million HIV-positive South Africans (including the Vaal Region), of which 90 percent are unaware of such infection (Kramer, 2001). It follows that this has the potential to have a very major negative impact on South African society at large, including the workplace.

Human trauma, clearly one of the many consequences of HIV/AIDS, also brings severely negative consequences to the workplace. The negative impact, which occurs within businesses, presents employers with increased labour turnover, reduced productivity and heightened absenteeism. In addition, increased strain is put on the costs associated with employee benefits (Healy, 1999).

According to Van Bassen (in Venter, 2000) it has been estimated that the pandemic that is HIV/AIDS will shortly account for between 5 percent and 6 percent of the payroll costs of every South African business and this excludes the further significant losses caused by absenteeism and lost productivity.

Slawski (in Efrat, 1997) points out that within the next 5 to 10 years, 25 percent of the South African working population is expected to be infected with AIDS.

When this happens, the average business can expect productivity to fall by about 5 percent. This is because there will be a large number of ill people in the workforce, as well as those taking compassionate leave to attend funerals and care for sick friends and family members.

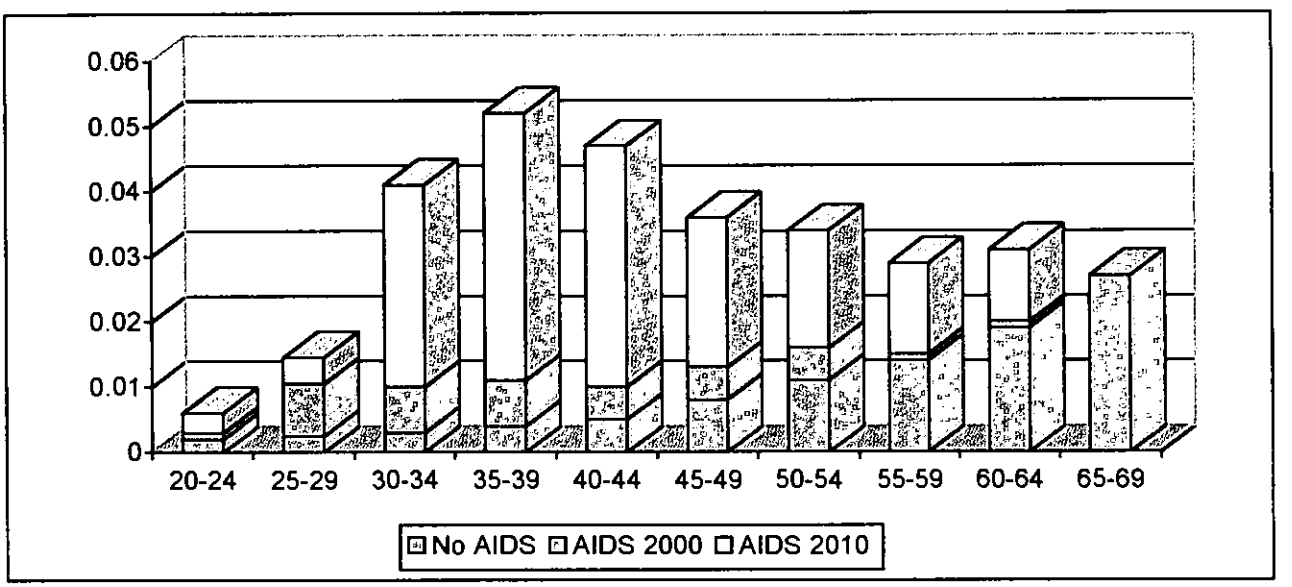
According to Kramer (2001) an AIDS-epidemic will claim some of the best business leaders and managers and a great number of workers at all levels of the production system. By claiming a large part of the urban population with disposable income and by impoverishing families and communities, it also affects the market base of African business. The cost of an average set of employee benefits is expected to double for many schemes by 2005 and to triple by 2010 (Kramer, 2001)..

AIDS will have the highest thrust on people aged 20 to 45 years. It is expected that by 2010, older members will be subsidising younger members (refer Figure 3.1 on p.57).

Moore and Kramer (2000) further points out that in schemes where the employer is fully responsible for increases in risk benefit costs, they project that this could add around 15 percent to the renumeration budget of a typical manufacturing Small Business by 2005 and 30 percent by 2010.

In schemes where this risk is passed on to members, life, disability and medical benefits are likely to be halved by 2005 and by one-third of their current level by 2010.

FIGURE 3.1: AIDS WILL MEAN OLDER MEMBERS MUST SUBSIDISE THE YOUNG



Source: Kramer, 2001:2

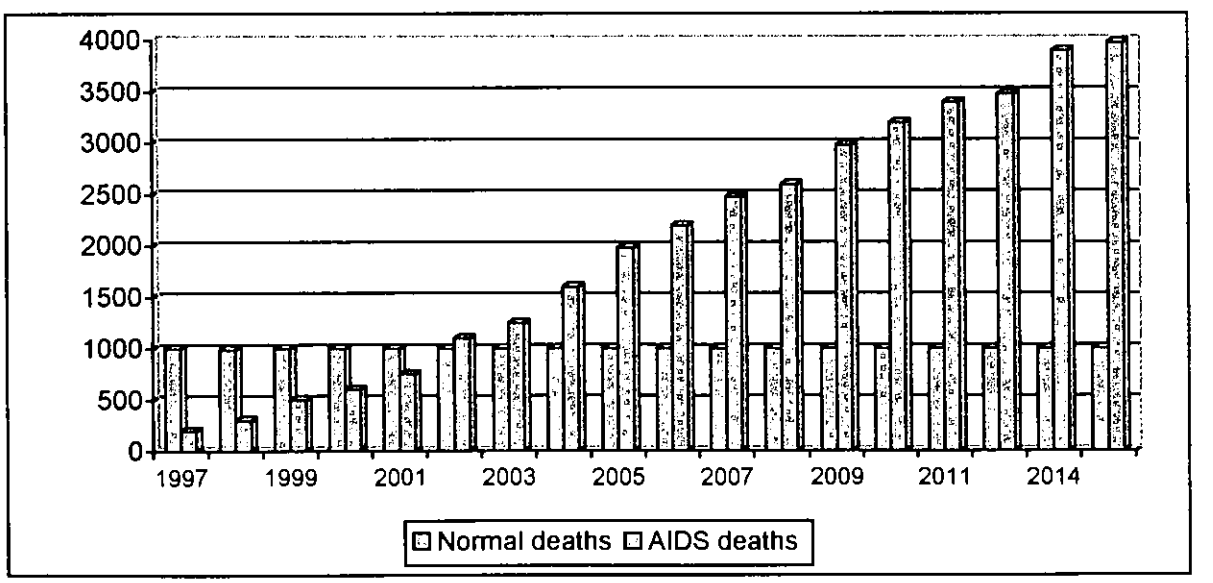
Kingborn (2000) states that South Africa's HIV/AIDS-epidemic is among the worst in the world and many businesses are recognising the need to manage its impact on productivity and competitiveness.

Projections indicated that more than four million South Africans would be HIV-infected by 2000 and almost six million by 2005. Levels of infection continue to grow in all nine Provinces. The epidemic will result in AIDS-illness and death mainly among 25 to 49 year olds, the core of the workforce.

The impact of the epidemic remains hidden, even in areas where it has reached an advanced stage. Its effects emerge gradually and are unlikely to manifest fully until after 2010. This is mainly due to the delay, averaging 8 to 10 years, from HIV-infection to AIDS and death. The stigma and fear of discrimination also cause people to hide their status.

Over the next 10 years, many South African businesses will begin to lose approximately 4 percent of their employees to AIDS each year (see Figure 3.2 below). The syndrome among co-workers, their friends or family will in some way affect virtually every manager and employee. These factors will impose several costs on businesses.

FIGURE 3.2: PROJECTED AIDS-DEATHS AMONG SOUTH AFRICAN EMPLOYEES



Source: Kingborn, 2000:22

Kingborn (2000) further points out that the vulnerability of businesses will vary depending on factors such as the type of production process, the risk

profile of employees, skills of infected employees and employee benefit structures.

Active efforts to prevent new infections and manage the impact of established infections will reduce a firm's vulnerability. Small Businesses with well-developed human resource and industrial relations management will be better equipped to manage HIV/AIDS costs and overall impact.

Representative data on the magnitude of costs to South African businesses is scarce. The available evidence indicates that for most businesses, the costs of HIV/AIDS among employees are likely to be devastating in any one year. Over time, however, costs will be substantial and in some Small Businesses illness or death of entrepreneurs or key employees may be disastrous (Kingborn, 2000).

The impact of HIV/AIDS on the business environment will be substantial, although many of the effects cannot be predicted with certainty.

According to Hilburn (2000) the most insidious effect of HIV/AIDS in the workplace is that on the morale of the workforce. An AIDS-afflicted colleague affects the work team as a whole, his suffering depresses his co-workers, his absenteeism reduces the productivity of the team, deadlines are missed, complaints become common and colleagues pay a high price in stress and in increased work loads. Business run the risk of losing capable workers to less stressful positions elsewhere and a high staff turnover almost always accompanies the presence of AIDS in the business. Again there are obvious implications for the training department.

According to Whiteside and Sunter (2000:99-100) the effects of HIV/AIDS on business are reduced productivity, increased costs and loss of customers. Profits are being depressed by a number of factors:

- Absenteeism is increasing not only because of ill health experienced by employees, but also because workers take time off to care for their families and for funerals.

- The morale of the workforce is sagging.

- Sick workers are less productive at work and cannot carry out the more demanding physical jobs.

- Accidents occur more frequently because of fatigue in the workplace.

- Employees who die or retire on medical grounds have to be replaced; their replacements may be less skilled and experienced and therefore may require training.

- The average age and experience of workers fall as the proportion of new and younger recruits rises.

- Employers are increasing the size of their work force to provide for deaths during apprenticeship and because of absenteeism generally.

- As skilled workers become scarcer, wages have to be increased for the limited pool available.

- The communities in the neighbourhood of a business need more support to weather the crisis.

- The costs of health care, medical aid and hospitalisation are rising.

- Where businesses have granted credit to customers for purchases and those customers are dying of AIDS; the balance of the loans has to be written off.

- Growth in the volume of sales and in some cases the actual volume of sales itself, is declining as the market shrinks through sickness and death.

The major concern for the business is to make a profit by selling goods and services for more than it costs to produce them. HIV/AIDS affects profitability through factors internal and external to a business. The external factors include changes in markets, such as increases in wages or decreases in demand and rising costs associated with the breakdown in institutions. These will be difficult for business to manage. It is the internal effects, such as increasing absenteeism, higher pension pay-outs, and breakdowns in worker discipline and morale, which require responses from firms (George, 2001).

George (2001) further points out that the cost of producing goods is a function of the cost of inputs such as labour, materials and utilities. The impact of HIV/AIDS may raise costs and reduce productivity for a number of reasons:

- Absenteeism: This includes more employees missing work due to ill health. Women's roles as caregivers will necessitate time off and funerals can be a major source of lost time. Employees may force themselves to come to work for fear of losing jobs, but effectively, be absent.

- Workers whose health is failing will be less productive and unable to carry out physically or emotionally demanding jobs.

- Replacements for employees who die or retire on medical grounds may be less skilled and experienced. The business incurs training costs.

- Employers may increase the size of the work force; this will result in an increase in payroll costs to cover for absenteeism.

3.3.1 DIRECT COSTS

Moore and Kramer (2000) points out that the affect of AIDS on benefit arrangements depends on:

- The structure of the risk benefits, for example, costs in schemes, which offer high benefits at young ages are more likely to increase rapidly.

- The age and gender profile of the members, because the sexually active population is most at risk of being infected with HIV.

- The income level of members because income is a proxy for access to AIDS-education.

- The geographical distribution of members.

- The business in which the members operate because some groups may have relatively high exposure to HIV.

- The extent and effectiveness of a business's AIDS-intervention measures, for example, AIDS-education programmes.

According to Martin (2000) AIDS would bring huge cost increases for employee benefit and medical schemes. The cost of an average set of benefits is expected to double for many schemes by 2005, and triple by 2010.

In schemes where the employer is fully responsible for increase in risk benefit costs, it is projected that this could add around 15 percent to the renumeration budget of a manufacturing business by 2005 and 30 percent by 2010. In schemes where the risk is passed on to members, life, disability and medical benefits are likely to be halved by 2005, and be one-third of their current level by 2010.

Martin (2000) further states that schemes which would be hardest hit include those which:

- Offered high benefits at young ages.

- Had a high proportion of younger members.

- Operated in high-risk areas.

- Had poorer members.

- Operated in business with a high exposure to HIV.

Shevel (2000) believes that to project the increasing cost of group life and disability cover, several factors have to be taken into account:

- The way in which risk benefits is structured.

- Member information, such as age, gender, income level, geographical distribution and the sectors where members are employed.

- The scope and efficacy of employers' AIDS-intervention measures and the extent of their liability for escalating costs.

Shevel (2000) further states that medical costs need to be evaluated in terms of the extent of corporate liability for post retirement medical benefits, the cost impact of capping AIDS-benefits while paying for treatment of opportunistic diseases if HIV-status is not disclosed, and the cost impact of community rating and medical inflation, to name a few variables.

Over the next 10 years, many South African businesses will begin to lose approximately 4 percent of their employees to AIDS each year. The syndrome among co-workers, their friends or family will in some way affect virtually every manager and employee. These factors will impose several costs on businesses.

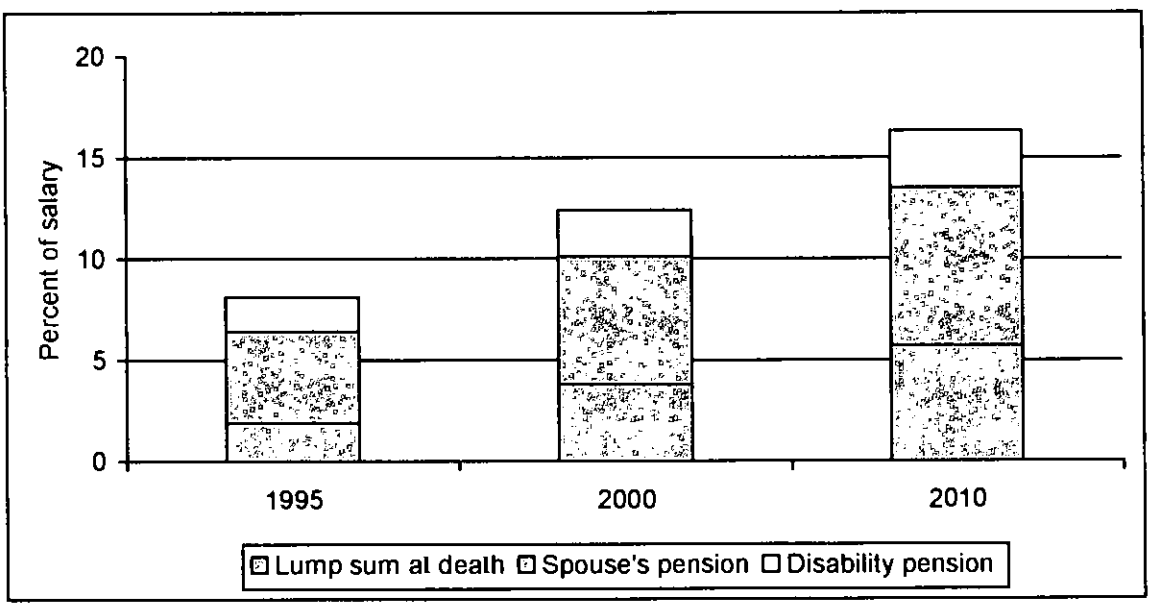
The direct costs of HIV/AIDS will come from increased claims on health care and other employee benefits. Costs will differ depending on benefit structures, but it is projected that the cost of many medical schemes could double within five years unless effective management of care is implemented. Without restructuring the cost of an average set of risks, benefits are expected to double over the next 5 to 10 years (Kingborn, 2000).

Moore (in Dasnois, 2000) believes that for many employers, the cost of an average set of employee benefits is likely to double by the year 2005 and treble by the year 2010. For instance, the cost to the employer of an average lump sum death or disability benefit is likely to jump from 1,9 percent of an employee's salary in 1999 to 3,8 percent in 2005 and 5,7 percent in 2010.

For defined contribution retirement funds, where the employer does not take responsibility for increases in costs, this additional cost will be passed on to members. This means that life disability and medical benefits are likely to be halved by the year 2005 and cut to one third of their current level by the year 2010.

George (2001) points out that HIV/AIDS will increase the cost of employee benefits, such as group life insurance, pensions and medical aid. The impact of HIV/AIDS on employee benefits is usually sudden and of a large magnitude (refer Figure 3.3 below). The figure shows how three benefits – a lump sum payment on death, a spouse pension, and disability pension are likely to rise in the face of increased mortality and morbidity. In 1995 these benefits were about 7 percent of payroll costs. By 2010 they would cost around 18 percent.

FIGURE 3.3: IMPACT OF AIDS ON EMPLOYEE BENEFITS IN SOUTH AFRICA



Source: Whiteside and Sunter, 2000:102

According to Kramer (2001) the cost of a typical set of risk benefits for a manufacturing business, expressed as a percentage of salary, may be expected to increase as follows over the next 10 years:

- Lump sum death or disability benefit: 1,9 percent in 1999, 3,8 percent in 2005; 5,7 percent in 2010.

- Spouse's pension: 4,5 percent in 1999; 6,3 percent in 2005; 7,8 percent in 2010.

- Disability pension: 1,7 percent in 1999; 2,3 percent in 2005; 2,8 percent in 2010.

- Medical contributions: R400 a month in 1999; R800 a month in 2005; R1 200 a month in 2010.

Kramer (2001) further points out that those who will bear the greatest financial burden from the direct cost of AIDS, will be employees who have recently converted from a defined benefit arrangement where the employer is fully responsible for increases in risk benefit cost, to a defined contribution arrangement, where increases in risk benefit costs result in fewer benefits.

Strugnell (2001) points out that for a typical employer, it would be no surprise to find the costs of providing a disability income benefit doubling, with the cost of providing a lump sum death benefit tripling over the next decade as the epidemic reaches critical mass.

Medical aids are similarly going to be faced with increasing costs of medication, in particular prophylactic and reactive treatment against opportunistic infections, and increased incidences of hospitalisation. The cost of providing medical aid benefits is therefore also likely to increase.

3.3.2 INDIRECT COSTS

Shevel (2000) points out that indirect costs would include the number of working days likely to be lost through sick and compassionate leave, and recruitment and training of replacement staff, including agency expenses and redeployment and retraining of staff incapacitated by AIDS.

Shevel (2000) further states that there are matters of pre-benefit medical testing, where applicable, counseling for staff who is HIV-positive and maintenance of strict confidentiality.

Strugnell (2000) believes that effects would be felt in increased absenteeism, reduced productivity, more funeral and compassionate leave, and increasing costs of recruitment and training due to more frequent staff turnover.

Martin (2000) warned that the cost of AIDS will be felt beyond the direct impact of the disease, and have been largely ignored by Small Business so far.

Indirect costs included:

- Increased costs of recruiting and training staff because of higher rates of death and disability.

- Costs of additional sick and compassionate leave.

- The negative impact on staff moral.

- Costs of ensuring occupational health and safety standards were inadequate.

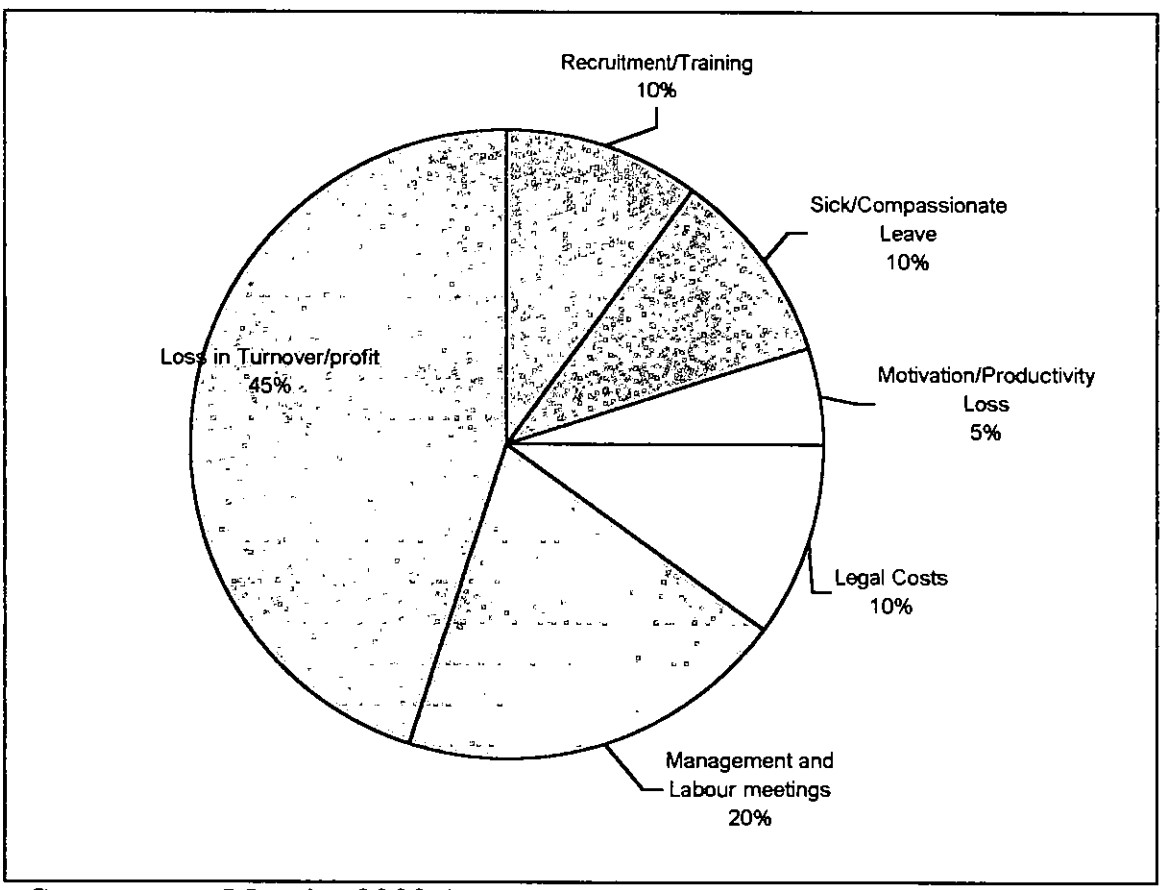
- Dealing with prejudice amongst staff.

- Ensuring that the HIV status of staff remained confidential.

- Management and labour meetings to discuss the AIDS-crisis.

- Loss of turnover and profits due to the impact of HIV/AIDS on clients (refer Figure 3.4 below).

FIGURE 3.4: INDIRECT COSTS OF AIDS



Source: Martin, 2000:2

Moore and Kramer (2000) state that businesses have mostly ignored the indirect costs of AIDS, which include:

- Higher costs of recruiting and training staff because of higher death and disability numbers.

- Costs of additional sick and compassionate leave.

- The negative effect on staff moral.

- Costs of ensuring occupational health and safety standards are inadequate.

- Dealing with prejudice among staff when some employees are HIV-positive.

- Ensuring that staff members' HIV status remains confidential.

- Management and labour meetings to discuss the AIDS-crisis as it develops.

- Loss of turnover and profit due to the effect of HIV/AIDS on clients.

Moore and Kramer (2000) further estimate that indirect costs could add a further 10 percent to the renumeration budget of a typical manufacturing business by 2005 and 15 percent by 2010.

According to Kingborn (2000) indirect costs are likely to have the most significant impact on many Small Businesses.

These include:

- Absenteeism due to illness, funeral attendance or caring for sick family members.

- Higher recruitment and training costs.

- Loss of skilled people to HIV/AIDS, which can disrupt production, lower performance and potentially increases market wages for people with scarce skills.

- Reduced job performance due to illness, stress and low morale among employees infected or affected by HIV/AIDS.

- Potential labour relation breakdowns and litigation costs if businesses fail to manage HIV/AIDS-related issues effectively.

Whiteside and Sunter (2000:108) believe that it is likely that AIDS will also have indirect impacts on the business community. Examples of this are:

- The business may be able to adapt to absenteeism and the death of employees. However, government is less able to do so, and the result may be increasing government inefficiency, which leads to delays in granting licenses, approving applications and so on.

- Service providers may operate less efficiently.

- Trade unions may mobilise and make demands around HIV issues.

- The increase in orphans and street children may increase the rate of crime, which will make it more difficult to retain skilled but internationally mobile staff.

- The police and defence force may experience increased mortality, particularly at the middle levels, which could decrease stability.

- The state health system will experience much higher demands being placed on it, which may lead to deterioration in the level and quality of service. This could put pressure on the business to use private hospitals to care for employers.

- Government resources may be diverted from infra-structural projects, crucial to the functioning of the business, into care and prevention programmes.

According to Hilburn (2000) we need to accept that greater numbers of employees will need to be trained to ensure that skills are available to do the job. At the same time, work pressures due to staff losses will make it more and more difficult to release others for training.

Productivity, the trainer's ultimate goal, will inevitably suffer as AIDS become more widespread, and it is not just the primary victims of AIDS

who will be affected. Absenteeism will escalate among afflicted workers, as they struggle with a succession of minor ailments in the early days, and with protracted periods of hospitalisation later on. Those not infected will increasingly be called upon to attend funerals, to help ill relatives, or to care for children whose parents can no longer cope or are already deceased.

Career planning for employees will have less significance in the light of the need to be constantly recruiting and training new workers. Under normal circumstances, mortality among 30 to 40 years olds is low, and businesses rely upon this age group for experience, leadership and productivity. AIDS, however, forces a rethink; it will take its greatest toll among the 30 to 40 years olds.

The indirect costs will also affect the bottom line in business. AIDS-patients will contribute towards lost work time, with others having to do their work while they are unavailable. Productivity will suffer if co-workers refuse to work with AIDS-infected employees. Finally it is obvious that recruitment costs will increase as it is generally accepted that AIDS is a lethal disease at this stage (Gerber, et al. 1998:247).

3.4 CONCLUDING REMARKS

HIV/AIDS is insidiously attacking and weakening the productive capability of business' human resources and the manner in which management addresses HIV/AIDS in the workplace will determine whether their business will survive.

More employees are leaving work because of HIV/AIDS-associated illnesses and more employees are dying of AIDS while in service.

Illness, absenteeism and business changes are already affecting productivity and service delivery. The costs of employee benefits and medical schemes are expected to escalate.

The business should have a direct interest in ensuring that HIV/AIDS does not unnecessarily affect costs and the business environment. The business community must invest pro-actively in impact reduction before the full force of the epidemic hits and costs spiral out of control. Above all taking HIV/AIDS into account should be a standard part of doing business.

In the following chapter the economic and social impact of HIV/AIDS to Small Business are determined.

CHAPTER 4

THE ECONOMIC AND SOCIAL IMPACT OF HIV/AIDS ON SMALL BUSINESS

This chapter explores the economic and social impact of HIV/AIDS on Small Business.

4.1 INTRODUCTION

HIV/AIDS in South Africa primarily affects those who are young, productive members of society. Analysts argue that HIV/AIDS will likely lead to increase absenteeism in the workplace, which will in turn lead to substantial declines in productivity, skills and available expertise. HIV/AIDS will affect employers, households and the economy negatively.

While the prevalence of AIDS-deaths will be higher in labour-intensive business, the impact of the disease will be as severe in capital-intensive business. This is because semi-skilled and skilled labour used in capital-intensive industries will have to be replaced pushing up the costs of training and recruiting new employees.

The premature death of the adult population, typically at ages when they have already started to form their own families and have become economically productive, can be expected to have a radical effect on virtually every aspects of social and economic life.

4.2 ECONOMIC IMPACT OF HIV/AIDS

According to ING Bearings (2000) AIDS will cause an annual loss of 3,1 percent in real gross domestic product (GDP) between 2006 and 2010. Between 2011 and 2015 the annual loss in real GDP is expected to be 4,7 percent.

As the virus continues to spread among the population and develop into full blown AIDS, the following economic problems will be experienced:

- A decreasing labour force.

- Lower labour productivity because of absenteeism and illness.

- Additional costs to business because of higher benefit payments and replacement costs.

- Lower labour incomes, as employees bear some of the AIDS-related costs.

- Reduced consumer expenditure caused by a smaller economically active population.

- Increased business demand for health services.

- Higher government expenditure on health services.

Sher (in van Zyl, 1999) believes that we can not even visualise what it will cost South Africa's economy in future, notably from 2005, when a million of HIV-positive cases develop into full-blown AIDS.

Businesses should be filled with trepidation knowing that one fifth of South Africa's economically active work force is HIV-positive.

We are talking about a loss of unskilled and skilled workers as well as training costs, much lower productivity and higher costs of health care and pension payouts in the event of deaths. Productivity will be affected through disease and funeral attendance, a higher incidence of accidents and even discrimination and tension in the workplace.

Katzenellenbogen (2000) points out that the impact of AIDS on the economy begins with the impact on the workforce and higher government and private spending on health care. The labour force will be 10 percent smaller on average over the next 15 years than it would be in the absence of the epidemic. Added to the labour shortage is a drop in labour productivity due to absenteeism. The skilled labour force will be 18 percent below what it would be in the absence of AIDS.

This will exacerbate South Africa's existing skill shortage, pushing up wages, costs and ultimately inflation. Businesses will also face rising recruitment, training, pension, medical and other costs.

Katzenellenbogen (2000) further believes that in about 11 years there will be rise in the wage bill due to the epidemic which will raise producer

inflation 4.5 percentage points higher than it would be without an epidemic. Interest rates may be higher because of reduced savings levels.

Growth is also lowered by the reduction in wage income as a result of the rise in illness and death rates. Health care demand will absorb more funds.

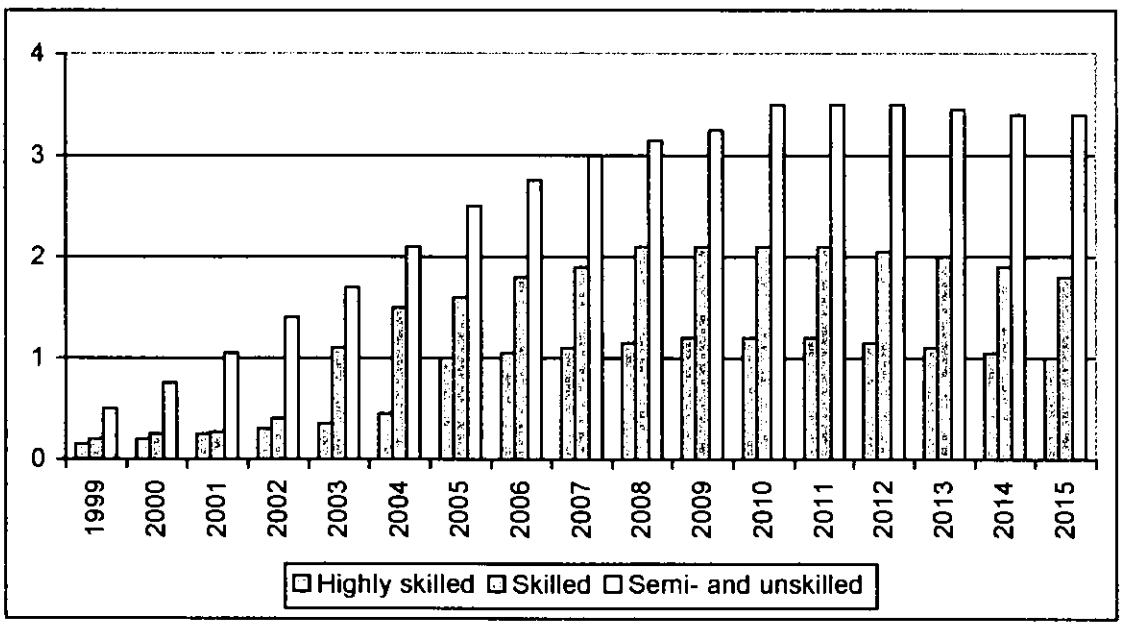
A lower population growth rate and a smaller labour force have a negative effect on demand for housing as well as durable and non-durable goods. Demand for housing will be more than 9 percent lower in 15 years due to the fall in the population growth rate. Higher spending on health care means South Africa's savings shortage may be all the more critical.

For government, the implications are a more than 4 percent reduction in tax revenue in 15 years. Reduced growth in revenue and higher health spending will mean rising pressure on the budget deficit. If government sticks to its strict fiscal discipline, this could further reduce demand and growth.

While this may not be a recession scenario, it is one that points to imminent and immense negative structural changes for the economy (refer Figure 4.1 on p.79).

Figure 4.1 follows on p.79.

FIGURE 4.1: PROJECTED AIDS-DEATH PER 100 WORKERS ACCORDING TO SKILL LEVEL



Source: Katzenellenbogen, 2000:22

Cullinan (1999) states that while the costs of HIV/AIDS can be measured in human terms, about 2000 people dying each day in five years' time, it is far more difficult to say how this will affect the country's gross national product (GNP).

Many of those infected are low-wage earners or unemployed, so they contribute little to the GNP. At the same time, wealthier people can afford anti-retroviral drugs to slow down the transition of their HIV infection to AIDS, thus prolonging their economically productive years.

Whiteside (in Cullinan, 1999) further points out that businesses (other than those in service industries) may well adapt to lessen the impact of sick or dead staff.

Businesses may, for example, decide to move towards capital intensification or outsourcing of non-core business functions. Businesses could opt for the multi-skilling of staff so that there is more job flexibility or employ extra staff.

What business does not understand is that the government does not have this flexibility. The government cannot easily replace sick officials and government's lack of capacity is going to affect business badly – from fewer Home Affairs officials to process work permits to fewer police officers to fight crime.

According to Billinghurst (1997) by the year 2007, up to 2 percent of South Africa's gross national product would be spent on AIDS-related activities.

Millions of rands of tax money would be spent on covering the medical expenses of AIDS-sufferers and equivalent losses would also be incurred through the resulting sick leave and lost productivity.

In addition to these two serious dents in our already tight budgets, money will also have to be spent on pension for the widows, widowers and children of AIDS-victims.

Peters (2000) believes that predicting to what extent HIV/AIDS will affect any given economy is not an easy task. Several recent publications by the World Bank shed light on the claim that HIV/AIDS will have devastating

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Peters (2000) believes that predicting to what extent HIV/AIDS will affect any given economy is not an easy task. Several recent publications by the World Bank shed light on the claim that HIV/AIDS will have devastating

effects on economies. The economic effects on HIV/AIDS depends on several complicating factors, including:

- Efficiency of the labour markets (its ability to replace skilled labour).

- Unemployment rate (percentage of skilled workers who would be able to replace those who can no longer work).

- Distribution of HIV infection by productivity of the worker (relative productivity of those who are infected).

- Time lost from work (loss of productivity).

- Proportion of the treatment, which is financed by household savings (loss of capital savings and thus investment).

- Effectiveness of formal and informal insurance mechanisms (their ability to sustain households).

Peters (2000) further points out that the situation is not as simple as the analysts would have us believe. A high HIV rate will have negative effects on the economy, but how negative depends on the demographics of the epidemic in any given country.

If we are to assess the impact of HIV/AIDS on our economy, we need more than simple figures on South Africa's infection rates (which are extrapolated from pregnant women).

We need to know how many skilled workers are infected:

- If the economy is training the replacement workers.

- How much time is actually lost from work and how that affects productivity?

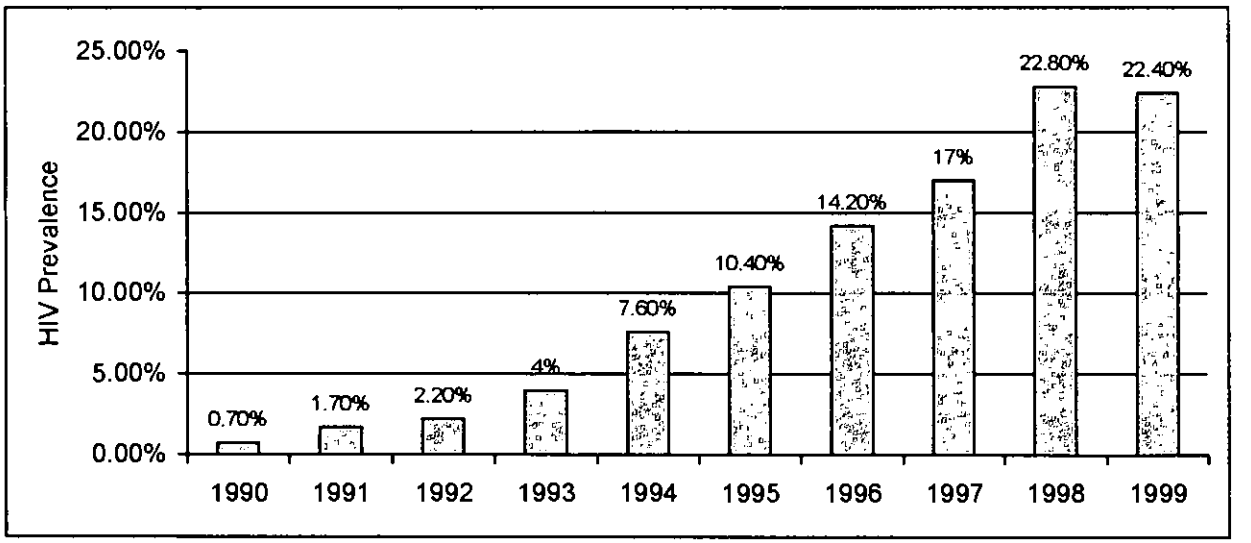
- How HIV-positive and AIDS patients are funding their medical care.

- How their households are coping with increasing costs.

Unfortunately, data on HIV infection in South Africa are not yet that intricate to predict accurately the effects the epidemic will have on our economy (refer Figure 4.2 on p.83).

Figure 4.2 follows on p.83.

FIGURE 4.2: HIV-INFECTION RATES OF WOMEN ATTENDING PUBLIC ANTENATAL CLINICS, 1990 TO 1999



Source: ING Bearings, 2000:4

According to Strugnell (2000) a version of the potential economic disaster travelling under the banner of AIDS was going to require the creative engagement of resources to, firstly, educate with the aim of behavioural change in those uninfected but at risk, rather than to simply transferring information to them, and secondly, to care for those infected.

ING Bearings (in Whiteside and Sunter, 2000) noted that, although data were imperfect, the AIDS-epidemic was expected to have an adverse impact on the South African economy. The "non-alarmist" scenario suggested that annual GDP growth would be between 0,3 and 0,4 percentage points lower than the no-AIDS baseline over the next 15 years. The key areas identified by the report include:

- South Africa is already battling with a skill shortage. AIDS will exacerbate this and raise renumeration and replacement costs for businesses.

- There will be a smaller labour force with lower productivity and income at the same time as demand grows for services such as health and welfare. Lower tax revenues combined with higher health spending will put pressure on the government's budget deficit. However, demand for housing as well as durable and non-durable goods could be negatively affected.

- A rise in the inflation rate together with a smaller savings pool could well put pressure on interest rates.

- Domestic savings may be squeezed to a point where foreign investment is vital to plug the gap. However, AIDS and the perception that it creates may deter such investment (refer Table 4.1 on p.85).

Table 4.1 follows on p.85.

TABLE 4.1: ECONOMIC IMPACT ON WORKFORCE OF HIV/AIDS

Direct costs	Indirect costs	Systemic costs
Benefits package ▪ Company-run health clinics ▪ Medical aid/health insurance ▪ Disability insurance ▪ Pension fund ▪ Death benefit/life insurance payout ▪ Funeral expenses ▪ Subsidised loans	**Absenteeism** ▪ Sick leave ▪ Other leave taken by sick employees ▪ Bereavement and funeral leave ▪ Leave to care for dependants with AIDS	**Loss of workplace cohesion** ▪ Reduction in morale, motivation and concentration ▪ Disruption of schedules and work teams or units ▪ Breakdown of workforce discipline (slacking, unauthorised absences, theft, etc.)
Recruitment ▪ Recruiting expenses (advertising, interviewing, etc.) ▪ Cost of having positions vacant (profit the employee would have produced)	**Morbidity on the job** ▪ Reduced performance due to HIV/AIDS sickness on the job	**Workforce performance and experience** ▪ Reduction average level of skill, performance, institutional memory and experience of workforce
Training ▪ Pre-employment education and training costs ▪ In-service and on-the-job training costs ▪ Salary while new employee comes up to speed	**Management resources** ▪ Managers' time and effort for responding to workforce impacts, planning prevention and care programmes, etc. ▪ Legal and human resource staff time for HIV-related policy development and problem solving	
HIV/AIDS programmes ▪ Direct costs of prevention programmes (materials, staff, etc.) ▪ Time employees spend in prevention programmes ▪ Studies, surveys and other planning activities Direct costs →	Indirect costs Total costs of HIV/AIDS in the workforce	← Systemic costs

Source: Whiteside and Sunter, 2000:112

4.3 SOCIAL IMPACT OF HIV/AIDS

The social disruptions that often follow HIV-infection are twofold. Some are by-products from the emotional upset of the person who learns of certain HIV exposure. Other social difficulties stem from avoidance or fear of others, which increases the person's sense of isolation. Anxiety, depression and anger are often detrimental to interpersonal relationships. In addition, HIV-positive persons may withdraw from social contact (Kelly and Lawrence, 1988:88).

Pollack, et al. (in Kelly and Lawrence, 1988:88) found out that most HIV-positive persons spent more time in solitary activities after they learned they were zero-positive, and most feared that their HIV exposure would negatively affect established relationships. More than half of those who were in steady relationships hesitated to inform their partner, fearing they would precipitate a break-up in the relationship. There is some evidence to suggest that such fears may be realistic. HIV zero-positivity led to dissolution of existing relationships for approximately one-third of the couples surveyed, and couple disruption was equally common among heterosexual and homosexual couples.

Kingborn (2000) believes that HIV/AIDS has the potential to result in social instability. The epidemic is virtually certain to increase poverty and inequality, as households face the loss of breadwinners and costs of care. More than a million children are expected to be orphaned by 2006 in South Africa, and many will lack nurturing, socialisation and education.

Kelly and Lawrence (1988:89) further points out that avoidance reactions of others can unwittingly heighten distress and leave the HIV-positive person feeling stunned, vulnerable and isolated from the very persons who had previously been a dependable support group. Because learning of HIV exposure often produces an emotional crisis, strong social supports are especially needed during this time. A strong network of family and friends can be important in helping the person to cope with this adjustment. Unfortunately, many homosexuals and drug users are estranged from their families, are already negatively stigmatised by society, and may lack other social supports. Some persons retreat into a self-imposed isolation, fearing re-exposure to new infections, out of concern over transmitting the virus to others, or simply because they are stunned by the news of their exposure. Obsessional thinking hinders both concentration and responsibility to others, leaving many persons unable to maintain their usual investment in work or close personal relationships to the same extent as before learning of their zero-positivity. During a personal crisis, it is common for people to become more self-absorbed and less sensitive to others. This is no less true during the personal crisis that often follows learning of HIV exposure. The meaning that an infected person attaches to zero-positivity may also contribute to social isolation. Self-labelling oneself as "contaminated" can foster self-isolation and feelings that the HIV-affected person no longer belongs in the mainstream.

When zero-positivity becomes known, there may be a loss of relationships and social supports, and even people who desire to maintain their social support systems may discover that others are now fearful and avoidant of them. Thus, even when the HIV-exposed person responds to zero-

positivity in emotionally health ways, the reactions of others can produce social isolation and rejection.

Fraser-Moleketi (1999) points out that a culture of silence and fear has developed around the HIV/AIDS-disease. Individuals refrain from disclosing their HIV status because of fear of rejection from and isolation in the community.

Harebottle (1999) believes that for those already infected, emphasis had to be placed on impact reduction and life extension. Workers could maintain productivity for many years after being infected and productivity losses and other costs were only experienced when they developed full-blown AIDS.

Grossett (1999) states that an increase in the prevalence of HIV/AIDS-inflicted employees will lead to an increasing number of disoptions in the workplace due to the discrimination and stigmatisation attached to the disease, unless the disease and its consequences are properly managed. We have an obligation to protect the uninfected and need to take into account the competing rights of the sufferer and those of the healthy populace.

The spread of AIDS is for the most part through sexual intercourse; therefore individuals can exercise some control. Contracting HIV is invariably a death sentence and the sufferer becomes a potentially lethal sex partner. It is hardly surprising therefore that the disease carries a social stigma, which the gay lobby in the West exploited in seeking special protection for HIV victims.

In the present politically correct climate, the epidemic continues to grow, suggesting that measures to educate people to treat everyone as if they have AIDS and to protect themselves through preventive measures, have largely failed (Rabinowitz, 1997).

Rabinowitz (1997) further points out that we are condoning the spread of AIDS by hiding from people the fact that they are infected. We are evading our responsibility to protect the healthy as well as the sick. The least we could do is to create a clear sanction against individuals who knowingly transmit AIDS to sexual partners or hide from them the fact that they are infected. This can not be done if people are ignorant of their situation. Criminalising non-disclosure to partners may discourage people from finding out about their HIV/AIDS-status, in which case we will be no worse off than now. It may lead to sexual ostracism of sufferers.

Msimang (2001) states that while an impression is created that people living with AIDS are finally getting the support they deserve from the community, the real picture is quite different and millions are still dying alone.

According to Mbuya (2000) any potentially life-threatening information is devastating, particularly for a young adult in the prime of life. To react with shock, denial, anger, anxiety, guilt, weeping, panic, hysteria or with numbed, depressed withdrawal, is completely normal and to be expected. Many people will need to work through a whole range of changing feelings and emotions before they can fully accept their situation, and begin to cope

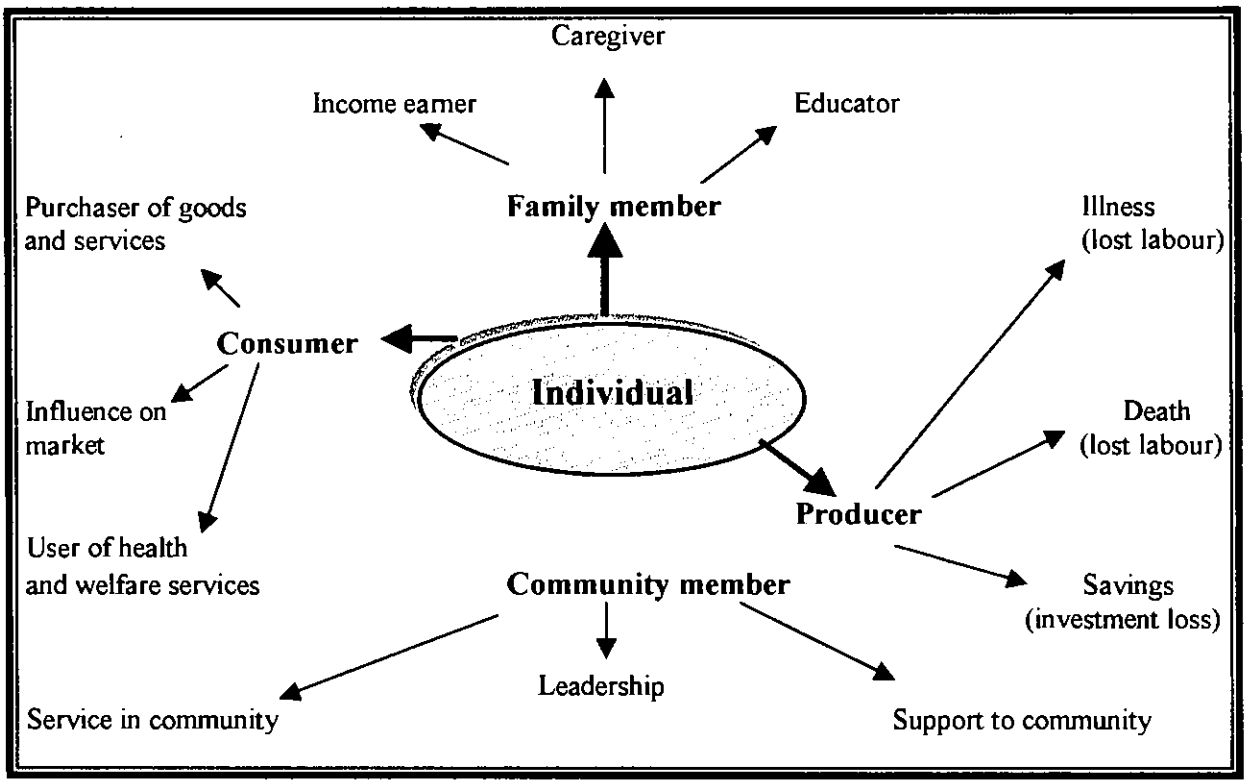
well with life again. However, with good support most people can learn to cope.

In this situation of extreme need, many people feel unable to tell relatives or friends of their HIV diagnosis for fear of stigma and rejection. Thus they do not have access to the traditional sources of support in South African society, the extended family and perhaps traditional healers. Even if they do confide in the family, are accepted and not rejected, support in South African society, the extended family and perhaps traditional healers of support may be limited by a lack of understanding of the problem. AIDS is a recent problem posing new dilemmas, and strikes at the heart of family life, security and childbearing. Relatives may be very confused about what advice to give, and how to balance the needs of husband, wife, their respective parents, children and other relatives.

Whiteside and Sunter (2000:83-84) state that social impacts arise because people interact in ways other than economic. South Africa is at the beginning of the AIDS-epidemic. Families, the public health service, and some businesses are feeling the impact of illness and death. However, it will take time to work through into society at large. The complexity of this is illustrated in Figure 4.3 on p.91.

Figure 4.3 follows on p.91.

FIGURE 4.3: THE INDIVIDUAL AS AN ECONOMIC AND SOCIAL ACTOR



Source: Whiteside and Sunter: 2000:84

Simon (1997) points out that public figures – who have less chance of persecution – have also not come forward to declare that they, or their family members, are HIV positive. Nor have businesses made it easy for employers to disclose their status.

As a result, ordinary people remain afraid to reveal that they have HIV/AIDS for fear of being thrown out of a job, home or family.

Skweyiya (2001) believes that a cardinal principle that must guide all efforts against HIV/AIDS, is the thesis that HIV/AIDS is a social and development issue.

HIV/AIDS requires that we all become activists and understand how the conjuncture of poverty and HIV/AIDS affects family and community life.

It also requires that we understand and address the various life-and-death issues that are important to families and that we understand and address the different responses of communities and other agencies to the epidemic.

According to Bennett (2000) the impact of HIV/AIDS is felt first in the home, "the first brick of the economy". As breadwinners become ill, incomes decline because he or she can no longer work, and costs, on health care for instance, increase. Families eat into savings if they have any. Children may be taken out of school and women may have to work less to take care of an ill family member.

4.4 CONCLUDING REMARKS

We are actually dealing with a very serious crisis, which not only impacted on society, but also the business and economy. It needed to be dealt with urgently and properly.

The cost to the country's economy health services and business will be tremendous and the labour supply will be affected as the disease targets the most productive age group.

The economic impact of AIDS after the loss of a breadwinner will be devastating, because AIDS would cause the sickness and death of many young adults. It would seriously damage the economy.

It would result in a decline in the total labour force, because many of those affected will be skilled and educated persons, which will impact negatively on productivity and training costs. There may be problems at places of employment based on discrimination or prejudice.

The next chapter establishes, analyse and examine intervention programmes for employees with HIV/AIDS.

CHAPTER 5

HIV/AIDS-INTERVENTION PROGRAMMES FOR EMPLOYEES

This chapter focuses on HIV/AIDS-intervention programmes for employees.

5.1 INTRODUCTION

HIV/AIDS-epidemic has already been in full swing for some years, generally underestimated simply because an HIV-infected person can still put in a full day's work. Now the Aids epidemic has begun in earnest, and morgues in many Small Businesses are unable to accommodate the influx of its victims.

Apart from a few notable exceptions, businesses were not planning for the epidemic at all or making token attempts to create awareness about it.

The danger is that businesses will wait until the impact of Aids become noticeable in their financial statements, and only then implement an HIV/AIDS-intervention programmes.

HIV/AIDS is affecting businesses in profound and costly ways. The epidemic poses a serious threat to global competitiveness for the South African private sector. Disease prevention and health promotion are not commonly thought to be business concerns, but HIV/AIDS is forcing a re-examination of the role of businesses in these areas.

5.2 HIV/AIDS-INTERVENTION PROGRAMMES

HIV risk reduction counselling can be conducted in almost any setting where persons at risk are seen, whether the setting is a "traditional" one for the delivery of health behaviour interventions. Because people at risk of HIV infection rarely seek out specific assistance in risk reduction and are often not "therapy oriented", it is desirable and usually necessary to bring intervention into the social, community or health care systems already used by those at elevated risk. This can be accomplished by integrating HIV prevention programmes into those systems, identifying persons at elevated risk, and offering behaviour change assistance to the identified high-risk clients. It can also be accomplished by developing outreach campaigns that target larger numbers of people in a community or community segments (Kelly, 1995:30).

Harebottle (1999) believes that the starting point for intervention is determining the stage of the epidemic within the organisation. It needs to know where it lies on the AIDS-curve. With 10-year demographic figures, it is now possible to establish an organisation's prevalence within a 5 percent range, as well as the outlook for the future.

According to Kingborn (2000) management of HIV/AIDS impacts on employees, operations and competitiveness. Effective, comprehensive responses will benefit businesses directly and have wider benefits in communities and society at large. Several specific responses are likely to be good investments for businesses:

- *Visible commitment of business leadership to HIV/AIDS-issues.* This is critical for effective responses in business, communities and the broader society.
- *HIV prevention.* Well-designed programmes that target all employees including management are critically important. Without them, rate of new infection will remain high for many years, even in regions with advanced epidemics. Costs averted are estimated to be between 3.5 and 7.5 times the costs of interventions. Key components include education, condom access, STD treatment and addressing high-risk situations, such as hostel accommodation or jobs that require employees to be away from home overnight or longer.
- *Reducing the stigma of HIV/AIDS.* Openness greatly facilitates prevention and impact management.
- *Workplace impact management.* Programmes should be guided by sound impact assessment, policies and strategy. Knee-jerk cost containment in one area can increase costs elsewhere. For example, very restrictive employee benefits can reduce morale and discourage early disclosure, making responses such as succession planning more difficult.

Kingborn (2000) further points out that programmes must include these key issues:

- Identify and reduce vulnerability of key aspects of production processes.
- Health care and support for infected and affected employees, to sustain their productivity, combat problems such as TB, and create

supportive conditions for employees to disclose their HIV status early.

- Strengthen human resource management, planning and development.
- Develop appropriate employee benefit structures, which balance sustainability and effectiveness in keeping workers motivated and productive.
- Invest in training, education, and the prevention of infection in learners, to ensure sustained growth of skills in businesses and the economy.
- Improve information on HIV/AIDS impacts and effective responses. At both business and sectoral level, better information is needed for sharper planning.
- Co-ordination between businesses, labour, government and communities at all levels to facilitate feasible, cost effective responses. Many businesses have found that they cannot manage HIV/AIDS impacts on employees without looking "beyond the fence". Inadequate or inappropriate responses by individual sectors or firms can also have knock-on effects on other businesses.

Kramer (2001) believes that a holistic approach to AIDS should cover the following areas:

- Projections on the effect of AIDS on the business – analysing the firm's demographic profile (such as race, gender, age breakdown, skills levels, geographic region) and determining a suitable risk profile of that population. The business' model and its scenarios can

then be adapted to perform projections for the specialised population.

- An actuarial analysis to quantify the direct cost of AIDS on the current set of employees benefits and to suggest more cost effective benefit structures which meet the real needs of members.
- Customised managed care products for medical schemes which offer affordable treatment and access to medical practitioners, discounted. Suppliers and scientifically sound protocols.
- Effective AIDS-intervention programmes, which meet legal and confidentiality requirements, from experts in epidemiology, clinical medicine and human resources.
- AIDS-education programmes specifically tailored to convey the message about the epidemic, using language and media which are culturally acceptable to the target audience. (There is some wonderful work being done here using business theatre).
- Effective treatment of sexually transmitted diseases.
- Human resource planning to manage the effect of HIV/AIDS on productivity, skills training and disability.
- An effective communication strategy to gain the commitment of all significant stake holders.
- Understanding of how AIDS will affect consumer markets, and the need to develop products to meet the specific needs of people who are HIV-positive, who will make up a growing proportion of the South African population.
- Counselling for employees who are HIV-positive. It is important to obtain expert advice on managing all aspects of the epidemic, thus freeing management to concentrate on the firm's core competencies.

According to George (2001) businesses can pursue three basic internal strategies for mitigating near-term and long-term consequences of the epidemic on an organisation:

- The first strategy aims to prevent new infections by initiating HIV/AIDS-prevention programmes. The most common are condom distribution, peer education, dissemination of educational material and theatrical shows.
- The second option is to avoid and reduce the costs associated with existing and probable infections. This has many humanitarian repercussions. Businesses may move away from labour-intensive to capital-intensive production technologies. They may avoid hiring new employees who are infected or who come from high-risk groups, and reduce benefits available to infected workers. A common trend is for businesses to outsource their work. This places the burden of HIV/AIDS onto the labour brokers
- In the third strategy, business tries to care for infected employees and create a work environment in which they can remain productive for as long as possible. This places a huge cost onto the employer. After extensive research some businesses have concluded that it will be more cost effective to provide treatment to all employees and their spouses rather than to fill skill gaps through rehiring and training.

5.2.1 HIV/AIDS-EDUCATION PROGRAMMES

According to Fleet Watch (1995) it is clear that the business has a long way to go on the subject of AIDS and the sooner businesses

realised the importance of their role in education, the sooner the problem could be dealt with.

Aids is a reality and the time has come to ask oneself the following questions:

- Do employers know enough about the disease to educate their employees?
- Do management care enough to educate employees?
- Is it not time that we opened our eyes and realised that AIDS is here to stay unless we do something about it?

An education programme is fundamental in reducing the potential incidence of and reaction to HIV/AIDS. Employees must be informed as to the transmission of the virus and the ways in which it can be prevented.

The various groundless fear and myths surrounding HIV/AIDS should similarly be put to rest to prevent the ostracisation of and discrimination against HIV/AIDS-sufferers that are in the workplace (Grossett, 1998).

Laverack, S. (2001) believes that HIV/AIDS-education programmes should be integrated into existing programmes and training courses. Peers can be trained to give HIV/AIDS-education and counselling in the workshops and workplace. Education must be ongoing so that its effectiveness can be monitored and people can be encouraged to talk and think about HIV/AIDS.

Workplace education programmes should be aimed at preventing the spread of the virus, and promoting a safe working environment. It should also be aimed at preventing unfair discrimination against employees with HIV/AIDS.

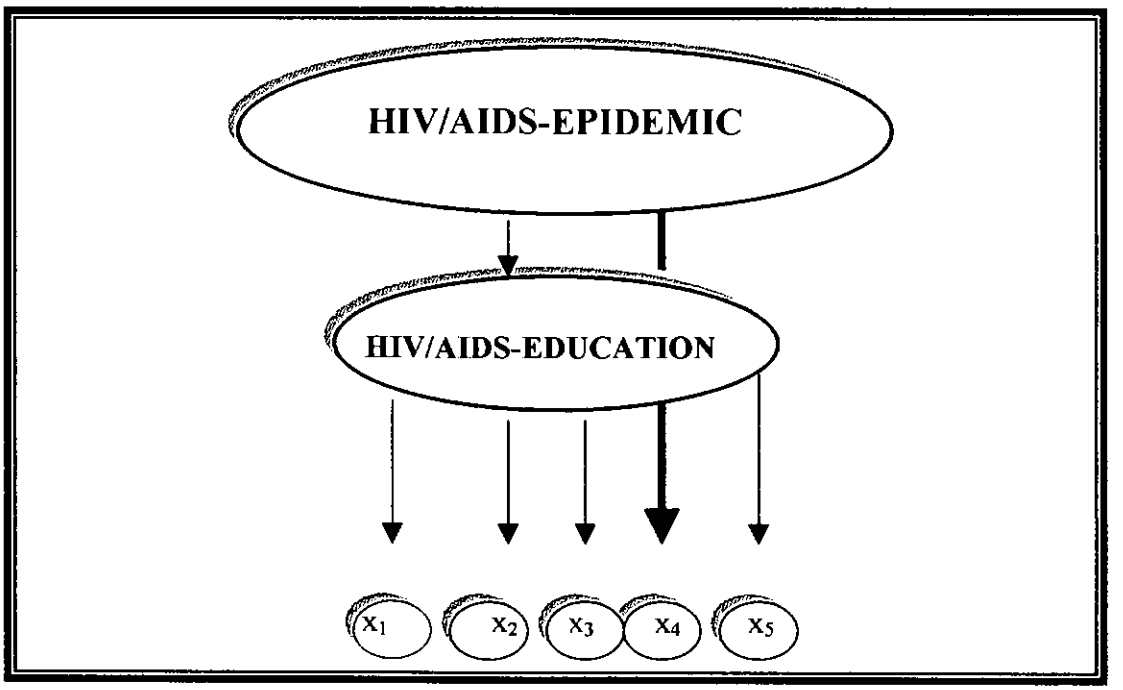
Shevel, (2000) states that AIDS-education, could save approximately R10 million in indirect costs over 10 years, equating to a return on investment of over 50 percent per annum.

This is likely to be the best investment the business could make, even if the investment markets recover substantially.

According to Webb (1997:160) other factors determining awareness are presumed to be operating, leading to the "risk environment" as a subjective phenomenon having geographical variation. A crucial aspect of this risk environment is the information available to individuals (X_{1-5}), and this translates as both direct (thick arrow) and indirect linkages (thin arrows), (refer Figure 5.1 on p.102).

Figure 5.1 follows on p.102.

FIGURE 5.1: INFORMATION FLOW AND HIV/AIDS



Source: Webb, 1997:160

Wilson, et al. (in Webb, 1997:160) states that information at an individual level has three sources: direct contact with someone who is seropositive or has AIDS, education and prevention initiatives, and inter-personal contacts.

Efforts have been concentrated on exposing staff at every level to peer education. In 1998 the programme focused on educating managers and improving peer educator skills by training mentors, and adding basic counselling skills. It included student employees and introduced the HIV/AIDS-training programme into the Adult Basic Education Programme (ABET). During 1999 the programme will monitor and ensure that all employees are exposed to education (Simon-Meyer, 1999:8).

Mbuya (2000:103-105) points out that no single strategy for AIDS-education will be the most effective in all countries. Certain factors can nevertheless be identified that are likely to promote responsible attitude and behaviour change, and a positive response to the AIDS-epidemic. Actively promoting AIDS-awareness and personal responsibility, and mobilising community resources at all levels to mount the campaign, are likely to achieve better results than trying to enforce responsibility through repression.

AIDSCOM (in Mbuya, 2000:104) states that people voluntarily reduce risk behaviour when:

- They understand the threat and how to protect themselves (information and knowledge).
- They believe the change will benefit them (personalising the risk).
- They are given the tools and services needed to facilitate the change.
- They are given the support to sustain change over time.

AIDSCOM (in Mbuya, 2000:104-105) further elaborates on the following points:

Information and knowledge

Information on the extent of the problem, how HIV is spread and how it is not spread, on AIDS-disease itself, an on what can be done to assist people, is essential. This means information is produced in appropriate forms for a number of different groups. An effective way to achieve this is through active participation in developing AIDS-awareness materials for

themselves, rather than a top down approach to health education. It should be information sharing, rather than information giving.

Personalising risk

For appropriate behaviour change, people need not only good knowledge, but also to personalise the risk, which is to see the risk as affecting them personally. How can this be achieved? The following factors are all likely to have an impact:

- Knowledge of how widespread HIV infection is in South Africa.
- Knowledge of how the virus is, and how it is not, transmitted including safe sex practices.
- Allaying of fears, myths and superstitions about AIDS.
- Exposure to specific individuals with HIV/AIDS, through the media and personal accounts of infection and disease.
- Personal contact with people with HIV/AIDS, such as friends or relations.

Accurate knowledge of the epidemic, an awareness of how people can actively reduce their own risk, and seeing individuals with AIDS are all relevant to personalising risk (refer Table 5.1 on p.105), which indicates three steps to motivate people to change their behaviour.

Table 5.1 follows on p.105.

TABLE 5.1: THEORETICAL ASSUMPTIONS VERSUS CURRENT PERCEPTIONS ABOUT AIDS

ASSUMPTION I Individual will not take any health action unless he or his family believe they are susceptible. DISBELIEF for many reasons e.g. - Limited understanding of germ theory. - Facts about AIDS couched in scientific jargon. - Frightened, don't want to know. - Feel that family is "protected".
ASSUMPTION II Individual must believe that the cost of abandoning present action will outweigh physical or emotional cost. - Pleasurable experiences with multiple partners too good to give up. - Danger of losing credibility in peer group. - Condoms unacceptable (would you eat a sweet with the wrapper on?)
ASSUMPTION III There must be some trigger factor or critical incident to get the individual into action. - Don't know anyone who has died of AIDS. - National figures (statistics) very low. - AIDS is not much of a problem or more would be said and done. In order to achieve appropriate behaviour change to reduce risk people must feel they personally have more to gain than to lose by such a change. This is the crucial message that education and AIDS must convey.

Source: Mbuya, 2000:105

According to Kelly and Lawrence (1988:62) printed materials such as pamphlets, brochures, or advertisements are necessary to educate persons about ways to reduce exposure risk. On the other hand, brochure-based

information alone may be insufficient to produce meaningful, wide-scale change in actual risk behaviour. For educational objectives to be met, individuals at risk for AIDS must initiate the steps of picking up, reading, and attending closely to the information presented in pamphlets or brochures. While the time and effort needed to do so are not great, there are few data to indicate how many individuals at high risk really do spontaneously read pamphlets or recall the most critical information contained in them. Research in other areas of health promotions does not support the contention that pamphlets are a highly effective way to instil the motivation to make changes in long-standing risk behaviour.

5.2.2 PREVENTION PROGRAMMES

Written materials on AIDS prevention are useful because they are inexpensive and can be mass-distributed or posted where targeted populations can read them. The content and language used in written materials can also be tailored to the specific populations for which they are intended. Many AIDS-prevention programmes, especially in large cities heave developed different brochures, with educational content tailored to the targeted group. This is an appropriate strategy because information and language relevant to one group might be ineffective or inappropriate for other groups of people.

In order to have the greatest impact, written AIDS-prevention materials must reach and be read by persons at risk. Businesses sometimes make AIDS-prevention brochures available to their employees. Health departments and public health clinics provide brochures about AIDS to persons receiving contraception counselling or treatment for drug use and

sexually transmitted diseases. Although these distribution methods for written materials on AIDS-prevention are exceedingly important and necessary, they are no longer sufficient (Kelly and Lawrence, 1998:61).

According to Kelly (1995:37-38) within the HIV/AIDS-prevention areas, two types of intervention models have been studied:

1) Group intervention that entails client contract over a series of session (usually between 6 and 12, for 90 minutes meeting) with progressive attention to education, vulnerability appraisal, risk reduction skills training, reinforcement of change efforts, and review or problem solving of implementation difficulties, and
2) "Workshop-style" intervention in which participants attend a single session of extended duration, such as a day long programme that addresses similar content to multiple-session programmes and is often followed by individual or group booster session or follow-up contact.

Webb (1997:205) states that in terms of the interaction between development processes and the HIV/AIDS-pandemic, the dominant conceptual model had been the adverse impact of AIDS-related demographic disturbance on economic growth at all geographical scales. The reconceptualisation of AIDS-prevention in recent years has transformed HIV/AIDS into a development issue as well as a health issue. The reasons for this transformation relate to the realisation that contextual factors are major determinants of high risk behaviour in relation to HIV infection, and that the partial resolution of these contextual inhibitors of behavioural change are fundamentally development issues. With

HIV/AIDS recognised as a disease symptomatic of underdevelopment, there is still the need to specify which development processes should be prioritised in terms of HIV/AIDS-prevention, other than the rebuilding of the health service infrastructure, and to what extent they should be seen as supplementary to, or congruent with short-term interventions.

Webb (1997:205) further points out that the crucial point in relation to development priorities is that programmes which address issues of water, agriculture, income generation and transport improvement, to name a few, will have social effects which will reduce the vulnerability of people to HIV-infection. Development programmes can supplement the short-term technical interventions, which focus on education, condom provision and STD treatment. The link has to be made between people's behaviour as a matter of individual volition, and people's behaviour as a necessary response to socio-environmental conditions. This leads us to the often-mentioned buzz phrase "empowerment".

Prevention through empowerment

Furthermore, Webb (1997:206) mentions that the link between context and the individual can be conceptualised as the process of empowerment, which is the provision of the ability to take control of a situation, to provide a sense of ambio-control and reduce vulnerability to HIV infection. With AIDS-prevention, two themes emerge: That of behavioural empowerment, and structural empowerment. The term "empowerment" is most often (but not exclusively) applied with specific reference to women:

- "Behavioural empowerment" allows girls and women to have more control over their sexual activity, either through resisting sexual advances or through negotiating safe sex. It is the increase in the decision-making ability of the women, so rendering them less vulnerable to infection, as the incidence of unsafe sex is reduce.

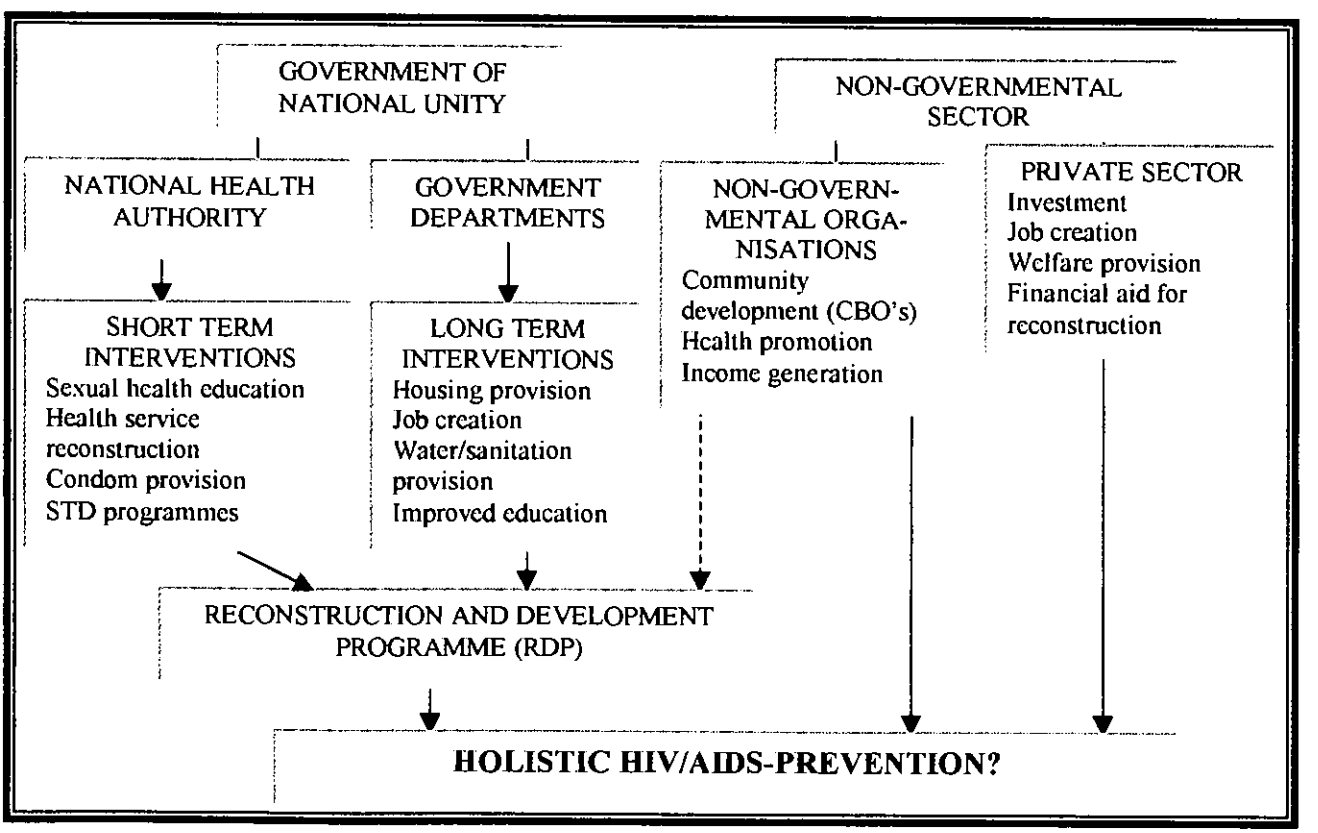
- "Structural empowerment" is the reduction of economic dependence on men, and the improvement of women's socio-legal status.

Zuma (in Webb, 1997:217-220) seemed confident that at least R100 million could be spent on AIDS-prevention in 1994 to 1995, with over half of this coming from foreign donors. An encouraging sign is that the National AIDS Plan (NAP) is to be managed as part of the Reconstruction and Development Programme (RDP), so facilitating inter-departmental co-ordination, as the AIDS-epidemic must be treated as more than a medical/health issue if prevention measures are to have any change of success. The priorities of the government as a whole may themselves prove to be essential components of a complete AIDS-prevention programme. The ANC manifesto, Zuma (in Webb, 1997:217-220) documented the social development programme:

- To provide jobs and training for 2.5 million unemployed over ten year.
- Build 1 million homes within the next five-year.
- Provide running water and toilets for 1 million families in five years.
- Supply electricity to 2,5 million homes in five years.
- Double the number of free school text books within a year.

These programmes would complement an AIDS-prevention programme to provide a context allowing for the prioritisation of AIDS (refer Figure 5.2 below). The participation of Non-Governmental Organisations (NGO's) and the private sector is crucial in the prevention effort, and the government is still trying to incorporate NGO's into the RDP without being seen to usurp both their influence at a local level, and more importantly, their funding base from abroad. The government is now in competition with the estimated 50 000 NGO's in South Africa for external funding, and there are some indications that the government, while recognising the importance of NGO activities, is attempting to regulate and determine NGO activity as a pre-condition for their participation in the RDP.

FIGURE 5.2: CONCEPTUAL MODEL OF THE FUTURE OF AIDS-PREVENTION IN SOUTH AFRICA



Source: Webb, 1997:218

Zuma (in Webb, 1997:220) further points out that the action of the government and NGO's must be complemented by the private sector, which will be badly affected by the epidemic in a number of ways:

- The workplace will not decline but it will change in structure, being more youthful, inexperienced and less well trained. Labour and retraining costs will rise and medical costs will spiral.

- There will be a disproportionately high number of losses amongst the skilled workforce. Experience from the rest of Africa has shown that this segment of the workforce is often the first to be affected.

- Absenteeism caused by AIDS-related illnesses will be more financially damaging in the long term than the loss of the workers through death. Employees will require more time off to attend funerals and absenteeism will increase when workers, or even the relatives of the workers, are sick.

- Lowered productivity will result, as the syndrome is characterised by recurrent bouts of ill health.

- Ostracisation at the workplace of people who are HIV-positive will affect morale and performance.

- As well as the direct impacts there will also be indirect effects, such as the drop in consumer spending as the economic effects of AIDS spreads throughout society.

The private sector can respond to the epidemic and supplement wider scales prevention programmes, through its own, possibly business – specific, workplace AIDS-policies. Policies include the provision of free or low cost condoms, and there are NGO's already active in this respect, such as the Population Services International Organisation. The social marketing of condoms in shebeens or spaza shops can be undertaken by encouraging existing entrepreneurial networks, while indirect intervention can take the form of extending networks with Smaller Businesses and encouraging economic development at a grass roots level.

Kramer (2001) believes that there is no simple quick fix to the AIDS-crisis. Failure to develop a proactive, holistic response may result in costly lawsuits and conflict between employers and employees. A Small Business which implements a programme which successfully prevents new HIV-infections will reap the reward 8 to 10 years later, when it incurs fewer costs related to AIDS.

Kramer further states that projections showed that a business with 1 000 employees, by spending R100 000 up front and another R25 000 a year on AIDS-education, could save approximately R10 million in direct costs over 10 years – a return on investment of over 50 percent a year.

This is likely to be the best investment any business could make, even if the investment markets recover substantially.

Metropolitan (in Shevel, 2000) points out that AIDS-programmes aimed at preventing new HIV-infections will only begin to save AIDS-related costs

after 8 to 10 years, once there is a reduction in the number of people manifesting AIDS-related conditions.

According to Harebottle (1999) prevention programmes are best for businesses with a low level of infection, while those with high prevalence will need to concentrate on helping the organisation to survive by taking steps to extend the healthy life of an HIV-positive employee and planning for the impact on productivity.

5.2.3 COUNSELLING PROGRAMMES

According to Green (in Strang and Stimson, 1990:232-233) the two key aims of counselling in HIV/AIDS are:

The prevention of the spread of infection

The same changes, which prevent an individual, infected with HIV passing it on also prevent someone not yet infected acquiring the infection. So someone who always uses a condom in sex will not, if they use it carefully and avoid breakage, acquire HIV infection sexually. Nor, if they are already infected, will they pass it on to a partner. The same principle applies to syringe sharing. The importance of this consideration is considerable. Many workers still see the HIV test as being "sine qua non" of successful counselling – it is clearly not. It is possible – indeed, essential to provide successful counselling to all those at risk, i.e. to sero-positives, sero-negatives and those who have not been tested.

Maximisation of psychological and social well-being

When counselling services are set up for those with HIV/AIDS it is the prevention of spreading the infection, which tends to attract most interest, at least from funding bodies. However, it is important to note that those who have AIDS or who are infected with HIV often experience a great deal of distress and disruption in their lives. One of the key aims of counselling is to reduce this distress and there is evidence that this is achievable. Even if counselling did not make any impact whatsoever on behaviour, it would still be important in reducing distress and helping those affected by the virus to maximise their quality of life.

Green (in Strang and Stimson, 1990:233) further points out that the above two aims refer chiefly to those who are at risk or who are infected. However, it is important to note that HIV often affects a wider range of people and these too will need help and counselling. The families of those who are infected, their lovers, wives, husbands, informal carers – all need support and help. Indeed, in some cases they may need more support and help than the person infected with HIV.

Community populations at greatest risk for HIV-infection are often described as difficult to reach, hidden from, and inaccessible to face-to-face counselling interventions. However, this is not necessarily the case. A large proportion of persons seen in any health, mental health, substance abuse treatment, or social service setting are individuals at risk for HIV/AIDS, and this is true for both public, community-based clinics, and private office practice settings. In some cases individuals may volunteer

information that leads a counsellor to identify them as a risk and in need of HIV-prevention counselling (Kelly, 1995:30).

In South Africa, counselling support for people with HIV infection and AIDS has lagged behind the medical response. However, a range of positive developments involving a wide variety of agencies is slowly being established. An important aspect of the World Health Organisation (WHO)/Ministry of Health Medium Term Plan on AIDS, started in 1995, is to promote preventive and supportive counselling.

It is important to examine both how traditional sources of support may be strengthened, and what new support structures are needed. People need to be mobilised at all levels, from community development workers, traditional healers, Red Cross volunteers, church counsellors, social workers and other professional counsellors, as well as workers at all levels in the formal health sector. They are needed to implement education programmes for AIDS-prevention, as well as to provide supportive counselling for infected people and their families (Mbuya, 2000:66).

HIV-infected employees can now work with dignity following the launch of Europ Assistance's Euro Med Q Care Plus assistance insurance scheme, which is aimed at providing health care for infected workers.

The scheme will also be of extreme benefit to dependants, in case of a breadwinner being infected, in that the infected person's working life will be prolonged.

Europ Assistance has paid about R150 000 worth of medical treatment for HIV-infected employees, which include medication, counselling and other treatments (Rogers, in Milazi, 1997).

Bryant-Mole (1994:26-27) states that at the moment there is no cure for HIV/AIDS, so most of the help is aimed at giving people information and support.

If someone finds out that they have HIV or worried that they might have the virus they may find it helpful to talk about the way they feel. There are a number of helplines that people can ring if they would like to talk to someone over the phone. Sharing their worries and fears with someone else can help people to feel less alone with their problems. Helplines can also give people information about HIV/AIDS.

Bryant-Mole (1994:27) further points out that a lot of towns now have AIDS Advice Centres. People, with or without HIV, can find out information from these centres.

There are now a number of AIDS hospitals. The people who work there are specially trained to look after AIDS-patients. The people who come to these hospitals are usually very ill. Many of them will be dying. The people in the hospital try to make their time there as happy and as comfortable as possible.

5.3 CONCLUDING REMARKS

The workplace is precisely an arena where education, prevention and counselling programmes can be beneficial. These programmes provide an important part of HIV/AIDS-intervention programmes if information made available to employees is relevant, accessible in terms of language and literacy levels to all employees and is culturally sensitive.

Besides good medical care, all HIV-positive people needed good counselling and the will to live. Providing an incentive to live would encourage people living with HIV to be productive for years.

It is not enough to limit AIDS-intervention programmes to the workforce; businesses must also help educate the communities, in which they operate, including sports clubs, learning institutions, churches and other community-based associations.

The well-educated community, on the risks of HIV/AIDS will help reduce the risk of infection among employees.

The following chapter highlights and discusses some of the key legal issues when drawing up HIV/AIDS policy.

CHAPTER 6

THE KEY LEGAL ISSUES WHEN DRAWING UP A HIV/AIDS-POLICY

Discussion in this chap is based on the key legal issues when drawing up a HIV/AIDS-policy.

6.1 INTRODUCTION

HIV/AIDS has finally moved off the streets and into the boardroom. The pandemic can no longer be seen as "someone else's problem" and it will soon start impacting on businesses' bottom lines.

Today it is common to hear about employers who require job applicants to prove that they are not HIV-positive before offering them work.

Factory workers are being dismissed because they are HIV-positive. Also domestic workers, police officers and fast food employees are often forced to undergo HIV-tests (Heywood, 1995).

There are several acts, which can be interpreted as being applicable to HIV/AIDS-sufferers. However, at this stage only one act deals directly with HIV/AIDS and that is the health act. Furthermore, there is little if any direct protection offered to AIDS-sufferers in the workplace.

A workplace policy is central to developing and implementing an effective HIV/AIDS-programme. The policy also defines the business as a progressive business, and demonstrates its concern and commitment.

6.2 THE PRIMARY LAW

Achmat, et al. (1997:71) mention that by May 1997, no legal judgements had been made in South Africa on issues directly about discrimination against people with HIV/AIDS at work. When they have to make judgements on this, the Labour Courts or other statutory bodies that have the power to arbitrate (make decisions) will look at:

- The Constitution (the interim constitution up to 3 February 1997 and the new constitution from 4 February 1997), which is based upon the principle of equality for everyone in South Africa.

- Case law built up in the Industrial Courts, which followed the principles of non-discrimination; fair labour practices and the reasonable rights and responsibilities of employers and employees.

- The latest scientific and medical knowledge about HIV/AIDS – especially that HIV cannot be transmitted by contact between people at work, and that people with HIV are usually as healthy and productive as employees who are not infected.

The new Constitution gives all employees the right to be treated fairly at work. The Constitution's Bill of Rights says: Everyone has the right to fair labour practices.

Together with the equality clause in the Constitution, this means that in the private and public sector the employer cannot unfairly discriminate against the employees, because the employee is a woman or because of things like race, religion, political beliefs or disability (refer Table 6.1 below).

TABLE 6.1: MEANING OF FUNDAMENTAL RIGHTS FOR PEOPLE WITH HIV/AIDS

SECTION IN BILL OF RIGHTS	RIGHT	WHAT THIS MEANS FOR PEOPLE WITH HIV OR AIDS
10	**Human Dignity** Everyone has inherent dignity and the right to have their dignity respected and protected.	A person or institution (e.g. a hospital or business) may not insult or take away any person's self-respect, by their words or actions.
12	**Freedom and Security of the Person** Includes the right to: Make decisions concerning reproduction; security and control over their body; not to be subjected to medical or scientific experiments without informed consent.	A person has the right to take his or her own decisions about medical treatment and pregnancy; e.g. you cannot be forced to test for HIV. You cannot be treated in a cruel or degrading way by any person or institution.
14	**Privacy** Everyone has the right to privacy.	If you have HIV/AIDS, you have the right to keep that information to yourself. An employer or hospital cannot force you to tell them, or force you to have a blood test to find out this private information.
16	**Freedom of Expression** Everyone has the right to freedom of expression, which includes freedom to receive or impart information or ideas.	This right is important, particularly as a way to ensure that proper information about how to prevent HIV is available in schools or prisons.

SECTION IN BILL OF RIGHTS	RIGHT	WHAT THIS MEANS FOR PEOPLE WITH HIV OR AIDS
18	**Freedom of Association** Everyone has the right to freedom of association.	A person can join any organisation they choose. A person cannot be forcefully separated from other people.
21	**Freedom of Movement and Residence** Everyone has a right to freedom of movement, to leave the country, to enter, to remain in and to reside anywhere in the country.	If you have HIV/AIDS, you are free to move around the country. You cannot be forced to live in a separate place, away from the rest of society.
22	**Freedom of Trade, Occupation and Profession** Every citizen has the right to choose his or her trade, occupation or profession freely.	People with HIV/AIDS can choose what kind of work they want to do; e.g. they may not be told that they cannot be a doctor, a teacher or a health care worker.
23	**Labour Relations** Everyone has the right to fair labour practices.	No person may be unfairly discriminated against at work.
24	**Environment** Everyone has the right to an environment that is not harmful to his or her health or well being.	This right is important for people with HIV who are living in state institutions such as prisons or psychiatric hospitals.
26	**Housing** Everyone has the right to have access to adequate housing. No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances.	People living with HIV or AIDS may not be refused a subsidy or loan to buy a house. Evicting a person from a house or flat because of their health is also unlawful.
27	**Health Care, Food, Water and Social Security** Everyone has the right to have access to: - Health care services, including reproductive care. - Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. No one may be refused emergency medical treatment.	Hospitals or doctors cannot refuse to treat a person with HIV or AIDS. People with HIV/AIDS have the right to disability grants if they are too ill to support themselves or their families.

SECTION IN BILL OF RIGHTS	RIGHT	WHAT THIS MEANS FOR PEOPLE WITH HIV OR AIDS
29	**Education** Everyone has the right to a basic education, including adult basic education.	If you have HIV or AIDS, you have the same right as all people to education. A school cannot refuse to educate you or your child because you have HIV or AIDS.
32	**Access to Information** Everyone has the right to access any information that is held by another person and that are required for the exercise or protection of any rights.	If a person feels that they are being discriminated against because of a policy, they can demand to see that policy, and then challenge it in court. You have the same right with private institutions (e.g. Small Business), and information that may be kept about you (e.g. medical records). This right may also include the right of people who are held in state institutions, such as prisons, to have access to education and life-skills training on issues such as HIV/AIDS.
33	**Just Administrative Action** Everyone whose rights have been negatively affected by administrative action has the right to be given written reasons.	If you feel that you are being refused a social service (e.g. a house or education) for unjust administrative reasons, then you can demand these reasons in writing.
34	**Arrested, Detained and Accused Persons** Everyone, who is detained, including every sentenced prisoner has the right to conditions of detention that are consistent with dignity.	Prisoners cannot be treated in a discriminatory or undignified way just because of their HIV status.

Source: Achmat, et al. 1997:41-43

According to Whiteside and Sunter (2000:157-158) the South African Constitution (Act 108 of 1996) is the supreme law of the country and all other laws must comply with its provisions. The Bill of Rights within the Constitution sets out a number of rights, which protects employees. As a result the government has, within the last five years, amended certain laws

and introduced new pieces of legislation to ensure that our labour laws are consistent with the Constitution.

There are several key pieces of labour legislation in South Africa.

These are:

- The Employment Equity Act No. 55 of 1998 (EEA).
- The Promotion of Equality and Prevention of Unfair Discrimination Act No. 4 of 2000.
- The Labour Relations Act No. 66 of 1995 (LRA).
- The Occupational Health and Safety Act No. 85 of 1993 (OHSA).
- The Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 (COIDA).
- The Basic conditions of Employment Act No. 75 of 1997 (BCEA).

Whiteside and Sunter (2000:158) further point out that HIV/AIDS is only expressly referred to in the Employment Equity Act, but there are provisions in all the other Acts which have relevance to HIV/AIDS. The Employment Equity Act will, because of its express protection for employees against unfair discrimination on their basis of "HIV-status", become the most important point of reference for decisions relating to the management of HIV/AIDS in the workplace.

There are also other pieces of legislation, policies and protections within the common law, which although not directly employment-related, impact on the management of HIV/AIDS in the workplace.

These are:

- The Medical Schemes Act No. 131 of 1998.
- The proposed notification of AIDS-disease and death.
- The Department of Health's draft National Policy on Testing for HIV.
- Common-law protection of the right to privacy and dignity.

The Constitution serves as the primary law of South Africa. The Constitution offers employee protection in three ways:

- It provides the Constitutional Court with the power to strike down any legislation that does not conform to the provisions of the Constitution.
- It provides a new interpretative context for understanding Labour Law.
- It provides protection from unconstitutional acts between the state and its citizens as well as between individual citizens.

While there is no explicit protection offered for AIDS-sufferers, there are a number of provisions that could be interpreted to include AIDS-sufferers within their ambit.

Section 23(1) of the Constitution provides that: Everyone has the right to fair labour practices.

Section 9(3) of the Constitution states that: The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds,

including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion conscience, belief, culture, language and birth (Grossett, 1999).

6.3 THE LABOUR RELATIONS ACT

In 1995, a new Labour Relations Act (LRA) was passed by Parliament. This new law regulates relations between employers and workers. It governs issues such as the right to join trade unions and employer organisations, and the right to strike and lock out.

The LRA allows employers and employees to decide on rules and regulations for their business sector through collective agreements, but it also refers to fundamental rights (basic human rights) that are the same for all employees, e.g. the right to equality.

Unlike the old labour laws, the LRA also gives job applicants the right to fair labour practices, including the right not to be discriminated against unfairly.

Under this new law, discrimination is "automatically unfair" if it infringes any of the fundamental rights of employees. Discrimination is only fair when it is based on "an inherent requirement" of a particular job (a skill or ability that you must have to do the job).

When is discrimination fair?

Discrimination of one kind or another takes place every day in human relations. Some kinds of discriminations are fair and acceptable. Others are unfair and must be challenged.

Discriminating against a person who is known or thought to have HIV is unfair because generally this fact has no influence on his/her ability to do the job.

Under the LRA, all employees and employers are treated equally and governed by the same laws. This means that domestic workers now have the same rights as factory workers, and people working for the government have the same rights as people working in the private sector (Achmat, et al. 1997:72-73).

Grossett (1999) states that employers and potential employees receive protection against unfair labour practices in terms of Schedule 7 of the LRA.

This presents a major change to the Labour Relations Act 28 of 1956, which only extended protection for unfair labour practices to existing employees. Part B of Schedule 7 of the LRA is titled Residual Unfair Labour Practices.

Sub-item 1(a) states that:

- For the purposes of this item, an unfair labour practice means any unfair practice or omission that arises between an employer and an employee involving the unfair discrimination, either directly or

indirectly against an employee on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief of political opinion, culture, language, marital status or responsibility.

Sub-item 2(a) of the Schedule goes on to say that:

- For the purpose of sub-item 1(a), employee includes an applicant for employment.

In terms of the LRA, HIV-positive employees or AIDS-sufferers, whether they are current employees or potential employees receive protection against discrimination. Like the Constitutional provision ensuring equality, this protection is envisaged in terms of HIV-positive employees suffering from a disability.

Heywood (1995) points out that a new Labour Relations Act has been passed in Parliament and is expected to be implemented between March and May 1996. The Act will help to eliminate discrimination in the following ways:

- It draws almost all South Africa's workers under its jurisdiction, including domestic workers, farm workers and job applicants.

- It defines what is meant by an unfair labour practice, making it clear that discrimination against job applicants and existing employees on the grounds of a person's "disability" will be illegal.

Heywood (1995) further states that if HIV is accepted as a disability by South African courts, then the LRA will at last put a stop to AIDS-discrimination.

People with HIV often live healthy and productive lives for many years. As a result, many countries already regard HIV as a "disability". Although HIV limits people in certain crucial spheres of life, in the workplace it allows them to live a normal life.

According to Strode (in Wray, 1998) the protection of workers infected with HIV was provided for in the Labour Relations Act (LRA), Employment Equity Bill, the Compensation Act and the Occupational Health and Safety Act.

The LRA protected workers from discrimination in the workplace and prohibited their unfair dismissal.

In terms of this Act, workers could not be fired simply because they were HIV-positive. The Act also said people might not be denied promotion or training because of their HIV-status.

6.4 THE EMPLOYMENT EQUITY ACT

Healy (1999) states that legislation deals with HIV-infection by way of the Employment Equity Act (EEA), in that pre-employment HIV-testing is prohibited, as is the testing of existing employees "unless such testing is determined to be justifiable by the Labour Court in terms of Section 50(4)" of the Act. Section 50(4) of the EEA makes provision for the issuing of an

order of the Labour Court, which provides for the testing of employees. Such an order may be considered to be appropriate within certain conditions such as the provision of counselling and the maintenance of confidentiality.

Healy (1999) further points out that such an order of the Labour Court could, for example, be made for employees in the processing of food, given that it could be deemed to be in the public interest to test employees in the food industry for HIV.

In essence, pre-employment tests of this nature would ordinarily be justified given the nature of the employment conditions, social policy, employment benefit considerations and the inherent requirements of the job. For example, an employer could not be required to employ a colour-blind electrician.

According to Whiteside and Sunter (2000:159) the Employment Equity Act No. 55 of 1998 (EEA) aims at ensuring equality and non-discrimination in the workplace through anti-discrimination measures and affirmative action (equality provisions). It also provides to express provisions on HIV/AIDS.

Section 6(1) of the Act aims to promote equal opportunity by eliminating unfair discrimination and in addition prohibits unfair discrimination, directly or indirectly, against an employee in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual

orientation, age, disability, religion, HIV-status, conscience, belief, political opinion, culture, language and birth.

Section 7 of the Act prohibits medical testing of an employee to determine that employee's HIV-status is prohibited unless such testing is determined to be justifiable by the Labour Court. The Act further states that it is not unfair discrimination to distinguish, exclude or prefer any person on the basis of an inherent requirement of a job. It is difficult, however, to identify any such situations related to HIV, though there may be such situations identified in future. Employers who believe that knowledge of an employee's HIV-status is justified must approach the Labour Court for authorisation before embarking on such testing. In general, employees with HIV should be treated in the same way as all other employees. This implies those employees with HIV-related illnesses and AIDS should be treated in the same way as employees with other life-threatening illnesses.

Although the Act does provide a prohibition on HIV-testing within the employment relationship, an amendment was introduced to define situations where testing is permissible; such as within a patient/health-care worker relationship.

Strode (in Wray, 1998) states that under current legislation employers may not discriminate against workers because of their HIV-status. Employers also have no right to force employees to disclose their HIV-status to them, or to force employees to accept mandatory HIV-testing. Employers had to provide a "Safe working environment" which included HIV/AIDS-education. Employees had the right to "reasonable accommodation" from

their employers, and should they get ill, employers had to try to make provision for them in the workplace.

Employers who engage in discrimination practices are committing grievous offences. They are denying the fundamental human rights of employees that have been secured in the Constitution. These include the right to privacy, dignity, equality and fair labour practice.

There is no excuse for this HIV-discrimination, especially since the disease is transmitted primarily through sexual intercourse. It is almost impossible to be infected at work by a fellow worker (Heywood, 1995).

Heywood (1995) further states that even in accidents, where blood flows freely, risk can be eliminated by using universal precautions, such as latex gloves.

6.5 A CODE OF GOOD PRACTICE

According to Heywood (1995) other initiatives are made to protect the rights of employees with HIV/AIDS. The Congress of South African Trade Unions proposed that the LRA be amended to include an HIV/AIDS Employment Code.

The code has been drafted by the AIDS Consortium and the AIDS Law Project.

Heywood (1995) further states that if the code were accepted, it would protect the rights of employees and also encourage the implementation of

HIV-education and prevention programmes in the workplace (during working hours).

Whiteside and Sunter (2000:159-160) point out that a code entitled Code of Good Practice on key aspects of HIV/AIDS and employment, which is to be appended to the Employment Equity Act (EEA), is promulgated. This code's primary objective is to provide implementation guidelines for employers and employees so as to ensure those employees with HIV/AIDS are not unfairly discriminated against. It has a secondary objective of providing guidelines on the management of HIV/AIDS in the workplace.

Grossett (1999) believes that in the absence of a Code of Good Practice dealing with HIV-related disputes, all forms of employment related HIV-testing, as well as any other discriminative employment practices related to HIV-positive employees will in all probability become "unfair labour practices".

This is in spite of the fact that part of the purpose of the 1995 Labour Relations Act is to prevent unfair labour practice jurisdiction arising again.

Employees who are no longer able to perform the functions for which they were originally employed, as a consequence of their HIV-status or having acquired AIDS, must, as provided for in the Code of Good Practice: Dismissal attached to the Labour Relations Act, be offered alternative employment.

If no alternative position exists, early retirement should be considered as well as any other option. Short of dismissal before dismissal itself is contemplated.

It does not follow that an HIV-positive employee is unable to function normally. Given proper medication, lifestyle counselling and social support, an HIV-positive employee may continue to function normally for many years (Healy, 1999).

Mdladlana (in Nxumalo, 2000) states at the launch of the Code of Good Practice on key aspects of HIV/AIDS and employment that there would be no pre-employment HIV/AIDS testing without the authorisation of the Labour Court.

Mdladlana (in Nxumalo, 2000) further points out that the primary objective of the code is to set out guidelines for employers and employees to create a non-discriminatory work environment. The code deals with HIV-testing, confidentiality, disclosure, equitable employee benefits, dismissals and procedures for managing grievances. Its secondary objective is to create a safe workplace for all employees and employers, manage occupational incidents and claims for compensation, prevent the spread of HIV, develop strategies for reducing its impact and support affected individuals.

6.6 GUIDELINES FOR AN HIV/AIDS-POLICY

People often hold conflicting views over the two approaches that HIV/AIDS itself should form a separate policy and that HIV/AIDS should be part of a more general life-threatening disease policy.

HIV/AIDS is a life threatening disease like cancer, so why treat it differently? The logic is that other life threatening diseases like HIV/AIDS may also have a severe impact on personnel. An advantage of this approach is that HIV/AIDS is not singled out for special attention with the consequent dangers of hysteria and stigmatisation. If HIV/AIDS is treated differently, it is placed outside the norm, which can create problems.

Others say, HIV/AIDS deserves special attention. HIV/AIDS does produce some special problems and possibly by including it as a part of a life threatening diseases policy it may not get the focus it desperately requires. In the workplace, there is the potential for hysteria and rejection of people who are HIV-positive or who have AIDS. Other life threatening diseases cannot be transmitted and are not so stigmatised (Du Plessis, 1990).

According to Evian (1991:45-54) the employer and employee are two parties directly concerned with HIV/AIDS and an employee policy. There are other parties less directly involved, who may want to influence the policy, for example labour unions. It is possible for such parties to become valuable allies and increase the credibility of the HIV/AIDS policy and any subsequent programmes. Conversely if both employer and unions hold very strong opposing views the resulting animosity might make it difficult to gain acceptance of the benefits of the policy. It is important therefore to

consider the extent to which such parties may become involved in future and the benefit of involving them in policy decisions at an early stage.

Evian (1991:54) further points out matters, which must be addressed in an HIV/AIDS-policy, they include:

- Employing HIV-infected people.
- Pre-employment or periodic HIV-testing.
- Disclosing one's medical diagnosis.
- Confidentiality of employee's HIV-status.
- Conditions of service for HIV-infected employees.
- Rights of infected and fellow employees.
- Prevention of discrimination towards HIV-infected employees and policies to deal with discriminatory practices in the workplace.
- Assistance and support for HIV-infected employees and their families.
- Provisions of in-house HIV/AIDS-education programmes in the workplace.
- Employee training programmes.
- Counselling of HIV/AIDS-infected employees.
- Prevention of HIV spread in the workplace.
- Establishment of HIV/AIDS-committees and task force.

Paton (1998) states that the guidelines include a step-by-step guide to drawing up an HIV/AIDS-policy and provide legal and practical advice on dismissals of employees with HIV/AIDS, testing employees, benefits, managing workers with HIV/AIDS, HIV/AIDS-education and the distribution of condoms.

The guidelines also examine the effect HIV/AIDS is expected to have on employee benefits and they propose the restructuring of these in a non-discriminatory and financially sustainable way.

Paton (1998) further points out that there are some key legal issues that must be considered when drawing up an HIV/AIDS-policy and managing people with HIV/AIDS:

- People with HIV/AIDS may not be discriminated against or dismissed simply because they have the virus or the disease. They are entitled to the same benefits, training and opportunities as other employees.

- Employees have the right to confidentiality. They do not have to inform their employer if they are HIV-positive.

- Employers must prevent the transmission of HIV during accidents. They are required to create a safe working environment and must therefore ensure the proper equipment is available and employees have been trained in how to prevent HIV-transmission.

- People infected at work may claim compensation. If there is the possibility that an employee has been exposed to HIV during an accident, a test should be done immediately with their informed consent to determine their baseline status. Thereafter they should be tested again at three and six months and if they are positive, an

application for compensation may be made to the Workman's Compensation Commissioner.

- Employees with AIDS may be dismissed if they become too ill to work. HIV-positive employees must be treated the same as any other employee with a life-threatening disease and can eventually be dismissed on grounds of incapacity. Employers are advised to develop objective and transparent procedures for assessing performance so all supervisors and managers understand the criteria for dealing with absenteeism, sick leave, and transfer to lighter duties and early retirement before dismissal.

- HIV-positive employees should be offered early retirement. Employees who can no longer work are given early retirement along with the normal benefits.

According to Grossett (1999) the following serves as guidelines for the formulation and implementation of an HIV/AIDS-policy:

- Gather information and analyse the situation. The information gathered should pertain to the organisation and the business in which it functions as well to the country as a whole. Types of information gathered must relate to actual or envisaged numbers of current or potential employees that have contracted the virus, as well as any legislation, both local and international that might have bearing on the policy.

- The establishment of any HIV/AIDS-policy should essentially be a tri-partite process. Support and consensus should be obtained from all the stakeholders in the employment relationship, including management, the unions and government.

- Decide what type of HIV/AIDS-policy, if any is needed (i.e. identify the main issues, which the policy must cover). These might include a statement outlining the business' position with regards to HIV/AIDS and AIDS-sufferers.

- Provision relating to education, hiring procedures, continued work, testing, business benefits, confidentiality and so on.

- Provision relating to the safety of all employees, and strategies implemented in this regard.

- Decide how the corporate HIV/AIDS-philosophy and policy will be communicated to employees.

- Decide what impact, if any, there will be on the usual hiring procedures and work relationship in general. Here, parties must consider the effectiveness and advisability of pre-employment, pre-training and pre-benefit testing, as well as considering ways to measure work performance.

- Decide what impact, if any, HIV/AIDS will have on business benefit schemes, and the suitability of any subsequent action.

- Stress the business' position on maintaining medical confidentiality.

- Decide how new knowledge about the disease and other aspects will be incorporated into the policy.

- Draw up and implement the policy.

- Re-evaluate and reassess the effectiveness of the policy on a regular basis.

- Apply knowledge of legislation concerning HIV/AIDS and related scenarios to achieve synergy between business policy and the law.

6.7 AN HIV/AIDS-POLICY

According to Van der Merwe (1988) top management should look at the following primary issues when considering an HIV/AIDS-policy:

- How to minimise the disruption caused by HIV/AIDS in the workplace.
- What should business policy be on HIV/AIDS?
- How to manage employees that are HIV-positive or with AIDS.
- Managing the fears of fellow employees about transmission of the disease.
- Avoiding legal exposure and financial costs.
- Media response on HIV/AIDS matters.
- Minimising productivity loss.

Holding (1991) believes that an HIV/AIDS-policy must address a number of issues if it is to be effective. Excerpts from an HIV/AIDS-policy may read as follows:

- HIV/AIDS-infected employees will not be discriminated against, and will not be treated differently from any other employee suffering from any life-threatening disease.

- Co-workers who refuse to work with an HIV-infected employee should be disciplined.

- Employers should guarantee strict confidentiality with respect to all information about that employee's medical condition.

- Education programmes should provide sufficient medical information to alleviate fears and teach preventive measures.

- Prospective employees should not be required to undertake HIV-tests, but instead should be asked for any information that allow the employer to access his suitability and capability for the job.

- HIV testing should only be carried out on the request of an employee and must be accompanied by appropriate counselling.

- Should an employee with AIDS become incapacitated through illness, the employment should be terminated on the basis of incapacity with the same benefits as accorded to an employee with any other life-threatening illness.

- Trade unions and employee representative bodies should be consulted and involved in all educational programmes.

- Assistance for people with HIV/AIDS should ideally be made available with health and counselling services and employee assistance programmes.

Healy (1999) states that policies relating to HIV/AIDS are becoming increasingly common and necessary. A number of important variables should be fully considered when developing appropriate policy. The Occupational Health and Safety Act obliges employers to do everything within their power to maintain a safe working environment. Employers also have an obligation in common law to provide a safe and healthy working environment.

Healy (1999) further believes that HIV/AIDS-policies should be drafted by employers in consultation with employees, and should contain clear undertakings with respect to non-discrimination and confidentiality.

Crossett (1999) maintains that despite the fact that many issues surrounding HIV/AIDS and employment remain unresolved in legislation, employers must approach the pending crisis in a manner that is both equitable and legal. This can largely be achieved through the structuring of a comprehensive HIV/AIDS-policy for the workplace, which considers the interests of all parties to the employment relationship.

Grossett (1999) further states that an HIV/AIDS-policy is important for the following reasons:

- It shows that the business has taken a firm stance with regard to HIV/AIDS, and in doing so has therefore enabled the business to give attention to the problem before an HIV/AIDS-crisis is reached.

- It generates a consistent approach with regard to the handling of HIV/AIDS-infected employees, and this protects the business from external criticism in not approaching each situation equitably.

- It allows the business to assess its own specific financial and human resources vulnerability to HIV/AIDS, and in so doing enables the business to assess any potential impact on Labour Relations.

- It allows the business to address the various issues surrounding discriminations and stigmatisation of HIV/AIDS-sufferers in the workplace.

Essentially, carefully formulated policies that are effectively communicated to employees play an integral role in avoiding unnecessary hardships and potential.

6.8 CONCLUDING REMARKS

The subject of HIV/AIDS has the potential to be a highly controversial issue in the workplace. However, in the light of South African legislation,

and potential employee that has full-blown AIDS or is HIV-positive, has the same rights as any other employee.

It is also a well-known fact that so far, there is no medical or scientific motivation for refusing to employ or work with someone who is HIV/ AIDS-infected, the employee organisations and employers should ensure that all employees are educated and in possession of facts relating to transmission of HIV/AIDS.

Existing and new labour legislation provides the legal framework within which workplaces should operate in respect of HIV/AIDS. Organisations should be reviewing their workplace policies, employment practices, protocols and employment conditions to check for compliance with the legislation.

If HIV/AIDS is going to be dealt with effectively, employers will need to be more sensitive to the possible ramifications of their business policies and practices. What might have seemed a standard business policy or practices in the pre HIV/AIDS years might now indirectly have the effect of excluding those with HIV/AIDS from pursuing their chosen career (Whiteside and Sunter, 2000:167).

Business that follows enlightened policies on HIV/AIDS stand to earn bonus points from their staff ranks.

The next chapter discusses the research findings of the empirical study undertaken and interpretations of survey are detailed.

CHAPTER 7

RESEARCH FINDINGS

In this chapter the findings of the empirical research undertaken will be analysed. Where possible, the findings will be compared with the theoretical background discussed in the preceding chapters.

7.1 INTRODUCTION

The empirical research in this study concentrated on Small Business organisations in various business sectors in the Vaal Region.

The empirical data was collected in two stages. The first stage was devoted to the analysis of the impact of HIV/AIDS, and it was conducted on a structured interview basis. The second stage focused on the distribution of the questionnaires.

First stage: Structured interview

A part of the interview focused on employment aspects with regard to HIV/AIDS, the influence of HIV/AIDS on business and HIV/AIDS policy in Small Business. The results were that the vast majority of the employers do not offer workplace HIV/AIDS educational programmes, because they believe that HIV/AIDS will not affect them. Other employers believe that by employing HIV/AIDS employees could create a negative business image, reduce sales, increase employee fears, trigger panic, decrease morale, increase turnover and reduce the quality of service. Further, the

interview revealed that few employers have HIV/AIDS policies and have implemented them.

Second Stage: Questionnaire

The second stage focused on the distribution of the questionnaires, directed at managers or owners of other forms of Small Business (manufacturing, repairs, etc).

The discussion of the responses to the questionnaires will be descriptive and, where appropriate, illustrated by tables. The most important and relevant features of the findings generated by questions will be discussed, in the sequence they appear in the questionnaire. Every discussion will be cross-referenced to the questions, with the related part and question number.

7.1.1 PILOT STUDY OF THE QUESTIONNAIRE

There is always a chance that some questions could cause problems and as such, questionnaire testing is needed to identify and eliminate these problems (Sudman and Blair, 1998:300).

A survey questionnaire was developed after a literature review of similar research projects. The questions applicable to this study were selected and adjusted. The format and contents of the questionnaire were finalised only after the questionnaire was presented to four managers or owners of Small Businesses and the respondents were asked to comment on the clarity or otherwise of the questions. Its contents were specifically evaluated in terms of non-ambiguity, relevance, general validity and interpretation. The following changes were suggested:

- Simplification of the terminology used.
- Reduction of, where possible, the number of open-ended questions.
- Reduction of the number of the questions.

The final questionnaire is bound as Annexure B.

The information requested in the questionnaire (see Annexure B) was broken down into categories:

- Information pertaining to the sector within which the business operates and the form of ownership it takes.

- Information pertaining to the size of the business organisation in respect of the number of employees and the number of members of management.

- Information pertaining to communication between management and the employees.

- Information pertaining to business changes and feelings about HIV/ AIDS.

- Information pertaining to HIV/AIDS influence and SWOT analyses.

- Information pertaining to intervention programmes and precautions for employees.

- Information pertaining to the effect of HIV/AIDS on employees and the business.

- Information pertaining to the business policy dealing with HIV/AIDS.

- Information pertaining to the risk of HIV/AIDS infection.

7.1.2 DATA COLLECTION

In the Vaal Region 1 000 Small Businesses (refer Annexure D) are registered (Town Council, 2000), for this study we have made use of the random sampling method, where we targeted every tenth Small Business for participation.

A total of 100 questionnaires (refer Annexure D) were distributed personally to business organisations in the Vaal Region, only 70 responded. The questionnaire was prepared in English. In cases where the respondents were not quite comfortable with the language, efforts were made to enable them to understand the questions. Every precaution was taken to ensure that the questions were understood and that quality answers were obtained.

7.2 SECTOR AND FORMS OF OWNERSHIP

The first section of the research questionnaire analyses the sector within which the organisation is conducting its business and the form of ownership.

The following questions (refer Annexure C) were used to collect this data:

Question 1: In which sector is your business operating?

Question 2: Which of the following is a form of your organisation's ownership?

The data collected is presented in Table 7.1.

TABLE 7.1: SECTOR/OWNERSHIP PROFILE

VARIABLE		FREQUENCY	PERCENT
Sector:			
	Retailing	13	18
	Manufacturing	18	26
	Repair Services	25	36
	Consulting and Advisory Service	-	-
	Other	14	20
Form			
	Sole proprietor	16	23
	Partnership	13	19
	Close corporation	31	44
	Co-operative society	1	1
	Other	9	13

Source: Own research

From Table 7.1 it can be seen that the majority of Small Business interviewed are close corporations and conduct their businesses in the repair services. Businesses that were classified under other turned out to be organisations whose business are both manufacturing and repair services.

7.3 LABOUR FORCE OF THE BUSINESS

The labour force of the business is the number of people employed in the organisations, and the number of those that are in the management positions.

The following questions were asked to collect this information (refer Annexure C).

Question 3: How many people are employed in your organisation?

Question 4: How many of those employed in your organisation are in the management position?

Question 5: What is the ratio of managers to employees?

Table 7.2 follows on p.150.

TABLE 7.2: MANAGEMENT/EMPLOYEE RATIO

VARIABLE	FREQUENCY	PERCENT
Number of employees		
Less than 10	38	54
Between 10 and 20	20	29
Between 20 and 30	6	9
Between 30 and 40	1	1
More than 40	5	7
Number of managers		
Less than 5	62	89
Between 5 and 10	7	10
Between 10 and 20	-	-
Between 20 and 30	-	-
More than 40	1	1
Ratio		
About 1 to 5	46	66
About 1 to 10	12	17
About 1 to 20	2	3
About 1 to 30	3	4
Other	7	10

Source: Own research

From the table it is clear that Small Businesses employ small numbers of employees and also those who occupy management positions are few. As a result, fewer employees report to one manager as can be seen from Table 7.2.

7.4 CHANNELS OF COMMUNICATION

This section examines the level or quality of communication between employees and management. The following questions were asked to collect the data (refer Annexure C).

Question 6: How would you describe communication between management and subordinates?

TABLE 7.3: RATING OF COMMUNICATION LEVELS

VARIABLE	FREQUENCY	PERCENT
Excellent	33	47
Good	29	42
Fair	8	11
Poor	-	-
Very poor	-	-

Source: Own research

From the above table, it is clear that generally communication is not regarded as a problem in many businesses, probably because of a small ratio of managers to employees.

7.5 BUSINESS CHANGES AND FEELINGS ABOUT HIV/AIDS

In this section the changes affecting the organisation and the organisation's feelings about HIV/AIDS are analysed.

The following questions in the questionnaire (refer Annexure B) were used to collect the data:

Question 7: Do changes in the following affect your business?

Question 8: Does your business try to predict changes that may happen outside it (to above mentioned factors)?

Question 9: Does your business think HIV/AIDS is a serious threat?

Question 10: Is the business aware of the possible consequences that HIV/AIDS can hold for it in the future?

Question 11: Do employees know and understand what is HIV/AIDS?

Table 7.4 follows on p.153.

TABLE 7.4: CHANGES/FEELINGS

VARIABLE	FREQUENCY	PERCENT
Changes: Technology (innovation)		
Yes	34	48
No	18	26
Not sure	18	26
Politics (government legislation, etc.)		
Yes	22	31
No	31	44
Not sure	17	25
Economy (interest rates, inflation)		
Yes	58	82
No	6	9
Not sure	6	9
Competitors		
Yes	43	61
No	14	20
Not sure	13	19
Customers		
Yes	41	58
No	16	23
Not sure	13	19
Labour unions		
Yes	27	39
No	24	34
Not sure	19	27
Prediction of changes		
Yes	48	69
No	22	31
Does your business think HIV/AIDS is a serious threat?		
Yes	12	17
No	58	83

VARIABLE	FREQUENCY	PERCENT
Is the business aware of the possible consequences that HIV/AIDS can hold for it in the future?		
Yes	5	7
No	65	93
Do employees know and understand what is HIV/AIDS?		
Yes	61	87
No	-	-
Not sure	9	13

Source: Own research

From Table 7.4 it can be seen that most of the respondents are aware of the factors that can affect their businesses and therefore try to predict changes that may happen outside them. It is also important to note that the majority (83 percent), of the respondents do not believe that HIV/AIDS is a serious threat and also an overwhelming majority (93 percent), of respondents are not aware of its possible consequences in the future. It is a cause for serious concern that the majority (83 percent), of the respondents agreed that their employees know and understand what HIV/AIDS is.

7.6 HIV/AIDS INFLUENCE AND SWOT ANALYSES

The business believe that HIV/AIDS have an abnormal influence is discussed. Also analysed are strengths, weaknesses, opportunities and threats affecting the business in dealing with HIV/AIDS.

The following questions in the questionnaire (see Annexure B) were used to collect the data:

Question 12: Does the business believe HIV/AIDS have an abnormal influence?

Question 13: In dealing with HIV/AIDS is your business aware of the strengths, weaknesses, opportunities and threats?

TABLE 7.5: INFLUENCE/PREDICT SWOT ANALYSES

VARIABLE	FREQUENCY	PERCENT
Influence: Employees		
Yes	36	51
No	25	36
Not sure	9	13
Customers		
Yes	19	27
No	37	53
Not sure	14	20
Competitors		
Yes	15	21
No	33	48
Not sure	22	31
Labour unions		
Yes	27	38
No	23	33
Not sure	20	29
Economy		
Yes	42	60
No	17	24
Not sure	11	16
Social		
Yes	45	64
No	13	19
Not sure	12	17

VARIABLE	FREQUENCY	PERCENT
Capital resources		
Yes	30	43
No	22	31
Not sure	18	26
Direct costs		
Yes	34	49
No	17	24
Not sure	19	27
Indirect costs		
Yes	35	50
No	15	21
Not sure	20	29
SWOT analyses: Strengths		
Yes	38	54
No	5	7
Not sure	27	39
Weaknesses		
Yes	39	56
No	8	11
Not sure	23	33
Opportunities		
Yes	35	50
No	9	13
Not sure	26	37
Threats		
Yes	43	61
No	6	9
Not sure	21	30

Source: Own research

It can be seen from Table 7.5 that many respondents believe that HIV/AIDS have an abnormal influence that can affect their businesses, whereas some of them did not believe HIV/AIDS have abnormal influence

and others are not sure whether HIV/AIDS have abnormal influence or not. It is also important to note from Table 7.5 that many respondents are aware of the strengths, weaknesses, opportunities and threats in dealing with HIV/AIDS in their businesses, whereas some of them are not sure.

7.7 INTERVENTION PROGRAMMES AND PRECAUTIONS

In this section the general outlook of the business contribution to HIV/AIDS intervention programmes and basic elements of practically applicable universal precaution for employees at work are analysed.

The following questions (refer Annexure B) were used to collect this data:

Question 14 – 24: Using the keys, please indicate the importance of the following as business contribution to HIV/AIDS intervention programmes and basic elements of practically applicable universal precautions for employees at work.

Table 7.6 follows on p.158.

RATING OF INTERVENTION PROGRAMMES/PRECAUTIONS FOR EMPLOYEES

Training and hygiene	Ways to transmit the disease	Avoiding of the disease – safe sex	Availability of first aid	Availability of condoms	Team work	Counsel-ling	Body fluid which is blood stained	Body fluid such as urine, sweat and saliva	Avoidance injuries wi "sharps"
41	38	47	37	31	25	26	43	34	38
59	55	67	54	43	37	38	62	49	55
17	17	13	14	13	19	23	15	15	19
24	24	19	20	19	27	33	21	21	27
12	14	10	15	16	22	17	9	14	12
17	20	14	21	23	31	24	13	20	17
-	1	-	1	6	3	3	3	6	1
-	1	-	1	9	4	4	4	9	1
-	-	-	3	4	1	1	-	1	-
-	-	-	4	6	1	1	-	1	-

Own research

The first line of figures represents the frequency and the second the percentage of the t

From Table 7.6 it can be seen that more organisations value safe sex (67 percent), of utmost importance than training and hygiene (59 percent) and counselling (38 percent).

7.8 EFFECT OF HIV/AIDS ON EMPLOYEES AND THE BUSINESS

This section of the questionnaire analyse the effect of HIV/AIDS on employees and the business.

The following questions in the questionnaire were used to compile the data in Table 7.7.

Question 25: Does HIV/AIDS affect the availability of any type of employee?

Question 26: Does HIV/AIDS affect the obtaining of raw materials, accessories, stocks and products or service to the business needed for its own production process?

TABLE 7.7: EFFECT ON EMPLOYEES AND THE BUSINESS

VARIABLE	FREQUENCY	PERCENT
Does HIV/AIDS affect the availability of any type of employee?		
Yes	35	50
No	35	50
Does HIV/AIDS affect the obtaining of raw materials, accessories, stocks and products or service to the business needs for its own production process?		
Yes	11	16
No	59	84

Source: Own research

It can be seen from Table 7.7 that half of the respondents are of the opinion that HIV/AIDS affect the availability of any type of employee. It is also important to note from Table 7.7 that most of the respondents claim that HIV/AIDS does not affect their businesses in production process.

7.9 BUSINESS POLICY DEALING WITH HIV/AIDS

In this section the business policy dealing with HIV/AIDS is analysed.

The following questions in the questionnaire (refer Annexure C) were used to collect data:

Question 27: Is there a formal policy dealing with HIV/AIDS in your workplace?

Question 29: Which parties were involved in the compilation of the HIV/AIDS policy?

Question 30: Does the HIV/AIDS policy apply to all workers?

Question 31: Does your business have any HIV/AIDS committee and HIV/AIDS task forces to offer HIV/AIDS education programmes?

Question 33: Is your business aware of other businesses that have an HIV/AIDS policy?

TABLE 7.8: POLICY DEALING WITH HIV/AIDS

VARIABLE	FREQUENCY	PERCENT
Is there a formal policy dealing with HIV/AIDS in your workplace?		
Yes	19	27
No	51	73
Which parties were involved in the compilation of the HIV/AIDS policy?		
- Top management	19	17
- Outside consultant	4	6
- Labour unions	1	1
- Other	46	66
Does the HIV/AIDS policy apply to all workers?		
Yes	31	44
No	39	56
Does your business have any HIV/AIDS committee and HIV/AIDS task forces to offer HIV/AIDS education programmes?		
Yes	4	6
No	66	94
Is your business aware of other businesses that have an HIV/AIDS policy?		
Yes	14	20
No	56	80

Source: Own research

From Table 7.8 it can be seen clearly that most (73 percent), of the respondents have no formal policy dealing with HIV/AIDS in their workplace, and many (56 percent), of the respondents are of the opinion that HIV/AIDS policy does not apply to all workers. It is also important to note from Table 7.8 that an overwhelming majority (94 percent), of the respondents have no HIV/AIDS committee and HIV/AIDS task forces to

offer HIV/AIDS education programmes. Moreover the majority (80 percent), of the respondents are not even aware of other businesses that have an HIV/AIDS policy.

7.10 RISK OF HIV/AIDS INFECTION

This section of the questionnaire analyses the risk of HIV/AIDS infection at workplace for employees and the public or customers.

The following questions in the questionnaire were used to compile the data in Table 7.9

Question 34: Is there risk of HIV/AIDS infection at your business?

Question 37: Is there risk of HIV/AIDS infection at your business for the public or customers?

Question 38: Does HIV/AIDS influence sales at your business?

Question 41: In you business, is the information regarding an employee's HIV/AIDS status kept confidential?

Question 42: Should HIV/AIDS-infected person be recruited?

Question 43: Should an HIV/AIDS-infected employee be dismissed?

Question 45: Can other employees refuse to work with an HIV/AIDS-infected employee?

TABLE 7.9: RISK OF INFECTION

VARIABLE	FREQUENCY	PERCENT
Is there risk of HIV/AIDS-infection at your business?		
Yes	28	40
No	42	60
Is there risk of HIV/AIDS-infection at your business for the public or customers?		
Yes	4	6
No	66	94
Does HIV/AIDS influence sales at your business?		
Yes	1	1
No	69	99
In your business, is the information regarding an employee's HIV/AIDS-status kept confidential?		
Yes	58	83
No	12	17
Should an HIV-infected person be recruited?		
Yes	21	30
No	49	70
Should an HIV/AIDS-infected employee be dismissed?		
Yes	14	20
No	56	80
Can other employees refuse to work with an HIV/AIDS-infected employee?		
Yes	30	43
No	40	57

Source: Own research

It is a cause for serious concern that an overwhelming majority (93 percent), of the respondents (refer Table 7.4) are not aware of the possible

consequences that HIV/AIDS can hold for them in the future, the following observations are also made from Table 7.9:

- Sixty percent of respondents claim that there is no risk of HIV/AIDS-infection at their businesses.
- Ninety-four percent of respondents believe that there is no risk of HIV/AIDS-infection at their businesses for the public or customers.
- An overwhelming 99 percent of respondents claim that HIV/AIDS does not influence sales at their businesses.
- Eighty-three percent of respondents' claim that in their businesses, the information regarding an employee's HIV/AIDS-status is kept confidential.
- Seventy percent of respondents believe that an HIV-infected person should not be recruited.
- Eighty percent of respondents are for the idea that an HIV/AIDS-infected employee should not be dismissed.
- Only 43 percent of respondents believe that other employees should not refuse to work with an HIV/AIDS-infected employee.

7.11 CONCLUDING REMARKS

This study focused on investigating the impact of HIV/AIDS on Small Business in the Vaal Region. The findings of the survey are analysed and the major features summarised, in preparation for using these results to prove the hypothesis formulated in an effort to provide an empirical window on the state of the preparedness of the Small Businesses in dealing with the impact of HIV/AIDS.

The research findings indicates that most businesses in the Vaal Region still do not have workplace-based education programmes despite studies that suggest these programmes can dramatically reduce the spread of HIV/AIDS in the future.

Some businesses privately acknowledged the likely long-term effects of HIV/AIDS were one reason for the trend away from labour-intensive processes and towards increased mechanisation and higher investment in systems.

Unfortunately even production processes dominated by robotics cannot entirely remove the human factor. People are needed to maintain, repair and re-programme the robots.

Most respondents were quite helpful and co-operative in their replies and responses. In the next chapter the focus will be on the recommendations towards encouraging Small Businesses in the Vaal Region, to recognise the essential that all role players work together to combat the problem as resources are simply not available to duplicate efforts.

The last chapter will evaluate data collected against the theory discussed in previous chapters and recommendations for further research is made.

CHAPTER 8

SUMMARY AND CONCLUSIONS

In this chapter an overview of the research will be made in the light of the findings of the research. The main conclusions based on the research output of the research will be reviewed and recommendations made for further research.

8.1 INTRODUCTION

The purpose of this study emanated from the realisation of the importance of the Small Business in both the formal and informal sectors in the Vaal Region. It also stresses the point that while South Africa was focusing on the apparent lack of concrete action by the government in the fight against HIV/AIDS, little attention had been paid to the inactivity of the country's business in responding to the challenges of the virus in the workplace.

Many employers and employees have already been significantly influenced by the impact of the HIV-positive condition of an employee or full-blown AIDS. This is hardly surprising, given the ever-growing number of HIV-infection (Healy, 1999).

8.2 OVERVIEW OF THE RESEARCH

8.2.1 SMALL BUSINESSES

Small Businesses enjoy the tradition of infinite varieties and solid achievements. They thrive everywhere. Few parts of our economy could survive without their products and services.

From the definitions of Small Businesses the following characteristics can be made:

- The owners are directly involved in the management of the enterprise.
- There are fewer than 100 employees.
- The annual turnover of the enterprise is less than R5 million.
- The total capacity assets of the business amount to less than R1 million.
- There are no more than five units (or branches) of industry.

Small businesses play an important role, including amongst other exists:

- Creation of job opportunities.
- Encouraging innovation and flexibility.
- Maintaining close relationships with customers and community.

- Providing employees with comprehensive learning experience.

Specific problems are also encountered by Small Businesses, which could be summarised as follows:

- Lack of property.

- Insufficient market conditions.

- Inadequate management expertise.

8.2.2 MAIN CONCLUSIONS BASED ON RESEARCH OUTPUT

The HIV/AIDS epidemic is at its most severe among the productive population in the workplace. Unlike any other epidemic that has hit the human race through the centuries, the majority of infections in this epidemic are among the economically active age group.

HIV/AIDS are seen by many businesses as such an overwhelming issue that they take the easy way out, by ignoring it, or giving it minimal attention.

The most insidious effect of HIV/AIDS in the workplace is that on the morale of the workforce. An AIDS-afflicted colleague affects the work team as a whole, his suffering depresses his co-workers, his absenteeism reduced the productivity of the team, deadlines are missed, complaints become common and colleagues pay a high price in stress and in increased

workloads. Businesses run the risk of losing capable workers to less stressful positions elsewhere and a high staff turnover almost always accompanies the presence of HIV/AIDS in an organisation. Again there are obvious implications for the training department.

The workplace is precisely an arena where education and awareness programmes can be beneficial. Employers can contribute to employee education by providing training and education programmes, which focus on awareness and prevention.

Regarding the hypotheses set in chapter one, the following conclusions can be made:

H1: It is clear that not all the managers or owners of Small Business in the Vaal Region are aware of the socio-economic impact of HIV/AIDS in the workplace (93 percent). Therefore the first hypothesis is rejected.

H2: The second hypothesis is also rejected, since not all the managers or owners of Small Business in the Vaal Region have a formal business policy dealing with HIV/AIDS issues in the workplace (73 percent).

The rejection of both hypotheses stress the importance of research of this nature and the fact that Vaal Region businesses are in general, not prepared for the potential devastating effect that HIV/AIDS may have on them and the Vaal Region's socio-economic as a whole.

8.3 RECOMMENDATION

Creating a climate of understanding and compassion, both in our communities and our workplaces, should therefore be a primary aim of our efforts.

The first wave of HIV/AIDS takes the life of a sufferer. The second wave brings the debris of grief, loss and pain for those who are left behind. The disease has already infected many people, it impacts on both those infected, and those affected.

Business should manage the disease and not turn a blind eye to it, as HIV-positive workers can still contribute to the economy.

It is not enough to limit HIV/AIDS education to the workforce, businesses must also help educate the communities in which they operate, including schools, sports clubs, churches and other community-based associations.

No programme can make the HIV/AIDS problem goes away. A business' performance will still be affected, but all business performances are likely to be affected by HIV/AIDS in some way.

The businesses that deal with the challenge in the most intelligent, most appropriate way will be less severely affected than businesses that stick their heads in the sand. They will achieve a competitive edge.

The most recent national statistics support the contention that HIV/AIDS will afflict all South African businesses. They show that nearly 25 percent of all workers are HIV-positive (Myslik, 2001).

Learning to live with HIV/AIDS is not just a challenge for individual suffers, it is a challenge for the business as well. So far, the individuals seem to be facing the challenge a lot better than many businesses.

This study forms the basis for further research in this field.

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PERSONAL INTERVIEWS

To maintain the anonymity of the original source of the empirical data, the designation of the **person interviewed** is used in the text reference and bibliography.

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Owner. 2002. Interviewed by T. D. Mngomezulu. **Vereeniging**, 17th January 2002. **Topic: The impact of HIV/AIDS on Small Business.**

Owner. 2002. Interviewed by T. D. Mngomezulu. **Vereeniging,** 19th January 2002. **Topic: The impact of HIV/AIDS on Small Business.**

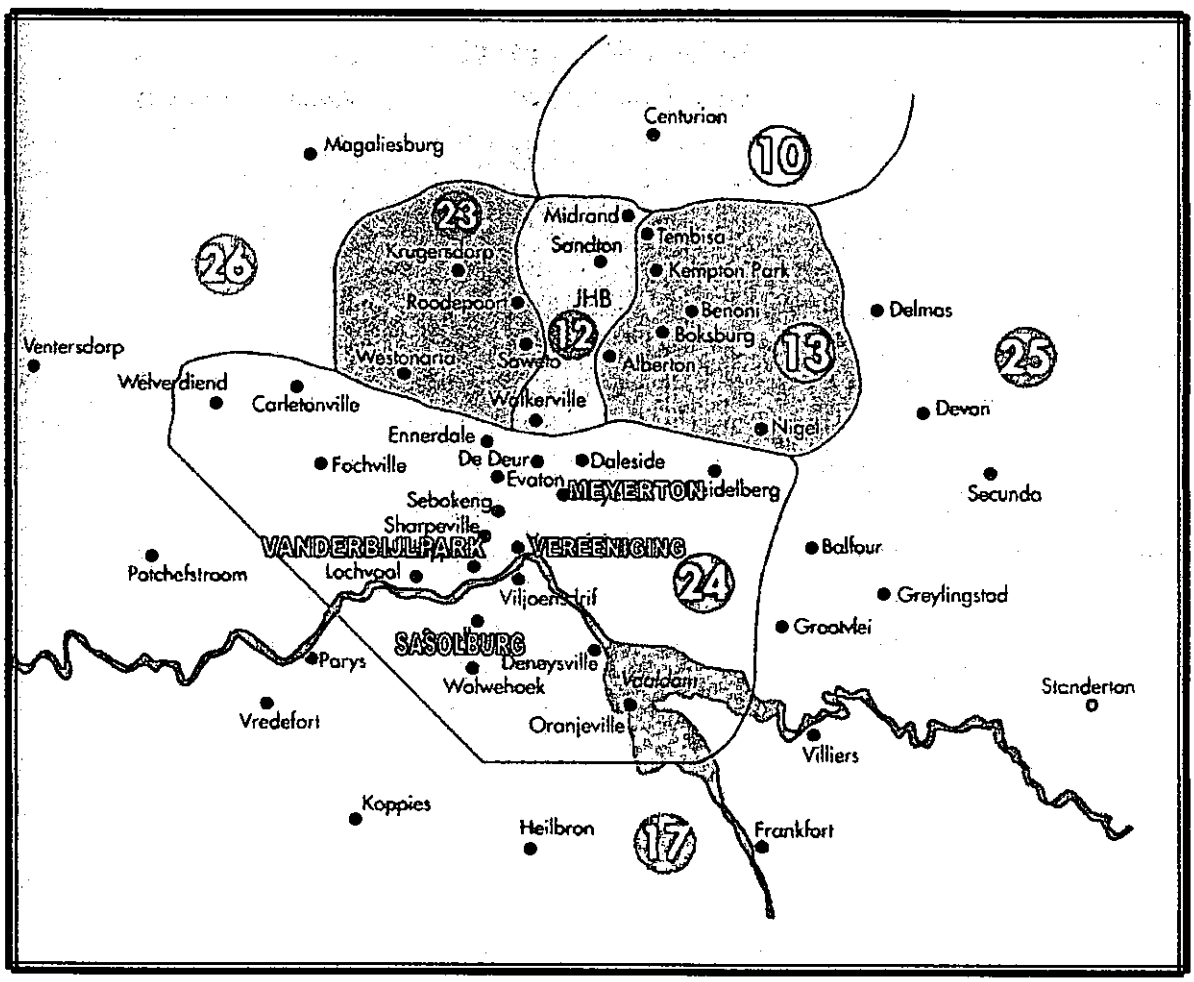
Owner. 2002. Interviewed by T. D. Mngomezulu. **Meyerton**, 31st January 2002. **Topic: The impact of HIV/AIDS on Small Business.**

Owner. 2002. Interviewed by T. D. Mngomezulu. **Sebokeng**, 8th February 2002. **Topic: The impact of HIV/AIDS on Small Business.**

ANNEXURE A

VAAL REGION MAP

ANNEXURE A


Centurion
Magaliesburg
10
23
Midrand
Tembisa
Sandton
Krugersdorp
Kempton Park
26
Roodepoort
JHB
Benoni
Delmas
12
Boksburg
13
25
Ventersdorp
Westonaria
Soweto
Alberton
Welverdiend
Carletonville
Wolkerville
Devon
Ennerdale
Nigel
Fochville
De Deur
Daleside
Evaton
MEYERTON
idelberg
Secunda
Sebokeng
Sharpeville
VANDERBIJLPARK
VEREENIGING
Balfour
Potchefstroom
Lochvaal
24
Viljoensdrif
Greylingstad
GrootVlei
SASOLBURG
Parys
Deneysville
Standerton
Wolwehoek
Vaaldam
Vredefort
Oranjeville
Villiers
Koppies
Heilbron
17
Frankfort

ANNEXURE B

INTERVIEW GUIDE

37 Cobalt Street
Steel Park
VEREENIGING
1939

1 October 2001

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT INTERVIEW

The interview will be aiming to investigate the impact of HIV/AIDS on Small Businesses in the Vaal Region, and the researcher will provide ideal guidelines for dealing with such impact at the end of the research.

The information that will be given in the interview will be confidential and the researcher will stand by the highest degree of confidentiality.

Thank you in anticipation for your co-operation and assistance.

Yours sincerely

.....

T. D. MNGOMEZULU
M.COMM

INTERVIEW GUIDE

AN INVESTIGATION OF THE IMPACT OF HIV/AIDS ON SMALL BUSINESS IN THE VAAL REGION

DATE: .....

NAME OF BUSINESS: .....

PERSON INTERVIEWED: .....

POSITION HELD: .....

INTERVIEWER: .....

1. General background.

2. Employment aspects with regard to HIV/AIDS.

3. The influence of HIV/AIDS on business.

4. HIV/AIDS policy in Small Business.

5. Other relevant information.

PERSONAL INTERVIEW

1. In which sector is your business operating?

- Retailing ☐
- Manufacturing ☐
- Repair services ☐
- Consulting and Advisory Services ☐
- Other (please specify) ☐

2. Which of the following is a form of your organisation's ownership?

- Sole proprietor ☐
- Partnership ☐
- Close corporation ☐
- Co-operative society ☐
- Other (specify) ☐

_____

_____

_____

3. How many people are in the employ of your organisation?

- Less than 10 ☐
- Between 10-20 ☐
- Between 20-30 ☐
- Between 30-40 ☐
- More than 40 ☐

4. Does employees know and understand what is HIV/AIDS?

- Yes ☐
- No ☐
- Not sure ☐

5. Are HIV/AIDS tests compulsory for prospective employees?

- Yes ☐
- No ☐

6. What will the business do if prospective employees are tested HIV-positive?

_____

_____

_____

7. What will the business do if fellow workers start protesting against an HIV-positive employee?

_____

_____

_____

8. Is the information regarding an employee's HIV-status kept confidential?

- Yes ☐
- No ☐

9. Are any HIV/AIDS intervention programmes available?

- Yes ☐
- No ☐

10. If yeas (please explain).

_____

_____

_____

11. Does HIV/AIDS affect the obtaining of raw materials, accessories, stocks and products or service to the business needed for its own production process?

- Yes ☐

- No ☐

12. Does HIV/AIDS affect the availability of any type of employee?

Yes ☐
No ☐

13. Does the business believe HIV/AIDS have an abnormal influence on the organisation's labour and capital resources?

Yes ☐
No ☐

14. Does HIV/AIDS influence sales?

Yes ☐
No ☐

15. Is there a formal policy dealing with HIV/AIDS in your workplace?

Yes ☐
No ☐

16. Who compiled the HIV/AIDS policy?

_____

_____

_____

17. To whom does the HIV/AIDS policy apply?

_____

_____

_____

18. Why does the business have no HIV/AIDS policy?

_____

_____

_____

19. Does the business deal with HIV/AIDS on the same basis as any other life-threatening disease?

Yes ☐

No ☐

20. Does the business provide any counselling for HIV/AIDS-infected employees?

Yes ☐

No ☐

21. If yes, please explain.

_____

_____

_____

ANNEXURE C

RESEARCH QUESTIONNAIRE

37 Cobalt Street
Steel Park
VEREENIGING
1939

1 October 2001

Dear Sir/Madam

RE: RESEARCH QUESTIONNAIRE

This questionnaire is aimed at investigating the impact of HIV/AIDS on Small Business in the Vaal Region, and the researcher providing ideal guidelines for dealing with such impact at the end of the research.

The information contained in this questionnaire is confidential and the researcher will stand by the highest degree of confidentiality.

Please respond to all questions and statements.

Thank you in anticipation for your co-operation and assistance.

Yours sincerely

.....

T. D. MNGOMEZULU
M.COMM

QUESTIONNAIRE

1. In which sector is your business operating?

   - Retailing ☐
   - Manufacturing ☐
   - Repair services ☐
   - Consulting and Advisory Services ☐
   - Other (please specify) ☐

_____

_____

_____

2. Which of the following is a form of your organisation's ownership?

   - Sole proprietor ☐
   - Partnership ☐
   - Close corporation ☐
   - Co-operative society ☐
   - Other (please specify) ☐

_____

_____

_____

3. How many people are employed in your organisation?

   - Less than 10 ☐
   - Between 10-20 ☐

- Between 20-30 ☐
- Between 30-40 ☐
- More than 40 ☐

4. Of the number of people employed in your organisation, how many are in management positions?
   - Less than 5 ☐
   - Between 5 - 10 ☐
   - Between 10 - 20 ☐
   - Between 20 - 30 ☐
   - More than 40 ☐

5. What is the ratio of managers to employees?
   - About 1 to 5 ☐
   - About 1 to 10 ☐
   - About 1 to 20 ☐
   - About 1 to 30 ☐
   - Other (please specify) ☐

_____

_____

_____

6. How would you describe communication between management and subordinates?
   - Excellent ☐

- Good ☐
- Fair ☐
- Poor ☐
- Very poor ☐

7. Do changes in the following affect your business?

	Yes	No	Not sure
- Technology (innovation)			
- Politics (government legislation, etc.)			
- Economy (interest rates, inflation)			
- Competitors			
- Customers			
- Labour unions			

8. Does your business try to predict changes that may happen outside it (to above-mentioned factors)?

Yes ☐
No ☐

9. Does your business think HIV/AIDS is a serious threat?

Yes ☐
No ☐

10. Is the business aware of the possible consequences that HIV/AIDS can hold for it in the future?

Yes ☐
No ☐

11. Does employees know and understand what is HIV/AIDS?

Yes	
No	
- Not sure	

12. Does the business believe HIV/AIDS have an abnormal influence on the following:

	Yes	No	Not sure
- Employees			
- Customers			
- Competitors			
- Labour unions			
- Economy			
- Social			
- Capital resources			
- Direct costs			
- Indirect costs			

13. In dealing with HIV/AIDS is your business aware of the following:

	Yes	No	Not sure
- Strengths			
- Weaknesses			
- Opportunities			
- Threats			

14. KEYS

1	=	of utmost importance
2	=	very important
3	=	important
4	=	of little importance
5	=	of no importance

Using the above keys, please indicate the importance of the following as business contribution to HIV/AIDS intervention programmes and basic elements of practically applicable universal precautions for employees at work.

	1	2	3	4	5	
- Training and hygiene						14
- Ways to transmit the disease						15
- Avoiding of the disease – safe sex						16
- Availability of first-aid						17
- Availability of condoms						18
- Team work						19
- Counselling						20
- Body fluid which is blood stained						21
- Body fluid such as urine, sweat and saliva						22
- Avoidance of injuries with "sharps"						23
- Avoidance of skin/mucous membranes contamination						24

25. Does HIV/AIDS affect the availability of any type of employee?

Yes ☐

No ☐

26. Does HIV/AIDS affect the obtaining of raw materials, accessories, stocks and products or service to the business needed for its own production process?

Yes ☐

No ☐

27. Is there a formal policy dealing with HIV/AIDS in your workplace?

Yes ☐

No ☐

28. If no, why does the business have no HIV/AIDS policy?

_____

_____

_____

29. Which parties were involved in the compilation of the HIV/AIDS policy?

- Top management ☐
- Outside consultant ☐
- Labour unions ☐
- Other (please specify) ☐

_____

_____

_____

30. Does the HIV/AIDS policy apply to all workers?

Yes ☐

No ☐

31. Does your business have any HIV/AIDS committee and HIV/AIDS task forces to offer HIV/AIDS education programmes?

Yes ☐
No ☐

32. If yes, please describe them.

_____

_____

_____

33. Is your business aware of other businesses that have an HIV/AIDS policy?

Yes ☐
No ☐

34. Is there risk of HIV/AIDS-infection at your business?

Yes ☐
No ☐

35. If no, please explain.

_____

_____

_____

36. If yes, what is it that the business is doing to prevent the infection?

_____

_____

_____

37. Is there risk of HIV/AIDS-infection at your business for the public or customers?

Yes ☐

No ☐

38. Does HIV/AIDS influence sale at your business?

Yes ☐

No ☐

39. If yes, please describe it.

_____

_____

_____

40. If no, please describe it.

_____

_____

_____

41. In your business, is the information regarding an employee's HIV/AIDS status kept confidential?

Yes ☐

No ☐

42. Should an HIV-infected person be recruited?

Yes ☐

No ☐

43. Should an HIV/AIDS-infected employee be dismissed?

Yes ☐

No ☐

44. If yes, please explain.

_____

_____

_____

45. Can other employees refuse to work with an HIV/AIDS-infected employee?

Yes ☐

No ☐

46. If yes, please explain.

_____

_____

_____

ANNEXURE D

LIST OF SMALL BUSINESSES IN THE VAAL REGION WITH 100 AND LESS EMPLOYEES (VEREENIGING, VANDERBIJLPARK, SASOLBURG AND MEYERTON)

ANNEXURE D

LIST OF SMALL BUSINESSES IN THE VAAL REGION WITH 100 AND LESS EMPLOYEES (VEREENIGING, VANDERBIJLPARK, SASOLBURG AND MEYERTON)

Businesses that structured interviews were conducted and questionnaires were distributed to:

1. MARIGOLD ICE-CREAM*
2. TSHEPISO BUTCHERY*
3. ICE-BLOCK SUPPLY*
4. LA OMA SLAGHUIS*
5. ARCON PARK FRUIT MARKET*
6. CRAZY HORSE ROADHOUSE*
7. HOT SPORT FAST FOODS*
8. CHEROKEE ROADHOUSE*
9. VAAL BODY REPAIRS AND SPRAY PAINTERS
10. **A & I BEARINGS**
11. RISIVILLE SUPERMARKET AND TAKE AWAY*
12. CHECK AND BUY SUPERMARKET
13. DAIRY TALK ICE-CREAM*
14. MARKET CAFÉ*
15. RENOWN FRESH MEAT*
16. KOPPISOL PLESIEROORD
17. WALDRIFT SUPERMARKET
18. PICK 'N BITE*
19. AMTEC
20. **ALUTECH**

21. TRADOR
22. POT OF GOLD
23. ORANGE AFVAL DEPOT*
24. PULA TAKE AWAY*
25. VIVA KOE-KOE SHOP
26. FRIESLAND TAKE-AWAY*
27. VAAL DISCOUNT SUPERMARKET
28. MANNY'S TAKE AWAY*
29. MULTI MEAT*
30. **R59 TRUCK & TRAILER SPARES**
31. CENTRAL INFORMATION SERVICES
32. GOOD LUCK CAFÉ*
33. THE CHICKEN KING*
34. CAPRI RESTAURANT*
35. MEAT AND MORE*
36. GINO'S TAKE-AWAY*
37. MARYLAND FAST FOODS*
38. CONTINENTAL CAFÉ*
39. FARM CHICKEN SHOP*
40. **FURNITURE TIMBER PALACE**
41. AFRICAN MAGNETS
42. EASY BUSY CASH AND CARRY
43. AURORA CONFECTIONERY*
44. JACKPOT CAFÉ*
45. TEXAS MEAT RANCH*
46. PALACE CAFÉ*
47. RAINBOW RESTAURANT*
48. SPEEDY FOOD SUPPLY*
49. JOJO FRIED CHICKEN*

50. N & M MOTOR TRAILER HIRE

51. TRADEX

52. TOP STAR CAFÉ*

53. COUNTRY FRESH*

54. SAVOY CAFÉ*

55. DELICIEUX CORNER*

56. MR FAT CAT VETKOEK*

57. HYPER CHICKEN*

58. RED CAP CHICKEN*

59. MACHINE TOOLS REPAIRS

60. ARC SPRAY

61. PIZZA HUT

62. DICKS ENGINEERING

63. DI-TECH ENGINEERING

64. ELCA ENGINEERING

65. EMCOR ENGINEERING

66. PHILLIPS SUPERMARKET

67. ERNEST LOWE HYDROTUBE

68. FERROUS HIGH PRECISION ENGINEERING

69. GENERAL PROJECT AND CONSTRUCTION SA

70. M.M.V. RACING

71. U AND POWER ELECTRIC

72. MOOLAS FRUITERERS

73. INDIAN DELIGHTS

74. HAPPER ENGINEERING

75. VEREENIGING COUNTRY CLUB

76. HARRISON AND WHITE CONTRACTORS

77. BELLA PIZZA

78. THREE RIVERS FISH & CHIPS

79. SANDT

80. ADVANCED ELECTRONICS

81. HARRY'S CAFÉ

82. VAAL PARK GROENTE

83. METAL BOX CENTRAL CAFÉ

84. FACTORY CARPET FITTERS

85. TUCK SHOP THETSO

86. MEAT HAVEN

87. QUEEN PIE

88. CHICKEN LICKEN

89. G D WIRE

90. AUTO MECHANICAL

91. TONY'S TAKE AWAY

92. RAINBOW BUTCHERY

93. CHOICE PIE

94. SIRLOIN BUTCHERY

95. PROTEA FISH & CHIPS

96. VAAL TAKE AWAY

97. KEUR BUTCHERY

98. M J S RESTAURANT

99. KOFFIEHUIS

100. MULTI RENTALS & TRANSPORT

101. IMPALA ENGINEERING

102. SPICY FOODS

103. BAFANA – BAFANA

104. DRIEHOEK MILK DEPOT

105. KALOELIE MILK DEPOT

106. BR BLITZ MILK DEPOT

107. CHESS KNIGHT ENGINEERING

108. CEMID CONSTRUCTION
109. COLLASIUS TECHNICAL SERVICES (COLTS)
110. SASOLBURG MECHANICAL ENGINEERING
111. D S CONSTRUCTION
112. LAPPOURRI
113. CELLOS PIPING CONSTRUCTION
114. CARAVEL MAINTENANCE AND ERECTION
115. BURLEY ENGINEERING
116. BRYAK ENGINEERING PRECISION
117. BRITON CONSTRUCTION
118. BLITZ ENGINEERING
119. MAGNUM ENGINEERING
120. QUALITY FABRICATORS
121. MANA PRECISION ENGINEERING
122. CLYPAC STEEL
123. MANCO FABRICATION
124. MANN MACHINERY SERVICE CC
125. MSR ENGINEERING
126. MULTI-TRADE DISTRIBUTORS
127. NUNROYS MARKETING AND ENGINEERING
128. MYSTEK ENGINEERING
129. NANEER ENGINEERING
130. BEARINGS INTERNATIONAL
131. NESSA ENGINEERING
132. TURAL-CANE FOUNDRY & ENGINEERING
133. D M E AUTO BODY PANEL BEATERS
134. NIC RAS CONSTRUCTION
135. NSA ELECTRICAL & ENGINEERING SERVICES
136. OLYMPIC CONTRACTION

137. P & W ENGINEERING
138. PARK ENGINEERING & MINING SERVICES
139. PEACO ENGINEERING
140. PRESTIGE CLEANING SERVICES
141. PETER'S PRECISION ENGINEERING
142. PLASMA WELD
143. PRO PIPE WORK
144. SALISTER DIESELS
145. BATAUNG FISH & CHIPS
146. DIPHOKO RESTAURANT
147. COUNTRY FRESH
148. SAVOY CAFÉ
149. BILTONG PARADISE
150. SPARK'S ENGINEERING
151. FRONTIERS RESTAURANT
152. ALFA TRIO PANEL BEATERS
153. THREE RIVERS BUTCHERY
154. VAAL FAMILY RESTAURANT
155. TIP-TOP BAKERY
156. MILKY PALACE
157. D & S CHICKEN BAR
158. MINI MARKET
159. QUICK SAVE
160. VAN ZYL'S PANELBEATERS
161. T E C AUTO REPAIRS
162. COLLY'S CASH & CARRY
163. RUST DIRE INN
164. CIVIC CASH & CARRY
165. BAFOKENG STORE

166. DON SUPPLY STORE
167. EDDIE FISH & CHIPS
168. MOKHALO SUPERMARKET
169. ZUIKERBOSCH MEAT MECCA
170. REFRITECH
171. FREEDOM GROUP
172. TAUNG TRADING STORE
173. VUKA SUPERMARKET
174. USCO I STORES
175. INDUSTRIAL CONCORDE CANTEEN
176. RITE VALUE
177. SAAMTREK CAFÉ
178. JANTENE CAFÉ
179. LUBE TECHNOLOGY
180. WYKO BEARINGS
181. ROTHDENE CAFE
182. HYDRO OIL COOLING ENGINEERING
183. HYDRO PRECISION ENGINEERING
184. SARAH'S FISH & CHIPS
185. MMABATHO FISH & CHIPS
186. AB FISH & CHIPS
187. BLUE CAFÉ
188. MICHAEL'S CAFÉ
189. MM FISH & CHIPS
190. GAMMATEC ENGINEERING
191. GOLDEN FOOD CENTRE
192. GOLD STAR FISH & SHIPS
193. CONCOR BUTCHERY
194. MODERN BUTCHERY

195. KHOZA'S BUTCHERY
196. MAZIBUKO CAFÉ
197. MOTAUNG FISH & SHIPS
198. MOKOENA CAFÉ
199. SEGABI CAFÉ & GENERAL
200. RECFAB ENTERPRISE
201. GOLFANATIX
202. TSHEALOPEFE SUPER MARKET CAFÉ
203. TSHEOLOPEFE SUPER MARKET BUTCHER
204. DEKELIDI CAFÉ
205. SAPAPU CAFÉ
206. MAKUME COMPLEX CAFÉ
207. MAKUME COMPLEX BUTCHERY
208. RAMAKAU MODERN HOUSE CAFE
209. NOVAK MOTOR ENGINEERING
210. HENSWAN EXHAUSTS
211. HIGHWAY CAFÉ
212. KHAFFINS RESTAURANT
213. MAHLODI FISH & CHIPS
214. MOLEFE RESTAURANT
215. NDABA PHUNYKA CAFÉ
216. BATLOAKA CAFÉ
217. SUNRISE BUTCHERY
218. SITHOLE FISH & CHIPS
219. DEL- ECHNOLOGY
220. BATT MOTORS SASOLBURG
221. DISCOUNT BUTCHERY
222. SUNCRUSH CANTEEN TAKE AWAY
223. ROAD RUNNER TAKE AWAY

224. LUXMI TAKE AWAY
225. CM CAFÉ BUTCHERY
226. VLEISKOR BUTCHERY
227. JONNY'S CAFÉ TAKE AWAY
228. KHAYALAMI FAST FOOD
229. GEARMAX
230. J.J.M. FILTRATION
231. ROOSTERS TAKE AWAY
232. KWA-JUNDA BUTCHERY
233. MASHIGO'S CAFÉ
234. M M BUTCHERY
235. PRO FISH & CHIPS
236. CENTRAL FISH & CHIPS
237. BAVELASE FISH & CHIPS
238. KHUTSONG CAFÉ
239. ZADCO BUILDERS
240. DENCOR INDUSTRIES
241. MAROGANGE BUTCHERY
242. LAMOLA GENERAL DEALER
243. HLOMBANE CHEAP BUTCHERY
244. IKHANA EATING HOUSE
245. B & G CAFÉ
246. FAIRY TALE
247. VET-KOEK DEN
248. MOTHER'S KITCHEN
249. FIVE STAR CLEANING
250. ASHMAN
251. WILLIES CONFECTIONERY
252. PORTOT MINI MARKET

253. EVEREST VLEISMARK
254. GOLDEN SUN
255. CE 1 SUPERMARKET
256. JUST RIB CAFÉ
257. PIZZA DEN CAFÉ
258. GLOBE ELECTRICAL
259. FULCO SPARE
260. C.C. ELECTRIC & APPLIANCE
261. HAPERS CAFÉ
262. FRESH MEAT SUPPLY
263. CIVIC BAKERY
264. EVATON MEAT MARKET
265. MAKOSA FRUIT & VEGGIES
266. THE MEAT CENTRE
267. MA MEAT MARKET
268. NYEMBE & SONS SUPERMARKET
269. PRO ROOF SHEETING
270. D & D PLANT MAINTENANCE
271. TEMBENI FISH & CHIPS
272. MNGUNA BUTCHERY
273. JACKPOT FISH & CHIPS
274. BOITUMELO FISH & CHIPS
275. HLAPHO SUPER MARKET
276. MORNIBA STAR
277. H & M METAL DEALERS
278. LEBEMBE BUTCHERY
279. VAAL CUPBOARDS
280. X-O-DUS ENGINEERING
281. C-CHOP CAFÉ

282. JABULA FAST FOOD
283. IIOC ENGINEERING CAFÉ & GENERAL DEALER
284. MA MAGGIE FAST FOOD
285. VAAL INDUSTRIAL BUTCHERY
286. SALEY SWEET
287. MONTOEDI (KARAVAAN)
288. MISTER GLASS
289. VAAL GEARBOX EXCHANGE
290. SEAL TIGHT
291. FOOD FOX CAFÉ/GENERAL DEALER
292. OCEAN FISH & CHIPS
293. CELIJO'S RESTAURANT
294. RIVERVIEW ALGEMENE HANDELAAR
295. EI PASO SPUR RESTAURANT
296. PANAROTTI PIZZA PASTA CAFE
297. PRIMA VERA CAFE
298. JOE'S CONFECTIONERY BAKERY
299. AUM PRECISION ENGINEERING
300. RELIANT ELECTRIC
301. MILKY PARADISE CAFE
302. KARAMEL KAFEE
303. CATS RESTAURANT
304. MILKY LINE CAFE
305. CAMELOT CAFE
306. TAULAS CAFE
307. CAMPANELLA PIZZA
308. SMULGENOT KAFEE
309. CUFFU MUG CAFE
310. TRICHROME ELECTRIC

311. AUTO PLASTIC BUMPER REPAIRS
312. COSMOS DELICATESSE
313. KALAHARI OASIS RESTAURANT
314. MR FUNKY FAST FOOD
315. HIGHLAND FREYER
316. SADDLES
317. LITTLE CAESARS
318. PONTIES CANTEEN
319. CHICKEN HYPER TAKE AWAY
320. EXCEED GEAR CUTTIGN & ENGINEERING
321. BARBECUE PALACE
322. KALOELIE MILK DEPOT
323. EKONO MILK DEPOT
324. VAAL MILK DEPOT
325. CONCORDE KIOSK
326. MODEL GLASS & PARTITIONS
327. MARK
328. JERSEY DAIRY
329. MIMOSA SWEETS
330. RADIUS ENGINEERING
331. TIEKIES TUISNYWERHEID
332. LEEUHOF GEMEENSKAPSAAL KAFEE
333. VEGGIE TOWN
334. WELCOME CAFÉ
335. ARCON PARK CAFÉ & SUPERMARKET
336. OUMA SE PLAASKOMBUIS
337. HOSPITAAL WINKEL
338. MADEIRA FISH & CHIPS
339. TOOLNET

340. RETIEF'S ENGINEERING

341. BRANDWEER KANTIEN

342. CATHERINE ROBSON KINDERHUIS

343. PLAZA CAFÉ

344. PEACEHAVEN SUPERMARKET

345. PIZZA ESPERANZA

346. CHRISALEX CAFÉ

347. MANNY'S FISH & CHIPS

348. RIKAMA SLAGHUIS

349. D L S ENGINEERING

350. LEKOA TECHNICAL SUPPORT

351. CENTRE SAVE

352. FALCON RIDGE SLAGHUIS

353. KRAAINES KAFEE

354. UNITASPARK FISH & CHIPS

355. VOPELS CORNER

356. NEDEMI VARS PRODUKTE

357. WATERDAL ALGEMENE HANDELAAR

358. TUCK SHOP

359. STARCAR

360. ELECTROMITE

361. VEREENIGING ABATTOIR CANTEEN

362. MARKET MEAT WHOLESALERS

363. SENTRAAL-WES KOOPERASIE

364. NEW GENERATION WHOLESALE

365. STER INRY

366. DUNCANVILLE CAFÉ

367. SUN HING

368. DIE POT

369. GOLDEN HARVEST MILLS

370. ALJIMM ENGINEERING

371. NEW INDUSTRIAL BUTCHERY

372. SIMPLY THE BEST (PIZZA)

373. OUR TAKE AWAY

374. L-KOM GROOTHANDELAARS

375. WILLARD CHIPS

376. GEILLIES RESTAURANT

377. AVONDRUS 1

378. AVONDRUS 2

379. PAUL PANEL BEATERS

380. VAAL PIPE & VALVE

381. TOEKOE'S TAKE AWAY

382. HIGHWAY CAFE

383. DRIEHOEK AFVALLE

384. VAAL MEAT BUTCHERY

385. POWERVILLE CANTEEN

386. MIMOSA KAFEE

387. VAAL DRIEHOEK VELLE

388. SANTO ANTONIO FRUITERERS

389. SUPER TRACK

390. DAN'S QUALITY

391. FOOD CITY CASH & CARRY

392. CONTINENTAL FRESH MEAT WHOLESALERS

393. PIZZA ROADHOUSE

394. WALK AWAY TAKE AWAY

395. ISCOR CAFÉ

396. LERATONG RESTAURANT

397. 20TH CENTURY CAFETERIA

398. ERSMIA MELKERY

399. TURNMILL HYDRAULICS

400. WEIRD WIZAD STEEL ART & DESIGN

401. SPRINGBOK CAFÉ

402. SHARPEVILLE SUPERMARKET

403. BAKERS DREAM

404. TV TAKE AWAY

405. PANAROTTIS PIZZA PASTA

406. MARJUAN COFFEE SHOP

407. BELLS RESTAURANT

408. THE AFRICAN LUNCH BOX

409. FIDELITY SPRINGBOK

410. BLACK PANTHER MOTOR SPARES

411. MEXICANO'S RESTAURANT

412. DEE SWEETS

413. MR FISHY

414. FRUITTI NUTTI

415. JOHNNY'S FRUITERERS

416. CORNER LOUNGE

417. LAEEKA'S BAKERY

418. PRESTIGE TUISNYWERHEID

419. INDUSTRIAL CAFÉ

420. NASHUA VAAL

421. THE COSY NOOK

422. AMBASSADORS RESTAURANT

423. LA MIRAGE RESTAURANT

424. GIGI'S RESTAURANT

425. POSKANTOOR KANTIEN

426. DA ROMANO RESTAURANT

427. DA ROMANO CONTINENTAL DELICATESSEN
428. NEW GOLDEN RAY RESTAURANT & TAKE AWAY
429. A TASTE OF ITALY
430. MISSUS GLASS
431. FRANEUR MELKERY
432. TOWER FRUITERERS
433. FALCKE FOODS
434. FUDGIES TAKE AWAY
435. WESTERN FAST FOOD
436. BUDGET BAZAAR
437. VEREENIGING TUISNYWERHEID
438. SOUTHERN FRIED CHICKEN
439. COURT YARD COFFEE SHOP
440. PARK PANEL BEATERS
441. SUNSHINE CAFÉ
442. AHMEDS SUPERSTORE
443. SHOOTERS
444. ICE-CREAM LANE
445. CHICO'S WHOLESALES
446. NEW YORK FRUITERERS
447. UNION CAFÉ
448. CONTINENTAL CAFÉ NO. 2
449. M & J INDUSTRIAL SERVICES
450. MACHINE TOOL PROMOTIONS
451. HELENA'S TAKE AWAY
452. IMPERIAL FRUIT MARKET
453. CAPE GATE TAKE AWAY
454. KLEIN BOY'S TUCK SHOP
455. PARK SQUARE TAKE AWAY

456. NEBRASKA BUTCHERY

457. RONNIES

458. CHOONARA'S SWEET SHOP

459. A R AUTO ELECTRIC

460. DEPOT CONTROLLER / POSTAL DISTRIBUTION

461. ZIYADUMA MUSIC SUPERMARKET

462. VEREENIGING FOOD POINT

463. JABULANI SUPERMARKET & SHOE REPAIR

464. 5 STAR RESTAURANT

465. CHOONARA SUPERMARKET

466. MAMS CURRY TAVERN

467. TAXIDO BUTCHERY

468. TAXIDO TREK SUPER-T

469. GELLIES RESTAURANT & TAKE AWAY

470. P. G. INDUSTRIES ENTERPRISE

471. SCHOLINGS

472. GELLIES FOOD CENTRE

473. COUNTRY FRESH DAIRY

474. ALPENHORN WURSTBUDE

475. BLOEMENDAL FOOD

476. PROTEA TAKE AWAY

477. EAT 'N MEAT

478. DAIRYVALE

479. PARK GATE

480. ROBVAN ENGINEERING

481. EXECUTIVE AUTO SPRAY

482. STAND FISH & SHIPS

483. JOLIDA FISH & CHIPS

484. VILLA RESTAURANT

485. CEILI JO'S RESTAURANT
486. MOTTA TAKE AWAY
487. GRAB A BITE TAKE AWAY
488. CHICKEN KING TAKE AWAY
489. PORTUGALITO TAKE AWAY
490. EVERYSEAL & GASKETS
491. HYDRO PRECISION
492. PROP SHAFT CENTRE
493. VANDERBIJLPARK DEPOT
494. WEST RAND
495. FREDDIE FISH & CHIPS
496. KIRI'S TAKE AWAY
497. AAA TAKE AWAY
498. JOE'S TAKE AWAY
499. ENSENE
500. MINI MAXI ARMATURE WINDERS
501. PHEHAMANG BUTCHERY
502. BATAUNG ZULU BUTCHERY
503. TRIPTIEK SLAGHUIS
504. TASTY TURBO TAKE AWAY
505. ATLANTIC FOOD CENTRE
506. VASCO DA GAMA
507. PRIMA SLAGHUIS
508. COLLEGE CAFE
509. RAY SONICS
510. ELITE AUTO
511. VAAL TRAINING CENTRE CAFÉ
512. JUST MEAT BUTCHERY
513. JUST CHICKEN BUTCHERY

514. ZE RICKS ROADHOUSE CAFÉ
515. EDDIES'S SUPERMARKET
516. LEGHABILE BUTCHERY
517. BP EXPRESS SHOP BAKERY
518. RAINBOW CAFÉ
519. GLASS FIT
520. ABACUS MICRO SYSTEMS
521. INTERNATIONAL CAFÉ
522. MIGHTY PIES
523. VILLA VERDI RESTAURANT
524. NORBAK SYSTEM
525. BLACK STEERS
526. MPHASANE CAFÉ & GENERAL DEALER
527. JONEL CAFÉ
528. BRATHEMS CHICKEN LICKEN
529. HOME PARTS CENTRE
530. HETDRé RADIATORS
531. LITTLE FISH & DELI SHOP
532. THE MEAT BOX
533. SOLY'S CAFÉ
534. VAL'S FISH & CHIPS
535. JOE'S TAKE AWAY
536. L MARINA
537. PONTO FRUIT
538. ARTEMIS
539. ELECTRONIA
540. MACTRIX
541. OEWERSPENS RESTAURANT
542. NANDOS KAFEE

543. COLONIAL BUSINESS MAN CLUB
544. FRIENDLY BUTCHERY
545. FAIRWAYS SUPERMARKET SCORE
546. CC'S DINER
547. NANDOOS CHICKEN
548. KING PIE
549. M.M.A.
550. FREIGHT LINER
551. DADOOS
552. CHOONARAS WHOLESALERS STORE
553. NETTAS SLAGHUIS
554. VASCO DA GAMA CAFÉ & FRUITERERS
555. PRETOORS VETKOEK DEN
556. VAN HEERDENS SLAGHUIS
557. ZUIKERBOSH LIQUOR OUTLET
558. FRANK'S FRUIT & VEGETABLES
559. LAMBSONS HIRE & SALES
560. XXX EXHAUST & SILENCER SERVICES
561. REPUBLIC CAFÉ
562. MISTER PIZZA
563. BON APPETITE
564. DIE VISWINKEL
565. LOLLY POT
566. SWEET FROM HEAVEN
567. CHATTERLEY'S
568. NIKITA'S OFFICE FURNITURE
569. METRALLARK
570. H & M TECHNOLOGIES
571. MIRAGE PIZZERIA

572. NAZRANA CONFECTIONERY
573. CAFÉ JULES
574. LITY'S FISH & CHIPS
575. MC SPICE CENTRE
576. SUPER SPICE CENTRE
577. R & F WHOLESALERS
578. SUPER SAVERS
579. HAFFEJEE CAFÉ
580. DELTA PIPE CONSTRUCTION
581. INDUSTRIAL SEALS & SUPPLIERS
582. SR SPICES
583. CASANOVA INN
584. MODEL SLAGHUIS
585. ALPHA MASHIGO STORE
586. BASOTHO GREEN GROCER
587. BATLOUNG GENERAL DEALER
588. BAPO FRUIT SHOP
589. GEARBOX SERVICE
590. PROGRESS HARDWARE
591. C DEPOT STORE
592. DAGBREEK BUTCHERY
593. EBONY FISH & CHIPS
594. EMTHONJENI STORE
595. ITOSOSE STORE
596. GILROSE SUPERMARKET
597. J.M. MOKOENA STORE
598. J RAMAKAU STORE
599. GESTETNER
600. ANTRIO DRY CLEANERS

601. P & A DRY CLEANERS
602. STEPHENS DRY CLEANERS
603. RADEBE'S DRY CLEANERS
604. ZENEX FILLING STATION
605. ARMSTRONG I, II & III PETROL STATION
606. SEFATSA FILLING STATION
607. VISION FILLING STATION
608. TK I, II & III FILLING STATION
609. NKUTHA FILLING STATION
610. NUMERI AIR CONDITIONING & REFRIGERATION
611. HIGH TECHNOLOGY CONSTRUCTION
612. MELOA'S FILLING STATION
613. UBISI'S FILLING STATION
614. CLUB LA MANCHA TAVERN
615. CLUB BARCELONE TAVERN
616. WILLIE'S TAVERN
617. SESOTHO TAVERN
618. MABATHO BOTTLE STORE
619. EXCELLENT HAIR SALON
620. SILVERTON SASOLBURG RADIATORS
621. LAPONTE HAIR SALON
622. SEW & KNIT CLINIC
623. CHARLES HAIR SALON
624. MAKGWABA RESTAURANT
625. LEBOKO'S COMMUNITY CONFECTIONERY
626. S.M. NTSIO GENERAL DEALER
627. BOLAONG PUBLIC PHONE
628. BAHLOAKOANE FRESH PRODUCE
629. M & M GENERAL DEALER

630. J. J. V. BOLTS & NUTS

631. ZENZELE DAIRY

632. RIALTO CAFÉ

633. MOKHEMA WHOLESALERS

634. BILLY HARDWARE

635. NEW YORK TO NEW YORK SUPERMARKET

636. RABALI'S PHARMACY

637. GOBIZITWANA BAR LOUNGE

638. CHILLIBITE RESTAURANT

639. PAINT & WALLPAPER HARDWARE

640. T. S. INSULATION & PAINTING

641. EASTERN SUPERMARKET

642. AL CAPONE'S LIQUOR STORE

643. SUPER LIQUOR STORE

644. WYNAND NOLTE EIENDOMME

645. PHOTO FAST

646. PHOTO GRAPHICS

647. GANDAN DESIGN

648. SIGN CREATIONS

649. BISCUIT KING

650. XXX SCRAPYARD

651. DIE VLEISWINKEL

652. VORSTER CREATIONS

653. CHALOVIA

654. KROMMENAALD

655. MOOLMAN FABRICS

656. T DESIGNS

657. HOUTWERK

658. KERATA HOUT

659. MODEL GLASS

660. THE BIG TIME

661. GROOTFONTEIN FURNITURE

662. TOP GLASS

663. AC APPLIANCES

664. DJ ELECTRONICS

665. SASMOVE

666. THE STATIONERY SHOPPE

667. ARME VERSLANKING

668. DIE SKOONHEIDSKLINIEK

669. EL-ME

670. SEALMECH HYDRAULICS VAAL

671. FIGURES MODEL

672. ACCORD LIFTING

673. HIGH STYLE HAIR

674. MARIANA'S

675. MARICHELLE SONBED

676. MELANI'S

677. A-Z BESTUURSKOOL

678. BATTERY DOE

679. ELMA AIR CONDITION & RETAIL

680. M. P. INDUSTRIAL ENGINEERING

681. HENMAR SASOL

682. PRO-VEHICLE ELECTRICIAN

683. SASOL AUTO BODY REPAIR

684. SASVAAL PANEELKLOPPERS

685. TURBO-FLOW

686. TAMMELETJIE

687. STOPNET

688. PIZZA DEN

689. O'HAGANS

690. FLEMINGO PLANT HIRE

691. MOCHACHOS

692. LEMON TREE

693. HARRY'S ROADHOUSE

694. DIAL-A-MEAL

695. COFFEE MOMENTS

696. A NOSSA CASA

697. A1 CAPONE'S DRANKWINKEL

698. SENTRA

699. GEM GARDENS

700. M. S. R. ENGINEERS

701. SPANKS ENGINEERING

702. QUALITY ROCK

703. PRO-TECH SECURITY

704. AFRICAN PEGMATITE

705. BOSRAND SAND COVERLAND

706. B & D PATTERN MAKER

707. CUMELA AFRICA

708. RESINITE S A

709. AFRICAN PRODUCTS

710. CITI BEARINGS

711. BLITZ CONCRETE WALL

712. SHINE MASTER

713. GILLIES A G

714. FERRO STEEL INTERNATIONAL

715. TRIPLE M ENGINEERING

716. TITAN INDUSTRIES

717. MALESELA TECHNOLOGY

718. ALMAR EXTRUSIONS

719. C B FOUNDRIES

720. COBO CONTRACTORS

721. SUPERIOR CASTING SUP & PATTERN MAKERS

722. PREVAIL ENGINEERING

723. EURO-PAINT & HARDWARE

724. D E F ENGINEERING

725. MARBOE CONSTRUCTIONS

726. TH & M LABOUR AND PLANT HIRE

727. McKINNON CHAIN

728. ALL BOLT & NUT MANUFACTURERS

729. ENGINEERING FABRICATORS

730. MARBOE & SONS

731. SPEARCO TOOL

732. ELLISON STORMILL

733. T D COMMUNICATION

734. CARLOS AUTO CENTRE

735. GAMMATEC ENGINEERING

736. G WINDER

737. V A W VAAL ARMATURE WINDERS

738. THAMES WIRE & CABLES

739. KEMFIED HIGH PRESSURE

740. RETIEF'S ENGINEERING

741. VAAL HIGH PRESSURE & PNEUMATICS

742. PETMAR ENTERPRISES

743. DIAMOND POWER

744. ELLA ENGINEERING

745. PIETER'S PRECISION ENGINEERING

746. VAAL DIE CASTING
747. ZIMMERMAN & JANSEN S.A.
748. MACHINE TOOL PROMOTION
749. TOY SUPERMARKET
750. BOSS GEAR CUTTING
751. MACKAYS METAL SPRAYING WORKS
752. CINTOOL ENGINEERING
753. E R D ENGINEERING
754. KLIP ENGINEERING
755. N & 0 ENGINEERING
756. LONE WIRE
757. ALL-IN-ONE ENGINEERING
758. GENERAL WELDING WORKS
759. FOCUS PATTERN MAKERS
760. J. B. N. ENGINEERING
761. VEREENIGING FOUNDRIES
762. DI-TECH ENGINEERING
763. HELM ENGINEERING
764. AKLIN INDUSTRIES
765. DELTARETT
766. TRICO SERVICES
767. COMPUTER DISCOUNT 3000
768. DE KLERK MICA HARDWARE
769. INTER-TURBO
770. BRAKE & TUNE-UP CLINIC
771. FUEL ELECTRIC ALBERTON
772. GASKET CENTRE
773. X-O DUS FRICTION ENGINEERING
774. HEALTH GENERAL DEALER

775. HEALTH BOTTLE STORE
776. MTHIMKULU'S FRIDGE REPAIRS
777. NAA'EEL'S CASH & CARRY
778. SEGOLE FRUIT & VEGETABLES
779. ASHANTI HAIR SALON
780. SPYKERMAN ENGINEERING
781. M & A BOTTLE STORE
782. CELE BOOKKEEPERS
783. FAIR PLAY LIQUOR STORE
784. MOLAETSA GENERAL DEALER
785. DAN'S CASH & CARRY
786. A R CONTROLS
787. FAIRY TALE ICE CREAM
788. VAAL KINE KIOSK
789. PANDA GARDEN RESTAURANT
790. MIRACLE AUTO BODY
791. LITTLE MAURITIUS
792. THREE RIVERS TUISNYWERHEID
793. PROGRESS CAFÉ AND BAKERY & TAKE AWAY
794. GIOVANNI'S PIZZA
795. RED ROSE CAFÉ
796. STEVE GENERAL DEALER
797. PIKKIES POP INN
798. FAMILY STORE
799. KHOALI FAMILY STORE
800. PRECISION & LAWNMOWER SERVICES
801. KUBHEKA LUCKY 7
802. LUCKY TRADING STORE
803. LAKESIDE GENERAL DEALER

804. ENYONI BUTCHERY

805. J M STORE

806. M J STORE

807. MADU-MAGEU

808. MINGO'S CAFÉ

809. VUKANI STORE

810. HENTER MOTORS

811. UNCLE SAM'S INN

812. THAFISA FRUIT MARKET

813. SOLLY STUDIO

814. PHOKENG CAFÉ

815. MALEKE GENERAL DEALER

816. P MOKOENA STORE

817. N E MOFOKENG STORE

818. SHARPEVILLE FISH & CHIPS

819. SHARPEVILLE TAILORS & GROCERY

820. VALET CENTRE

821. SHARPEVILLE A BEER HALL

822. SHARPEVILLE DISTRIBUTION CLUB

823. M J MOKOENA GENERAL DEALERS

824. TRANSVAAL TRADING STORE

825. TRANSVAAL CASH STORE

826. STAR BUTCHERY

827. GIGI SWEETS

828. T C PAVING

829. COSY CARPETS

830. ONSITE SERVICE

831. S V SWEISWERK

832. REMO HOUTWERK

833. ULTRA FIBRE

834. TRIANGLE PANEL BEATERS & SPRAY PAINTERS

835. GELEENTHEID

836. BLINDS

837. PRO TUINDIENSTE

838. PARK SQUARE SUPERMARKET

839. SLEUTEL & SKOON WINKEL

840. REIVILO INDUSTRIAL

841. ALCARE

842. MOOLMAN DIENSTE

843. DYNAMIC MODELS

844. TRV SUPERMARKET

845. BAFANA FURNISHERS

846. BABY-GO-AROUND

847. PICK-A-BED

848. WEST STAR

849. DAYGLO MOTOR SPARES

850. DIAMOND POWER

851. MR FIX IT

852. PCN DRUKKERS

853. THOMAS TYRE CENTRE

854. REDWOODS RESTAURANT

855. MOBILE TUNING & SERVICING

856. VAAL MATTRESS

857. CANDLE MAKERS

858. LAUNDRY SERVICE

859. PADDY'S PANEL BEATERS

860. EXEUTIVE UPHOLSTERS

861. TOP DOG TRAINING & KENNELS

862. MR POOL REPAIR

863. T J POOLS & PAVING

864. VB LAPAS

865. A J KINGS VISION

866. MAGIC LAWNS

867. MAGIC CARPETS

868. SULIMAN'S CARPETS

869. MINI CARPETS

870. ECONOFLEX

871. CITY LIFE FURNITURE & PAWN BROKERS

872. JANSEN HOUTWERKE

873. SYLVESTER PAVING & WALLS

874. HARRY-MPHA PAVING & BETON

875. FLORANI KWEKERY

876. EUTE PAVING

877. WW PLUMBING

878. SEMFENS

879. VAAL CEILINGS

880. DELJ ENGINEERING & CONSTRUCTION

881. EXPRESS BUTCHERY

882. VAAL CV CENTRE

883. B & M PAVING

884. CENTURY PAVING

885. RIVER PAVING

886. THE DRAIN SURGEON

887. PANTHER PAVING

888. THE ELECTRO CLINIC

889. TRANSVAAL BLIND & AWNINGS

890. GEARBOX MASTERS

891. TRELLIDOR

892. SHADENETS

893. DAY-GLO SUPERMARKET

894. MOM AMIE HAIR BEAUTY CLINIC

895. AL-MAR HAAR SKOONHEIDSALON

896. LA LUNA SALON

897. SALON LE CHIC

898. BRIDE & GROOM BOUTIQUE

899. MUHAMMED LOCKSMITH

900. SF FAB

901. C B INTERIOR

902. HARLEY TOOLS CENTRE

903. K G HAIR SALON

904. HIGHWAY CAFÉ

905. DUNCANVILLE BUTCHERY

906. FRUIT SHOP

907. HAMBURGER HUT

908. FRANCE CAFÉ

909. DAN & DONS

910. ROXOUND ENGINEERING

911. AFRICAN CABLE CANTEEN

912. BRODERICK CANTEEN

913. EVKOM CLUB CANTEEN

914. MITCO CLUB CANTEEN

915. NORDBERG MANUFACTURING CANTEEN

916. TRANSPORT CATERING SERVICES

917. BRICK & TILE

918. DORBYL VECOR RESTAURANT

919. S A BROUERY KANTIEN

920. TNT PANEL BEATERS

921. PULA FAST FOOD

922. RAND WATER BOARD CANTEEN

923. LIBRA CANTEEN – FEDMECH

924. PRESTIGE CATERING

925. MEYERTON FRESH MEAT

926. SONSKYN KAFEE

927. ROTHDENE VLEISHANDELAARS

928. LES MAXIMES RESTAURANT

929. STEEL PARK MOTORS

930. JOHN CRANE

931. MEYERTON FRUIT SHOP

932. MEYERTON RESTAURANT

933. HAVEN BUTCHERY

934. LEKKERBEK

935. VLEISWINKEL

936. KALAHARI DESERT DINER

937. KWIKKIE TUISNYWERHEID

938. LUCKY'S ROADHOUSE

939. BURGER BOX

940. MUD MAN

941. PETE'S RESTAURANT

942. CLUB HOUDINI

943. GREEN SLEEVES

944. SYBEON

945. DIE KOFFIEHUIS

946. ADAM'S RIB

947. THE MINI MARKET

948. 101 PRODUKTE

949. MASTER VARIETY STORE

950. RAND AIR

951. SWANEPOEL MELK DEPOT

952. AYLESBURY ICE-CREAM

953. DIGGERS GRILL VEREENIGING

954. NATIONAL CAFÉ AND SUPERMARKET

955. BILTONG BAR

956. HYPER CANTEEN

957. SONNEBLOM TUISNYWERHEID

958. WIMPY BAR

959. NAZRANA BAKERY

960. SASOLBURG AUTO BODY REPAIRS

961. QUICK SAVING

962. NATASHA TAKE AWAY

963. EBONY FISH & CHIPS

964. DAY-GLO HARDWARE

965. E DEPOT

966. OXFORD FISH & CHIPS

967. ALARM DOCTOR

968. AFRIKAN0 TAP & TILE

969. MIKE'S CAFÉ

970. PHENOL CONSTRUCTION

971. TUMELO SCRAP METAL DEALERS

972. EDDIE BOTTLE STORE

973. MEYERTON FRUIT MARKET

974. WILRO PLUMBERS

975. RITTAH'S MOTOR SPARES

976. TAXI RANK TAVERN

977. GT'S RUB & CRAB

978. ALRODE COOLING PROJECT

979. A M ALARM & ELECTRONIC

980. C. T. J. BEZUIDENHOUT

981. QUICK'S LOANS

982. AMERICANA HARDWARE

983. BOTHMA & SONS TRANSPORT

984. BARNET AUTO SPARES

985. KAREE ARMATURE WINDERS

986. CONVEYOR SPLICING SERVICES

987. DE PARSKUYP DRANKWINKEL

988. DE PARSKUYP BOTTLE STORE

989. CONVEYOR TECHNIQUE

990. DYNAMIC AIR

991. VAAL PLUMBING

992. CAMPANELLA PIZZA & PASTA

993. EXO FLEX

994. ERICA KWEKERY

995. HERMIT CRAB SEA FOOD

996. FRIK'S FENCING

997. ELCA ENGINEERING

998. ELECTWELD

999. ELMA AIR CONDITIONING & REFRIGERATION

1000. CAR & TRUCK AUTO

- ***The structured interviews were only directed to the foodstuff businesses with asterisks.***
- ***The questionnaires were only distributed to the Small Businesses printed in bold.***