The role of HIV/AIDS committees in effective workplace governance of HIV/AIDS in South African small and medium-sized enterprises (SMEs)*

Jocelyn R Vass

Abstract

The primary purpose of this study was to assess the role, status and scope of workplace HIV/AIDS committees as a means of effective workplace governance of the HIV/AIDS impact, and their role in extending social protective HIV/AIDS-related rights to employees. In-depth qualitative case studies were conducted in five South African small and medium-sized enterprises (SMEs) that were actively implementing HIV/AIDS policies and programmes. Companies commonly implemented HIV/AIDS policies and programmes through a workplace committee dedicated to HIV/AIDS or a generic committee dealing with issues other than HIV/AIDS. Management, through the human resources department and the occupational health practitioner often drove initial policy formulation, and had virtually sole control of the HIV/AIDS budget. Employee members of committees were mostly volunteers, and were often production or blue collar employees, while there was a notable lack of participation by white-collar employees, line management and trade unions. While the powers of workplace committees were largely consultative, employee committee members often managed in an indirect manner to secure and extend social protective rights on HIV/AIDS to employees, and monitor their effective implementation in practice. In the interim, workplace committees represented one of the best means to facilitate more effective workplace HIV/AIDS governance. However, the increased demands on collective bargaining as a result of an anticipated rises in AIDS-related morbidity and mortality might prove to be beyond the scope of such voluntary committees in the longer term.

Keywords: *HIV/AIDS, committees, workplace, governance, small and medium-sized enterprises (SMEs).*

Résumé

Le but de cette étude fut d'évaluer le rôle, le statue et le champ de comités de VIH/SIDA dans un milieu de travail comme moyen efficace de gérer l'impact du VIH/SIDA dans des lieux de travail, ainsi que leur rôle à étendre, aux employés, les droits sociaux et protectifs liés au VIH/SIDA. Des études de cas qualitatives et détaillées ont été menées auprès de 5 petites et moyennes entreprises sud-africaines qui exécutaient, de manière active, les politiques et les programmes du VIH/SIDA. Les sociétés communément exécutaient les politiques et les programmes du VIH/SIDA, en milieu de travail, à travers un comité dévoué au VIH/SIDA ou bien un comité générique qui s'occupe d'autres sujets en dehors du VIH/SIDA. La gestion, à travers le département de Ressources Humaines et la personne chargée de santé en milieu de travail, a souvent conduit la formulation initiale d'une politique. De plus, la gestion dominait le budget du VIH/SIDA. La plupart des employés, membres de comités, étaient des volontaires, et souvent ces volontaires étaient des ouvriers et des employés de services. Alors qu'il manquait la participation des cadres et des représentants de syndicats. Etant donné que le pouvoir des comités était largement consultatif, les membres de comités géraient, de manière indirecte, afin d'assurer et d'étendre les droits sociaux et protectifs de VIH/SIDA aux employés, ainsi que de contrôler une mise en œuvre efficace de ce derniers. Entre temps, les comités en milieu de travail représentent un des meilleurs moyens de faciliter davantage la gestion efficace du VIH/SIDA dans un milieu de travail. Cependant, les exigences croissantes des négociations liées à l'augmentation prévue de la morbidité et la mortalité liées au SIDA pourraient, à long terme, être au-delà du champ des comités volontaires.

Mots clés: *VIH/SIDA, comités, lieu de travail, gestion, petites et moyennes entreprises.*

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Jocelyn R Vass, Chief Research Manager, Human Science Research Council
Private Bag X41, Pretoria, 0001, South Africa. Tel: +27 12 302 2412 Fax: +27 12 302 2413 E-mail: jvass@hsrc.ac.za

Introduction

A key factor in the effective governance of HIV/AIDS in the workplace is the collaboration of employers and employees. Thus, guidelines on best practices for effective HIV/AIDS management in the world of work promote the establishment of collaborative mechanisms, including committees at national, regional, company and workplace level (Department of Labour, 2000; International Labour Organisation [ILO], 2004). However, there is very little research available that explores the role, dynamics and challenges of such committees, especially in the workplace. The key research objective of this study was to assess the role, status and scope of workplace committees as a means of effective workplace governance of the HIV/AIDS impact in the participating companies. A secondary objective was to assess the extent to which such committees created new opportunities to extend social protective rights to South African employees to mitigate the scourge of HIV/AIDS more effectively.

In-depth qualitative case studies were conducted in five SMEs in Gauteng province in South Africa, which documented the implementation of HIV/AIDS policies and programmes. Four companies were medium-sized employing 50-500 employees, while the fifth company was small and employed fewer than 50 employees. Most of the companies were in the manufacturing sector, while one was in the services sector. Results for Company D were reported separately as D_1 and D_2, as these were two different sites belonging to one company.

Background

HIV/AIDS interventions in the South African private sector are largely led by corporates with extensive access to financial resources, and information and knowledge networks. Thus, local studies show consistently that small companies tended to lag behind in the management of the epidemic and access to HIV/AIDS services, while medium-sized companies performed relatively better in this regard (Connelly & Rosen, 2003; Ellis & Terwin, 2004). A study conducted in 2004 showed that while 96% of large corporates and 64% of medium-sized companies had a HIV/AIDS policy, only 17% of small companies had the same. While the existence of a policy does not necessarily reflect effective governance, it does indicate a written commitment to a set of principles and procedures, an essential step in the management of the HIV/AIDS impact. Further, both the International Labour Organisation Code of Practice on HIV/AIDS and the World of Work (ILO, 2004) and the South African Code of Good Practice: Key aspects of HIV/AIDS and employment (Department of Labour, 2000) promote the development of workplace-based HIV/AIDS programmes to facilitate the protection of employee rights and the delivery of HIV/AIDS prevention programmes, care, treatment and support. However, the successful attainment of these objectives requires appropriate institutional and governance capacity within workplaces. This is especially relevant to SMEs, who often suffer resource and capacity constraints in HIV/AIDS management (Connelly & Rosen, 2003). Thus, lessons may be learnt from SMEs that have allocated resources and capacity.

Table 1. Summary of fieldwork activities

	Key informant interviews	Group interviews	Focus group discussions
Company A	1 (Managing director) 1 (OH) 1 (Operational director) 1 (Trade union)	1 (HIV/AIDS committee)	2 (14 employees)
Company B	1 (Managing director) 1 (OH)	1 (HIV/AIDS committee) 1 (Trade unions)	2 (17 employees)
Company C	1 (MD) 1 (HR) 1 (Training officer) 1 (OH) 1 (Operational Director)	1 (HIV/AIDS committee) 2 (Trade unions)	2 (14 employees)
Company D_1	1 (MD) 1 (HR director) 1 (Trade union)	Not applicable	1 (12 employees)
Company D_2	1 (Senior management)	1 (Trade union)	1 (13 employees)
Company E	1 (HR management consultant) 1 (HIV/AIDS employee coordinator) 1 (Trade union)	1 (2 employees)	Not applicable

The post-apartheid labour legislative framework is largely founded on the principle of consensus-seeking and industrial democracy to resolve differences in a cooperative rather than an adversarial manner. Thus, there exists in the South African labour regulatory framework a range of collaborative mechanisms, often manifested in multilateral committees; some with clear legislative powers, while in others they are left undefined. This paper sought to assess the extent to which this cooperative workplace culture may be observed in the management of HIV/AIDS as well, and the impact on securing HIV/AIDS-related rights and benefits.

Methodology

This study formed part of a larger research project. The research methodology followed was qualitative in nature, and included the development of in-depth case studies of five SMEs, which were recruited using the snowball sampling technique. Thus, referrals from disease management providers were used to recruit an initial list of 15 companies, five of which eventually agreed to participate. These five companies had to:

- Employ less than 500 employees
- Have an existing HIV/AIDS policy and programme
- Allow the research team to interview employees.

The research team conducted semi-structured key informant and group interviews with management and trade union representatives, as well as employee representatives on the workplace HIV/AIDS committees. Where there were no HIV/AIDS committees, those involved in the HIV/AIDS programme were interviewed. The management representatives usually included the managing director (MD), human resources (HR), training or industrial relations (IR) directors, and the occupational health (OH) nurse. In two companies, the operational director was also interviewed.

As part of the larger research project, separate focus groups were conducted with employees from the production and administrative sections of these companies. Focus group discussions were held after the conclusion of interviews with the committees, trade unions and management representatives. The purpose of the focus group discussions was to reflect on employees' real experiences and their evaluation of the activities of the HIV/AIDS committees, thus hopefully providing a more objective view rather than a one-sided and subjective view from insiders on the HIV/AIDS committees. Where relevant, data generated in these focus groups were included in this article. See Table 1 for details of the fieldwork conducted.

Interviews were conducted once informed verbal consent had been obtained, and generally lasted for an hour. In order to maintain confidentiality and anonymity, names and other identifying details were not recorded. In the focus groups and group interviews, respondents were also asked to maintain confidentiality of the content of the group discussions afterwards as well. The right to withdraw during discussions applied, where respondents felt that confidentiality might be at risk. An additional (and indirect) form of protection for respondents was to conduct separate focus groups for production and administrative employees. Historically, these groups of employees have been more homogeneous (predominantly black and semi-skilled, or white and skilled), and often might have had comparatively different life experiences in the workplace. It was also felt that, given the sensitivity of HIV/AIDS, they might reflect more comfortably among known colleagues. Given the voluntary nature of the focus groups, bias might have crept in, as those with differing opinions might have excluded themselves or were not available due to operational requirements.

The interviews were based on a set of core questions. Probing and follow-up questions were asked depending on the flow and nature of respondents' inputs. The core exploratory questions were the following:

- What is the nature and role of the HIV/AIDS committees?
- What are their powers and how effective are they in realising HIV/AIDS policy and programmes?
- What rights and benefits have been granted to employees as a result, and what has been the role of the committees in this regard?
- What have been the role of the trade unions in the HIV/AIDS committees and the management of HIV/AIDS?

The research proposal and the research instruments (interview guidelines and consent forms) were submitted to the Human Science Research Council ethics committee for consideration. Full ethical approval was granted subject to changes to the research instruments. All interviews were recorded on tape recorders and in written form, and were transcribed. Thematic content analysis was used to code and analyse the data, based on a number of themes identified in the core questions, sub themes that arose in the process of conducting the fieldwork, and subsequent reflection. Where possible documentary evidence, such as written company HIV/AIDS policy documents, were also collected and used to verify some of the information collected during the interviews. After the conclusion of the larger research study, presentations on the outcomes of the case studies were presented to those participating companies who had made such a request. This provided useful feedback to HIV/AIDS committees on the dynamics and impact of their HIV/AIDS interventions among their employees.

Results

The development and implementation of HIV/AIDS policies and programmes in most of the participating SMEs was driven by a workplace committee, either dedicated to HIV/AIDS, or a "generic" committee dealing with broader employee issues. Thus, three companies had a dedicated HIV/AIDS workplace committee, established with the sole purpose of facilitating the implementation of HIV/AIDS policies and programmes. These non-statutory committees appeared to co-exist with other statutory committees, facilitating sharing of information and feedback on HIV/AIDS activities. On the other hand, in Companies D_1 and D_2, HIV/AIDS was discussed at site level with the trade union representatives as part of the statutory employment equity (EE) committee as provided for under the Employment Equity Act. This was motivated by a managerial decision to centralise HIV/AIDS policy development and implementation at head office level. It was argued that, "…a committee [dedicated to HIV/AIDS] makes sure that nothing gets done". In Company E, there was no HIV/AIDS committee, but an employee HIV/AIDS coordinator, elected by the employees, who liaised with the HR consultant and management on HIV/AIDS matters. This practice was largely attributed to the fact that, as a small company, it did not have sufficient resources to sustain an independent structure. The key rationale forwarded by management for a dedicated HIV/AIDS committee was that employee representation would facilitate "… buy-in from the floor", facilitating a "bottom-up" approach and workforce involvement in the HIV/AIDS programme. It was also recognised that it was a business "best practice" advocated by private sector role models.

Composition of dedicated HIV/AIDS committees

Participation on the committees was voluntary, and members came from the general workforce, senior management, the occupational health practitioner, and trade union shop stewards. There was a predominance of production employees, and relatively poor representation by administrative or non-production employees. Furthermore, this skewed employee representation had racial overtones, as most production employee members were African, whereas administrative employees were predominantly white, or to a lesser extent, coloured. When asked about this phenomenon, employee committee members in Company A and Company B felt that "…they [white or administrative employees] do not believe that it [HIV/AIDS] affects them". In Company C though, there was a much higher representation of white employees, largely due to the active participation of a trade union representing artisanal employees.

Management representation was largely from the HR, IR or training departments, and the occupational health practitioner. In Company A and Company B, the MD also participated in the committee. However, none of the committees had line management representation. Formal trade union representation was marginal. Thus, in the dedicated HIV/AIDS committees, shop stewards either served in an individual capacity (as in Company A), or were not actively involved. For instance, in Company C, one of the trade unions participated actively (representing artisans), while the other union (representing production employees) was not actively represented. At the two sites in Company D, with a generic EE committee, the shop stewards had either withdrawn or had marginal participation. In this case, it appeared that trade union participation was mostly a consequence of statutory requirements on employment equity, rather than HIV/AIDS *per se*.

Control of HIV/AIDS budget and expenditure

The case studies suggested that management had virtually sole control over the nature and size of the HIV/AIDS budget. Thus, one of the most glaring weaknesses of the committees was that the employee committee members had very little access to, and knowledge of the HIV/AIDS budgets and expenditure levels. The exception was Company B, where the management and employees had set up a joint fund with equal contributions to pay towards the medical treatment and care of HIV-infected employees. In this case, all committee members and employees had full knowledge of the financial status of the joint fund, and medical expenditure on HIV/AIDS. Interestingly, though, with regard to expenditures related to the treatment of infected employees, most employee committee members (except Company B) regarded such information sharing as a breach of confidentiality, and did not express a wish to have access to such information. As a result none of the members had any idea of the aggregate expenditure on treatment interventions. Finally, none of the trade unions had ever requested information on the HIV/AIDS budget or expenditure trends, with the exception of Company D_2. In this case the shop stewards queried the HIV/AIDS budget, but largely in the context of management proposals to cut labour costs in general.

The role of trade unions

None of the trade unions had been involved in the initial development of the HIV/AIDS policy or its implementation. None had negotiated formally on behalf of their respective trade unions, nor presented changes to the proposed HIV/AIDS policy based on union guidelines. Thus, all the policies concluded in these case studies were done outside formal

collective bargaining arrangements and without official support from the trade union offices concerned.

The study found that in two companies, internal labour disputes on non-HIV/AIDS issues had resulted in poor cooperation with regard to HIV/AIDS. In Company C, the inability to resolve a retirement benefit dispute had negatively affected the participation of one of the unions and its membership in the HIV/AIDS programme, especially the voluntary counselling and testing (VCT) service. In the case of Company D_1, the union had withdrawn from the EE committee, in response to disputes on a range of HR issues, thus affecting negatively their participation in HIV/AIDS management as well.

Role of HIV/AIDS committees in policy development

All of the committees operated on a consultative basis, and did not have any formal powers of decision-making. However, the results suggested that these committees influenced the nature and direction of HIV/AIDS policy and programme implementation in a direct and indirect manner. Firstly, influence was directly derived from representation of senior management on the committees, especially those promoting or championing the business importance of HIV/AIDS, in line with HIV/AIDS "best practice" case studies. The exception was Company E, where the management representative felt that "…we [the company] are in the business of production, and not HIV".

A related finding was that senior management, notably the HR department, generally drove the development of the initial workplace HIV/AIDS policies, often with the assistance of the occupational health practitioner. External consultants also played a prominent role, especially in the absence of an on-site HR department, as is often the case in South African SMEs. The exception was Company A, where the committee had been party to the initial policy development process. Thus, employee committee members and trade union representatives in most cases responded reactively, and tended to "rubber-stamp" the initial HIV/AIDS policy. Overall though, it appeared that high levels of commitment by management representatives were key in the acceptance and implementation of recommendations suggested by the committee.

Employee committee members argued that the apparent absence of a meaningful response to the initial policy was related to a lack of independent institutional support, information and resources. Thus, a lack of access to information sources and technology, such as the Internet and computers, was cited as contributory reasons. In most cases they acknowledged their reliance on, for instance, the occupational health practitioner for information. Over time however, external sources of information in the communities, such as nongovernmental organisations (NGOs) working on HIV/AIDS, played a role in improving the capacity of some employee committee members.

Secondly, influence was also indirectly derived by the committees. Thus, even though employee committee members were not party to the initial policy development process, they had played a key role *post facto* in communicating mandatory rights and non-mandatory provisions flowing from such policies to employees, and monitoring their implementation in practice. Thus, the committees facilitated the distribution of information to employees in the form of posters, leaflets and so forth. Another example related to the development of provisions to ensure confidentiality in testing protocols, for VCT or HIV prevalence surveys, and the delivery of AIDS medication.

This does not imply that such communication was necessarily effective, as most of the focus group discussions suggested high levels of distrust, especially with regard to perceptions of potential breaches of confidentiality regarding disclosure of HIV status and test results. In most cases, committees identified such gaps in trust and knowledge among the workforce as areas needing redress. Thus, in the case of Company C, the committee was instrumental in developing procedures whereby AIDS medication was delivered to infected employees without breaching confidentiality. In Company D_2, some focus group participants felt that, in accessing ART, "… a positive employee would be fighting a losing battle" as confidentiality would have to be breached in the absence of clear and agreed procedures.

In as far as monitoring infected employees' rights to the continuation of employment was concerned, most committees found this to be complex area, given high levels of employee distrust of so-called job security guarantees. On the one hand, in Company A, in the absence of a company-subsidised anti-retroviral treatment (ART), the committee was involved in procedures to terminate the employment of AIDS-sick employees on the grounds of medical disability. This was not necessarily an optimal solution and flew in the face of a commitment to job security. In Company B, on the other hand, AIDS-sick employees were being relocated to "…lighter jobs" where appropriate, in cooperation with line management, but with due regard to appropriate disclosure of HIV status. While job relocation was not necessarily a problem-free process, joint funding of ART in Company B enabled affected employees to continue in employment. Unlike Company A, retirement on the grounds of medical disability did not necessarily become a primary consideration once AIDS morbidity became evident. Other companies in the study did not have clear procedures as

Table 2. Summary of company HIV/AIDS-related interventions

Type of intervention	Company A	Company B	Company C	Company D_1	Company D_2	Company E
HIV/AIDS policy	Yes	Yes	Yes	Yes	Yes	Yes
Existence of dedicated workplace committee	Yes	Yes	Yes	No, part of EE committee	No, part of EE committee	No committee, HIV/AIDS employee coordinator
Peer educators	Yes	Yes	Yes	No	No	Yes
Education and awareness	Yes	Yes	Yes	Yes	Yes	Yes, limited provision
On-going VCT	Yes	Yes	Yes	Yes	Yes	No, once-off provision
Prevalence survey	Yes	Yes	No	Yes	Yes	No

to how job security would be ensured. These examples illustrated some of the complexities faced by committees in ensuring that HIV/AIDS related rights were equitably implemented in line with policy provisions.

An important finding was that the committees played a key role in the progressive development of HIV/AIDS policies, from basic prevention programmes (including education and awareness programmes), peer educators, VCT and HIV-prevalence surveys, to more advanced and expensive services such as disease management programmes, including nutritional support, the treatment of opportunistic infections and in some cases the provision of ART. Table 2 provides an overview of the main elements of HIV/AIDS-related interventions, and the extent to which each applied to the companies in the study. While the provision of these interventions was unevenly distributed, it was clear that programme development had been very dynamic.

A striking feature was that this progression of rights and services occurred in the absence of any formal negotiations with the unions involved, nor in response to such union demands. Furthermore, all of these interventions had financial implications – HIV prevalence surveys, VCT and ART being among the most expensive. It might be that this progression was attributable to an appreciation by management of the seriousness of the HIV/AIDS impact. However, the study also suggests that a contributory factor might have been the role of, and feedback from employee representatives on these committees, on the needs and experiences of employees. Thus, examples previously cited, such as protocols on confidentiality for AIDS medication applied here. Other examples of innovative solutions included the Family Day in Company B, where teenagers of employees received information sessions; in Company C the committee was investigating the possibility of "…do it yourself" HIV tests in order to encourage employee participation. In Company B, joint funding of opportunistic infections was the first initiative undertaken by the committee. Many committee members had also trained as peer educators in order to assist employees regarding education and awareness of the company policy and other HIV/AIDS-related issues.

The case studies also suggested that active committees played a fundamental role in ensuring the continuity of HIV/AIDS intervention programmes. In at least three companies, committees expressed concerns about declining employee interest in the programmes. Thus, at Company B the committee was considering conducting a "…needs analysis" in order to "…find a way to people". At the time, most were exploring viable alternatives to improve employee participation. On the one hand, this might suggest an apparent failure to sustain employee interest in their programmes. On the other hand, and more positively, the concerns expressed by some committees might also reflect a commitment to a continued analysis of obstacles and threats to the HIV/AIDS intervention programme, in order to shift their strategic direction towards greater success. At the time of the research, the committees were entering a period of evaluating programmatic progress and searching for solutions to keep the HIV/AIDS programmes "alive".

Role of committees in provision of care and treatment

Most of the committees managed to secure limited access to care and treatment of opportunistic infections, nutritional support and anti-retroviral provision through very innovative workplace solutions. These included the introduction of a co-funding model with equal employer-employee contributions and/or arrangements whereby companies paid for ART following the exhaustion of medical benefits. The latter benefit applied to all the participating companies, except Company A

Table 3. Summary of company HIV/AIDS-related treatment and care

Type of intervention	Company A	Company B	Company C	Company D_1	Company D_2	Company E
Medical aid provision	Optional; unaffordable	Optional; unaffordable	Optional; unaffordable	98% membership	Compulsory membership	50% membership
Company pays for ART not covered by medical aid	No, treatment for opportunistic infections	Yes, joint fund for opportunistic infections.	Yes	Yes	Yes	No ART coverage

and Company E. Table 3 provides an overview of the provision of HIV/AIDS-related treatment and care interventions among the participating companies.

As shown in Table 3, medical aid coverage was poor among many production employees, as the premiums were often deemed unaffordable. Further, in the absence of formal collective bargaining to negotiate access to paid ART provision, the alternative arrangements outlined here provided interim yet viable solutions. It is possible that the latter had been facilitated by the fact that at the time of the research, most companies had not had major negative impacts on the labour force and costs through extensive AIDS morbidity and mortality rates. As such, the cost of care and treatment had not been prohibitive, facilitating a form of company subsidisation. Further, management cited the declining market price of ART as a contributory factor. At the time of the study, the rollout of the government care and treatment programme had just commenced, and had not been a primary consideration, as most adopted a "wait and see" attitude or felt that for now they would "…go it alone". However, there might be a limit to which companies would be prepared to carry the costs, given a significant increase in the AIDS burden. This was likely to test the capacity of the HIV/AIDS committees in deriving further rights and benefits related to care and treatment in the absence of collective bargaining.

Discussion

While this study only included a small number of SMEs, there are a number of lessons to be learnt that are particularly instructive given the relatively poorly resourced context within which most SMEs operate in South Africa. There is no legislative imperative for the establishment of HIV/AIDS committees, as most of the governance provisions of the South African Code of Good Practice on Key aspects of HIV/AIDS and Employment are completely voluntary. Thus, the existence of dedicated HIV/AIDS committees in these companies suggested the adoption of a cooperative culture in the management of HIV/AIDS as well. This applied even to those companies which did not establish dedicated HIV/AIDS committees. However, this cooperative approach was imbued with complexities, and the case studies illustrated some of the challenges that were encountered in practice.

The apparently cooperative context was partly undermined by the finding that the consultative powers of the committees (dedicated or generic), the dominance of HR and OH management representatives, and the capacity and resource constraints of employee and trade union representatives often resulted in the rubber-stamping of initial HIV/AIDS policy development. This confirmed similar research findings elsewhere. One study showed that in most companies the HR department was generally the key to directing company strategy (70%), followed by the HIV/AIDS committee (20%) (DeLoitte & Touche, 2002). This pointed to a massive gap between the importance of the role of the HR department and that of the HIV/AIDS committee. While the cited study primarily included large firms with relatively extensive HR departments, this phenomenon was also likely to apply to SMEs.

In addition, the low level of involvement by trade unions exacerbated this imbalance in authority. One study showed that trade unions (22%) played a more marginal role in drawing up company policy, compared with employees other than trade unions (33%), with directors (44%) and HR/consultants (72%) dominating the process (DeLoitte & Touche, 2002). Other studies confirmed the marginal role of trade unions in managing HIV/AIDS in the workplace (Bowler, 2004; Mapolisa, Schneider & Stevens, 2004). Thus, a lack of substantive impact by trade unions on HIV/AIDS management was probably not peculiar to SMEs, and tended to apply across the board, except perhaps in selected industries such as mining.

However, it raised concerns about the nature of institutional support received by shop stewards from their respective trade union offices. Thus, even though some of the unions represented in this study had very prominent national profiles, this had not translated effectively into HIV/AIDS activism on the shop floor. The lack of union-based training, the apparent absence of union policy guidelines, and the lack of visible involvement by

trade union officials in HIV/AIDS policy development were all manifestations of the disjuncture between the public and shop floor faces of the trade unions in these companies.

In this study, four of the companies belonged to an industry bargaining council and therefore did not engage in plant-level collective bargaining. As a result most of the unions had very little local leverage in negotiating "bread-and-butter" employee issues. One might therefore argue that the relatively weak history of the unions in these SMEs contributed to their inability to be legitimate and credible partners and to participate meaningfully in the management and implementation of HIV/AIDS policies. Finally, the presence of pre-existing collective bargaining disputes among the parties complicated trade union participation in HIV/AIDS management as well, emphasising the need to assess the approach of trade unions in balancing HIV/AIDS and other shop floor issues.

As far as the HIV/AIDS committees were concerned, the study suggested that the merits of the voluntary system of participation needed to be considered carefully. Thus, the volunteer system seemed to be acceptable in these companies, especially given the sensitivity of HIV/AIDS among the workforce, as well as the high level of personal commitment and sensitivity that appeared to be required from committee members. However, uneven coverage of sections of the workforce on the committees seemed to have had unintended consequences. This related particularly to the dominance of production employees relative to the poor representation of white-collar, administrative employees and line management. Furthermore, in most cases the latter sections of the workforce often also displayed low levels of participation in prevention activities. This might perpetuate the stereotype that HIV/AIDS was a predominantly "black" disease and did not affect other (white or skilled) employees. The experience of Company C, where the trade union representing artisans (predominantly white employees) was very active on its committee, however proved the contrary.

Thus, there might be a need to consider alternative mechanisms to establish such committees. While a volunteer system implied that the most committed persons (at a personal level) were likely to come forward, this should be counter-balanced by sufficient coverage of the different sections of the workforce. Improved levels of representation might begin to improve the extent to which prevention messages were adequately and clearly communicated to all sections of the workforce.

The case studies suggested that the one-sided control of the HIV/AIDS budget by management had been unchallenged thus far. However, it appeared that the overall cost of managing HIV/AIDS has not been prohibitive. Significant cost increases in the future, as a result of increased AIDS morbidity and mortality, might require that both employee representatives and the relevant trade unions participated more fully in the budgeting process.

On a more positive note, it appeared that the HIV/AIDS committees, despite their lack of formal power, derived their influence on the development and implementation of HIV/AIDS policies and programmes indirectly. Thus, as shown in this study, rights and benefits might still accrue to employees even if the policy development process had not been inclusive from the start. The committees therefore played a crucial role in facilitating processes and procedures that advocated and communicated the rights enshrined in the Constitution and other labour legislation, especially with regard to the principles of confidentiality, nondiscrimination and nondisclosure. The main point was that rights enshrined in policy had no utility unless the targeted workforce was aware of them, and their implementation was tracked and monitored. This was important for empowering employees and building trust and confidence in HIV/AIDS prevention programmes. The study showed that distrust among the workforce persisted, but creative solutions to handle potential breaches of confidentiality were crucial for developing and maintaining that trust.

Furthermore, in the process of grappling with the obstacles of implementation in HIV/AIDS programmes, committees had developed innovative, local solutions to extend benefits such as ART, outside the formal collective bargaining process. As such, these case studies suggested that, in these SMEs at least, the HIV/AIDS committees represented a new institutional opportunity to extend employees' rights and social protection on HIV/AIDS.

The question arises as to whether these findings implied that non-union based HIV/AIDS committees should be the preferred means for building effective institutional governance of HIV/AIDS in the workplace. On the one hand, the rise of these committees reflected the relative weaknesses of the trade unions, the new competencies and attitudes required by the nature of the epidemic, and a shift towards a more cooperative culture within the workplace. On the other hand, however, one of the main contextual factors with regard to the relevance of these committees as an institutional mechanism was that their appropriateness and relevance might only extend as far as the relative impact of the disease.

Thus, in all of these case studies, the impact of HIV/AIDS had been relatively limited. Even those with relatively high HIV prevalence (20% in Company E for instance) had not had major AIDS-related effects in terms of labour costs, labour

productivity, profitability and other business indicators. The demands placed on the committees thus far were relatively problem-free, not discounting the seriousness of the epidemic. Certainly, the challenges of implementation, such as poor take-up of VCT and fears regarding confidentiality and the failure to adopt protective behaviours among the workforce, were raising the bar regarding the capacity within these committees. For instance, the process of relocating AIDS-sick persons to lighter jobs without compromising confidentiality of HIV status was a critical issue with which some of the committees were having to deal. Thus, more formal negotiation processes might be imminent, as more serious issues such as extending sick leave for the AIDS-sick, job security and relocation to less strenuous jobs became more common and widespread. Given the long-term consequences of the HIV/AIDS epidemic this also implied that all institutions key to industrial democracy, including trade unions, should develop long-term capacity to ensure the long-term sustainability of the management of HIV/AIDS. Thus, stronger and well-supported governance structures might be the key to successful mitigation, especially among SMEs.

Finally, the case studies in this research study were not meant to represent trends within the larger population of SMEs. However, the research did provide more in-depth knowledge on underlying dynamics as well as greater insight into available means for developing and improving governance capacity in the management of HIV/AIDS among SMEs in particular.

Recommendations

The single most effective intervention for meaningful HIV/AIDS governance would be the support and empowerment of employee representatives and shop stewards at the workplace, especially among SMEs. Firstly, where the volunteer system was maintained, representation should be encouraged from all sections of the workforce. Further, the Department of Labour should develop more effective communication and information networks to share information and resources on HIV/AIDS, and monitor the implementation of the code of good practice on HIV/AIDS. The EE inspectorate could play a key role in this regard. Finally, the trade unions needed to address the lack of training and policy information among shop stewards, through centralised collective bargaining agreements or HIV/AIDS policy guidelines, visible support by local officials, and independent training programmes. This would also address the seemingly marginal participation of shop stewards in shaping HIV/AIDS programmes to articulate and meet the specific needs of their members and the broader workforce.

Conclusions

This research study suggests that workplace HIV/AIDS committees could play a key role in improving HIV/AIDS governance capacity in the South African workplace. Furthermore, such committees represent an opportunity for monitoring the implementation of mandatory rights, empowering employees in advocating and communicating such rights, and securing additional rights and benefits related to HIV/AIDS prevention, treatment and care. The study also suggests that in these SMEs the demands on the collective bargaining process had been relatively muted thus far. However, given the anticipated rise in the negative impact of AIDS morbidity and mortality, this might change. In the interim however, an effective and representative stakeholder committee offered one of the best means for effective mitigation of the HIV/AIDS impact, and the extension of employee rights and protection in the workplace.

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