— Introduction to the special issue —

HIV prevention in the world of work in sub-Saharan Africa: research and practice*

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Context and role of the private sector

Unlike some diseases that affect the vulnerable (such as children), HIV primarily affects those most productive in the population. Within this context the private sector has a considerable role to play in managing HIV and AIDS and in contributing to comprehensive national responses. As the HIV epidemic expanded in sub-Saharan Africa, it threatened to weaken an already fragile skills base in many countries, placing pressure on worker recruitment and replacement costs, aggravating absenteeism, and contributing to the direct and indirect costs of production and performance (International Finance Corporation, 2002; Ellis & Terwin, 2005; Global Business Coalition on HIV/AIDS & Booz Allen Hamilton, 2006).

In South Africa, amid debate over the motivations of company responses to the HIV epidemic and in a context of inaction and denial by the government, large firms took the lead in the provision of antiretroviral therapy (ART) to all employees with HIV who qualified for treatment; they did so well before the South African public health sector made the treatment available in 2004 (Dickinson, 2004). Debswana Diamond Company (De Beers’s operation in Botswana) led this initiative in 2001, followed by Anglo American in 2002 (The Economist, 2002; Van der Walt, 2007). Since then, many corporate firms on the continent have developed well-established programmatic responses to HIV and AIDS (Family Health International, 2002; Dickinson, 2009).

National business coalitions have also played a major role in responding to HIV epidemics in sub-Saharan Africa by facilitating the development of workplace policies and programmes, establishing public–private and community partnerships, and generating dialogue between sectors, with businesses providing in-kind contributions and donations (UNAIDS, 2011a). Against this backdrop, company efforts to address HIV in the workplace have been at the forefront of the global response (Sprague & Dickinson, 2008).

The need to document and replicate successful HIV/AIDS responses has been repeatedly stressed by all stakeholders. Indeed, national strategic plans in African countries prioritise the dissemination of a growing body of experience and innovation in HIV-related care, treatment and support strategies, across public, private and non-profit sectors (see Government of Botswana, 2003; Government of Lesotho, 2007; Government of South Africa, 2007; Government of Uganda, 2007). While a range of HIV/AIDS-related activities takes place in the world of work in African countries every day, gaps in our knowledge remain.

Since 2004, African researchers have come together to create a platform for high-quality applied research on HIV in the workplace, among academics, business people and other interested partners. The aim has been to build on and formalise the network of researchers, particularly new and younger researchers; to signal the importance of supporting university-based research on HIV in the world of work; to conduct quality, evidence-based research on this topic; to inform workplace policies and practices; and, to disseminate the findings of research among other researchers and decision-makers responsible for addressing HIV and AIDS in their organisations. To this end, the South

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African Business Coalition on HIV/AIDS (SABCOHA), the Foundation for Professional Development (FPD), the Health Economics and HIV/AIDS Research Division (HEARD), and the University of the Witwatersrand (Wits) hosted the 3rd HIV/AIDS in the Workplace Research Conference, held in Johannesburg, South Africa, in November 2010, with the theme of ‘HIV prevention and possibility.’

From HIV treatment to prevention

Considering the sheer loss of human life extracted by AIDS across the continent, many critics agree that actors at all levels — governments, key leaders and prominent non-governmental organisations (NGOs) — have “failed to respond to the epidemic decisively, which allowed it to fester and spread” (Kalipeni & Mbugua, 2005). As happened elsewhere, many early HIV/AIDS responses in Africa were characterised by fears of promiscuity, homosexuality, stigma, denial, blame, inaction and delay (see Shilts, 1988; Mann, 1999; De Cock, Mbori-Ngacha, 2002; Herek & Capitanio, 1993; AJAR, 2003; Beyrer, 2010). Because of weak national and institutional responses, the death toll due to AIDS, and some governments’ contention that antiretroviral (ARV) drugs for Africans were simply unaffordable, the fight for access to ART in Africa has been one of the hallmarks of the HIV/AIDS response (Lindsey, 2001; Mbali, 2003; Altman, 2008). Led by civil society, together with the United Nations and other international organisations, the campaign for access to affordable HIV treatment has been a galvanising symbol of social justice in Africa and globally, denoting hope for the management of a seemingly invincible disease (Jong-wook, 2003; World Health Organization, 2003). As a consequence, in the evolution of the response to HIV and AIDS in Africa, much of the focus has been on affordable treatment, not prevention (Mbali, 2003; Power, 2003).

The HIV epidemics in sub-Saharan Africa vary in their timing, drivers and severity. As of 2008, seven southern African countries became home to generalised HIV epidemics, with national adult HIV prevalence exceeding 10% in Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (UNAIDS, 2010; cf. Celentano & Beyrer, 2008). As many as 30 million Africans have died of AIDS since the early 1980s (Cook, 2008). By 2002, sub-Saharan Africa had captured over 77% of global AIDS deaths (De Cock et al., 2002). With over 28 million still living with HIV in sub-Saharan Africa (UNAIDS, 2010), the impact and burden on the public health sector and on health personnel has been incalculable.

In this context, the private sector has employed its own resources to keep employees healthy. Much of the sector’s effort has been focused on strategic planning to manage the risks and impacts of HIV and AIDS on companies. This includes workplace policy formulation based on agreement among company stakeholders (Global Business Coalition on HIV/AIDS & Booz Allen Hamilton, 2006). Most workplace HIV/AIDS policies communicate the common principles of non-discrimination and non-stigmatisation towards individuals living with HIV and maintaining confidentiality of their HIV status. These principles are in keeping with the International Labour Organization (ILO) (2010), the United Nations (2001 and 2006), and other international and national legal conventions and standards (cf. Global Reporting Initiative, 2003; Global Business Coalition on HIV/AIDS, 2006). Beyond this, most organisations’ policies spell out the organisation’s position on HIV/AIDS; indicate employee benefits and assistance, including different types of leave of absence for illness or to attend funerals and other forms of reasonable accommodation (e.g. work restructuring due to illness, flexible work schedules, opportunities for rest breaks); outline in-house HIV/AIDS programme goals and focus (such as HIV prevention, treatment, care and support); describe the performance management aspects of the programme, including any monitoring and evaluation; and outline the organisation’s communication strategy (International Finance Corporation, 2002; Ellis & Terwin, 2005; Whelan, 2007).

Within companies, much HIV prevention has come in the form of HIV/AIDS education and awareness campaigns targeted to staff, but more recently extended to key business partners such as suppliers, contractors, distributors and communities. Workplace education sessions or workshops generally include content such as the main modes of HIV transmission, HIV prevention methods and the prevention and treatment of sexually transmitted infections (STIs), safer sexual behaviour versus HIV-risk behaviour, voluntary HIV testing and counselling, and resources that can be accessed for additional information and support within or outside the workplace (such as peer educators or social workers) (Dickinson, 2009; ILO, 2010). As part of their HIV-prevention interventions, organisations normally provide free condoms, STI treatment, post-exposure prophylaxis for HIV, and prevention-of-mother-to-child-HIV-transmission (PMTCT) services in medical stations throughout firm operations in Africa (Family Health International, 2002; ILO, 2010). In many African countries, these services have progressively been made more available in the public health system as well. Historically, companies have been weak on targeting the particular health needs of women, biological and social vulnerability related to HIV acquisition, and gender norms related to masculinity and gender relations (power and negotiation during sex) (Sprague, 2008). Equally, attention to individuals’ sexual orientation has not been a feature, though this may change if NGOs begin to partner more actively with the private sector. There is some anecdotal evidence of this (see Sonke Gender Justice Network, 2011).

Ultimately, HIV and AIDS interventions in the world of work and outside have tried to contain and mitigate the impact of the epidemic through HIV prevention, treatment, care and support. Often, however, HIV-prevention efforts have not changed behaviour. Even so, in recent years the focus has returned to HIV prevention due to a number of key factors: in light of the 2008 global economic recession and many research and technological advances in HIV-prevention interventions, international and African organisations have begun an earnest dialogue on the ‘prevention revolution,’ with UNAIDS (2011b) putting forward the target of zero new infections in its 2011–2015 strategy ‘Getting to Zero.’ Indeed, with more than 7 000 new HIV infections per day.
globally (UNAIDS, 2011b), there is a dire need to institute universal, comprehensive HIV-prevention strategies to avert new HIV infections. But HIV-prevention efforts in southern Africa, in particular, have been less than successful (Dworkin & Erhardt, 2007).

In addition, in the face of the global economic crisis there has been a shortfall in international HIV/AIDS funding, with businesses, government and taxpayers attempting to cover some of the losses. Meanwhile, the fact that new HIV infections outpace the number of individuals initiating ART (UNAIDS, 2011b) places emphasis on scaling-up HIV prevention to reduce premature morbidity and mortality in African populations (Jamison, Feachem, Makgoba, Bos, Baingana, Hofman & Rog, 2006; Celentano & Beyrer, 2008).

Several HIV-prevention strategies have gained prominence on the continent. The traditional public-health paradigm has emphasised the three established pillars of HIV prevention: condom promotion and distribution, voluntary HIV counselling and testing (VCT), and treatment of other STIs (De Cock et al., 2002; Potts, Halperin, Kirby, Swindler, Marseille, Klausner et al., 2008). In contrast, experts and United Nations agencies have argued for a longer-term focus on the structural determinants that increase vulnerability to HIV acquisition (Merson, O’Malley, Serwadda & Apisuk, 2008).

With regard to HIV testing, Potts et al. (2008) contend that there has not been sufficient evidence of a general reduction in higher-risk behaviour among individuals testing HIV-negative, although there has been some degree of reduction in risk behaviour among those who test HIV-positive. Those authors therefore suggest that “HIV testing is...unlikely to substantially alter the epidemic’s course,” although HIV testing remains the key entry point into prevention, care, treatment and support (Potts et al., 2008, p. 749). The third pillar of HIV prevention is the treatment of STIs. Although the success of treating STIs as a method for averting new HIV infections has not been demonstrated at the population level, the evidence base indicates that at the level of individual STI management it is essential in reducing susceptibility to HIV transmission (Centers for Disease Control and Prevention, 1998; Fleming & Wasserheit, 1999).

Given the relatively limited success gained by previous HIV-prevention methods, researchers and practitioners have long pushed for a shift from emphasis on individual behaviours to so-called structural factors. This effort seeks to address the physical, cultural, social, community, economic, legal or other policy features that impact on HIV transmission — for example, by delaying the age of sexual debut, addressing people’s underlying vulnerability due to gender and poverty, increasing the proportion of protected sex acts, and encouraging adherence to HIV treatment (Coates, Richter & Caceres, 2008; Rao Gupta, Parkhurst, Ogden, Aggleton & Mahal, 2008; Rotheram-Borus, Swendeman & Chovnick, 2009). Structural strategies may be combined with biomedical interventions to reduce risk and vulnerability to HIV. Combining consideration for biomedical, behavioural, and structural factors in interventions is referred to as ‘combination prevention’ (Rotheram-Borus et al., 2009).

The 2010 conference in South Africa

With HIV prevention being a key priority area for national and international HIV/AIDS responses, the Graduate School of Business Administration at the University of the Witwatersrand (Wits Business School), the Health Economics and HIV and AIDS Research Division (HEARD) at the University of KwaZulu-Natal, together with the South African Business Coalition on HIV/AIDS (SABCOHA), hosted the 3rd HIV and AIDS in the Workplace Research Conference, in Johannesburg, from 9–11 November 2010. Delegates reflected on the intersection of workplace HIV responses, academic research, and surveillance, with a particular focus on strengthening HIV-prevention interventions in Africa and linking HIV-prevention research to workplace practices. The conference offered an opportunity for business stakeholders to step back and reflect on their HIV/AIDS programmes, using the lens of research and practice to consider what has worked and what lessons could be extracted, with the representatives keen to understand the latest trends in HIV-prevention research and their feasibility for workplace implementation.

The conference committee reviewed 78 abstracts, with 28 selected for oral presentation and a further seven prominent researchers invited to present their pioneering research during the plenary sessions. The prevailing themes of the conference presentations are captured below.

**Partnerships for HIV prevention: public, private, community**

Extending an organisation’s workplace HIV/AIDS programme beyond its employees presents financial and logistical challenges, including raising fundamental questions about the organising principle and purpose underlying such programmes. Past conference discussions included the topics of whether to extend treatment to one spouse or two, how to address sex workers working in mining communities in relation to HIV prevention, and determining where a company’s responsibility for healthcare begins and ends. Research in this area has included the roles of companies in responding to HIV and AIDS in communities, partnerships across sectors, traditional healers in relation to workplace programmes, and community and workplace peer education (see Dickinson, 2008 and 2009).

**Gender, women’s health, and HIV and AIDS**

With the feminisation of HIV epidemics (approximately 60% of people with HIV are female), much attention has been paid in recent years to the factors that create an enabling environment for women to acquire HIV disproportionately compared to men. The conference speakers and submissions considered the social constructions and meaning of gender, gender stereotyping, sexual identities and norms, intimate partner and sexual violence, and the impact of sexual risk behaviour on women’s greater biological and social vulnerability to HIV acquisition. Intimate partner violence, gender as a social relation, and individuals’ perceptions of gender received much attention, as did the linkages between youths, gender and HIV-risk behaviour (see Pronyk, Hargreaves, Kim, Morison, Phetla, Watts et al., 2006; Jewkes, Dunkle, Nduna & Shai, 2010).
Migration
Growing globalisation and urbanisation has brought the cross-border movement of populations in Africa. This phenomenon is taking place together with internal migration within African countries where individuals search for improved livelihoods and job security. Migrants to urban areas are often attracted to the informal economy, with the informal sector being a neglected space in African national and global legislation concerning workplace responses to health and HIV. The health implications and HIV-programming possibilities that have emerged in this area have become a focus of investigation, as revealed by the last conference and this one. Increasingly, experts argue that migration should be viewed as a process driven by economic and social factors, and not as a ‘problem’ to be addressed by punitive measures. Thus, research has explored the informal workplaces in which migrants do business and the opportunities for HIV-prevention programming therein (see Richter, 2008; Vearey, 2008).

Treatment
Many workplaces now run or support HIV-treatment programmes that complement the public provision of ART. The continuing barriers to optimal treatment provision (e.g. the structure of delivery) and uptake (e.g. psychosocial issues and confidentiality concerns) are ongoing areas of investigation and debate. More recently the World Health Organization’s emphasis on treatment as an HIV-prevention method is an important approach. The prevention of new HIV infections in children through PMTCT is an obvious example of this paradigm: individuals on ART become less infectious, with a range of well-documented benefits to their health and survival. Notably, HIV transmission can be dramatically reduced when HIV-positive individuals are treated and if their partners undergo counselling and testing, with couples receiving HIV-prevention counselling and HIV-positive partners receiving treatment adherence support to maintain an undetectable viral load. ‘Treatment as prevention,’ however, is not fully understood nor widely accepted (see The Lancet, 2011). While the conference received no papers on ART as HIV prevention, maximising the effects of ART for primary HIV prevention while considering evidence-based combination strategies was a lively area of debate.

Youths
Young people are the future drivers of the economy and society. One-fifth of the global population comprises young people aged 15 to 24, and the majority of these individuals are living in middle- and lower-income countries (UNAIDS, 2011c). Youths have always been an ideal target for HIV prevention. Many specific HIV-programming efforts, such as addressing multiple concurrent partnerships, intergenerational sex and safe medical male circumcision, have implications for youths. Yet, in reality, youths are seldom engaged in intervention designs. Issues raised for discussion and follow up at the conference included: the HIV-related knowledge, attitudes and behaviours of youths; the community, school and other structures that can be used for improving outreach to youths; understanding the association between medical circumcision and HIV risk, which varies greatly across contexts and countries; how to ensure that sexual concurrency is addressed according to the contexts and priorities of young people; and the involvement and participation of young people in the planning and deployment of HIV/AIDS interventions (see Halperin & Epstein, 2007; AIDSTAR-One, 2009; UNAIDS Reference Group on Estimates, Modelling and Projections, 2009).

HIV prevention, broadly
This conference category included biomedical and structural HIV/AIDS interventions, particularly those that have effectively linked theory to an evidence base; research on workplace programmes that have been evaluated and shown to be effective; and methods for monitoring, measuring and reporting on successes in organisations. The paper submissions included the topics of biomedical interventions to prevent HIV infections (male and female condoms, male circumcision, and microbicides), as well as combination HIV prevention. Also included was research in the behavioural sciences, including structural approaches to HIV prevention (see Rao Gupta et al., 2008; Rotheram-Borus et al., 2009).

Not all the conference submissions underwent peer review for publication in this special issue of the African Journal of AIDS Research. While some of the promising research presented at the plenary sessions (mentioned in this introduction), such as studies on microbicides, safe medical circumcision, HIV and TB co-infection, and intimate partner violence, does not appear as articles here, the presentations did inform and generate considerable conference debate.

Selected research presented during the plenary sessions
The need for comprehensive combination HIV prevention was echoed throughout the conference, suggesting that any single approach may be frustrated by its own limitations, one of which may be the inability to prompt prolonged behaviour change or to prevent target populations from negating the HIV protection gained by way of increased sexual risk behaviour. The latest biomedical HIV-prevention research presented focused on safe medical male circumcision and female microbicides. Dr Neil Martinson of the Perinatal HIV Research Unit (a research unit of the University of the Witwatersrand) shared the outcomes of a noteworthy study conducted in South Africa in 2005 which demonstrated the HIV-prevention effectiveness of male circumcision (the randomised trial showed a 65% reduction in risk of HIV infection among circumcised men). Similar results were achieved in trials in Kenya and Uganda. Although there is no direct protective effect for women, there is evidence to suggest that women will experience lower STI rates as a result (De Bruyn, Martinson, Nkala, Tshabangu, Shilaluka, Kubin et al., 2009).

Koleka Mlisana, the director at one of the sites involved in microbicide trials by the Centre for the AIDS Programme of Research in South Africa (CAPRISA) at the University of KwaZulu-Natal, shared details of the CAPRISA 004 tenofovir gel trial involving 889 women at higher risk of HIV
& Mansoor (2010). Over the 30-month trial, the microbicide was found to be 39% effective in reducing a woman’s risk of acquiring HIV. This figure was higher at 12 months (50% effective), but it was noted that the participants’ use of the gel was reduced over time. A safe and effective microbicide is critically important for HIV prevention and in empowering women to take control of their own HIV-infection risk (Abdool Karim, Abdool Karim, Frohlich, Grobler, Baxter, Mansoor et al., 2010).

Overview of the articles

Moving to the articles published in this special issue of AJAR, the range and types of research methods used are striking. These incorporate anthropology, public health, bioethics, development studies, economic modelling, political science, human rights and psychology. The selection of articles reveals the skill of some researchers in accessing and engaging hard-to-reach marginalised and key HIV-affected populations, such as youths, migrants, women and employees in the informal sector, using mainly qualitative methods.

Vearey, Richter, Núñez and Moyo use three qualitative case studies of migrants engaged in informal trades, together with existing literature, to explore the HIV-programming implications for migrant groups in the informal sector in urban South Africa. South Africa is remarkable for its high population mobility, with an estimated 3.6 million people working in the informal (non-agricultural) sector, many of them migrants. However, HIV-related responses among informal enterprises fall far short of those established in the formal sector. This is in spite of calls made by national frameworks and the ILO for HIV/AIDS responses to encompass informal workplaces. Findings from the first case study by Vearey and colleagues indicate that migrants labouring as waste-pickers at city dumpsites form a sizeable group in an established, viable industry, yet they have not benefited from exposure to HIV/AIDS education and programming. Those migrants in the sample who were already living with HIV reported that they had not received public health messaging outside of their attendance at a clinic. As informal entrepreneurs and migrants, this group would likely face greater difficulties in accessing HIV treatment, care and support. The second case study of men who work in bars in inner-city Johannesburg indicates that despite being a high-risk environment where transactional sex routinely takes place, combined with frequent alcohol use, bar employees did not benefit from internal HIV-prevention programmes or external campaigns from other stakeholders (e.g. government, community-based organisations or NGOs). The third case study of migrants who are members of burial societies demonstrates that such organisations could easily provide health-related information, education and resources to members (while they are still alive). The authors stress that in a generalised HIV epidemic, such as in South Africa, where migration across borders is common, the association between HIV and migration is complex. If national HIV/AIDS responses are to be comprehensive, as embedded in national strategic plans, then they must engage with the process of migration, rather than simply focusing on migrants as a key affected population; furthermore, informal workplaces must become a focal point for programmatic interventions. Vearey and colleagues conclude that the informal sector remains one of South Africa’s critical points of entry for HIV prevention, treatment, care and support for migrants in particular.

A qualitative investigation by Casale, Rogan, Hynie, Flicker, Nixon and Rubincam addresses one key driver of HIV transmission in South Africa: sexual risk behaviour rooted in constructions of gender and sexuality. With a focus on young people, the authors sought to understand the relationship between gendered sexual identities and vulnerability to HIV infection. Against a background of literature that views sexual risk behaviour as an outcome of established gender inequalities, the authors explore gendered perceptions of HIV risk among male and female youths in a high-HIV-prevalence community in KwaZulu-Natal. The authors investigate how gendered perspectives are linked to HIV-risk behaviour in particular, and to health behaviour more generally. They found that the important theme of ‘responsibility for spreading HIV’ was embedded in certain perceptions among these youths, including varied understandings of the gendered culpability for the spread of HIV and the relationships between gender roles and HIV transmission. The authors conclude that HIV-prevention interventions need to sufficiently engage with gender and sexuality. They recommend using school-based programmes as a vehicle for HIV/AIDS education in order to engage youths in discussions about perceptions of gender and HIV, and to overturn stereotypes and misinformation concerning HIV-risk behaviour.

Gilbert and Selikow use a review of the academic literature and relevant documents to consider the contextual factors underpinning the differential vulnerabilities of women and men in South Africa. Their analysis finds that a perilous mix of economic, political, biomedical and cultural forces has combined to produce today’s feminised HIV epidemic. They identify the most common ingredients in this mix as patriarchy, sexual norms (such as intergenerational sex and having multiple sexual partners), high levels of violence against women and women’s subordinate position to men, as well as inadequate material resources. The authors argue that intervention strategies, particularly in the sphere of HIV prevention, must therefore be gendered, taking into account the specific social and cultural contexts in which women’s sexual risk behaviour and health-seeking behaviour is rooted. They put forward a gender-inclusive approach to HIV prevention, treatment and care which includes: addressing women’s economic dependence on men, challenging social and cultural norms of masculinity and violence, understanding the social constructions of gender, and incorporating men into HIV/AIDS responses.

Chawana and Knapp van Bogaert use South Africa’s current challenge to scale up universal, free HIV treatment to all who require it as the very real situational context for their study. They construct a Markov model to project the economic outcomes of providing treatment to a hypothetical
cohort of HIV patients on HAART (three-drug combinations of ART). They consider the two scenarios of adherence and non-adherence to treatment, and especially the economic implications of non-adherence. In the model of non-adherence, quality-adjusted life years (QALYs) were reduced by 56%. The authors emphasise that continuing therapy to non-adherent patients is not cost-effective in South Africa, and, controversially, they argue that restricting treatment only to ART-adherent patients has moral merit. While considering the ethical implications emerging from this assessment, the authors recommend that interventions to improve treatment adherence are essential from both a public health and cost perspective. Different ART cost scenarios call attention to the costs of treatment over time and the savings of preventing new HIV infections. The value of this work is in demonstrating that we cannot consider solely moral or economic arguments, as these aspects are inextricably bound.

Smith, Ahmed and Whiteside tackle the debate about AIDS exceptionalism. The argument against making HIV and AIDS ‘exceptional’ has centred on its perceived proportion of the global disease burden — namely, that HIV epidemics in some regions are confined to particular population groups, that ‘excessive’ funding may have had a negative effect on some health systems as a whole (fleeting funds and resources from responses to other diseases), and that the high cost of treatment for a given number of infections is unsustainable for some countries. Using existing data and literature to support their position, the authors argue that HIV and AIDS should be treated as exceptional in the hyperendemic region of southern Africa, in parts of Eastern Europe (where the HIV epidemic is exacerbating troubling demographic and social changes), and in resource-poor settings, mostly in Africa. In southern Africa, marked reversals in development indicators are apparent and the region will not meet some Millennium Development Goals (MDGs), particularly concerning maternal and child health (MDGs 4 and 5), due to AIDS deaths. Furthermore, existing challenges for food security have increased, with community support networks overstretched due to increased mortality and the dependence of survivors on extended families. In regions where new HIV infections and treatment costs have generated concerns over donor dependency and sustaining the existing responses to HIV and AIDS, an HIV epidemic must be viewed as a long-wave event. Thus, the authors contend that expenditure has not been out of step with the disease burden. Moreover, the cost-effectiveness of ART, which has dropped dramatically in price, has not yet been well captured in terms of the cost-savings of preventing new HIV infections, reduced hospitalisations, healthier workforces, and reduced premature mortality. The authors conclude that the labelling of AIDS exceptionalism ignores the complexity of different HIV epidemics and thwarts the effectiveness of responses.

In an action research study of 28 peer educators from a South African mining company, Dickinson uses the failure of HIV-prevention efforts to bring about behavioural change as a starting point to discuss the role of health communication. He explores the potential of peer educators to counter HIV/AIDS myths by constructing instructional stories with relevance to different aspects of HIV transmission, behavioural risk, and the origins of the disease. Thus, stories created by peer educators could effectively serve as an alternative to factual messages. For example, the myth that ‘shallow penetration prevents HIV infection’ was contradicted by one peer educator’s story, ‘Burning Fire,’ where a woman sees a small fire near her sleeping child. Seeing that the fire is small, she attends to other concerns. By the time she returns the fire has erupted into a blaze. The moral: a small problem can grow; any unprotected sex act can result in HIV acquisition/transmission. Dickinson shows that peer educators offer a window into the myths, cultural beliefs and practices surrounding HIV which circulate among people at any point in time. Though the skill set of a peer educator varies by individual, they can effectively devise and relate stories that support core messages about HIV. Dickinson proposes the need to develop the skills set of peer educators and suggests their potential to use whatever message form is appropriate to a situation. The author’s findings reveal that storytelling — an essential part of the African tradition — could be a robust tool in health communication for behaviour change.

Sprague, Simon and Sprague investigate the findings of three surveys examining HIV stigma and employment discrimination: one global and two national (in Kenya and Zambia). The results demonstrate the existence of high levels of employment discrimination based on HIV status worldwide: respondents’ experiences included forced disclosure of HIV status for employment purposes, social exclusion (shunning, blame, labelling and gossip) in the workplace, employers’ refusals to hire or promote following employees’ disclosure, and terminations of people known to be living with HIV. The findings indicate that employment discrimination based on HIV status is similarly experienced by people in all African subregions. Employed people with HIV in Kenya and Zambia similarly reported discrimination in hiring, loss of promotions and termination due to their HIV status. To address the findings, the authors introduce an innovative conceptual framework, the employment continuum, which maps the multiple points within workplaces to address HIV-related stigma and discrimination, from recruitment to departure. Such awareness and attention to the needs of people living with HIV can promote working environments that protect human and civil rights and promote the holistic health and productivity of all employees. Ultimately, the survey findings call attention to the workplace as a primary site for intervention and behaviour change, particularly in high-HIV-prevalence settings in southern Africa where large numbers of employees are living with HIV.

Bhagwanjee, Govender, Akindola, Petersen, George, Johnstone and Naidoo explore the psycho-social barriers to HIV disclosure, through the lived experiences of 19 HIV-positive male miners. The authors relate treatment-adherence behaviours and disclosure choices to specific psychological factors, including knowing one’s HIV serostatus, perceived control over one’s health and quality of life, pressures surrounding being labelled as HIV-positive, and fear of social stigmatisation. The participants’ ART adherence was negatively affected by non-disclosure.
and difficulties in coping. In terms of recommendations, the authors offer a model for understanding treatment adherence behaviour, which combines educational, psychological and relational strategies to ensure optimal adherence. The authors suggest that psychological factors (beliefs, attitudes and behaviour) impeding optimal ART adherence may be addressed through counselling, constant communication with a healthcare provider, addressing the link between knowing and accepting one’s HIV status, and building self-efficacy and capability in managing one’s health. Addressing the relational factors that impact on individuals can encompass disclosing to one’s partner and/or family members in order to gain needed support and to achieve wellness in the family as a unit (rather than as a collective of individuals).

Building a network of HIV/AIDS researchers in sub-Saharan Africa

A primary objective of the conference was to strengthen the existing network of researchers in this field (both junior and established), while providing an opportunity for them to present their work to business stakeholders. A salient feature of current research in southern Africa is the wide acceptance and positioning of HIV as a socially driven epidemic within the research questions, designs and methods, as an alternative to the dominance of the biomedical paradigm that existed for many years. In our African universities and research units, we have begun to develop a generation of researchers, trained in the use of qualitative and quantitative methodologies, who are able to apply interdisciplinary approaches to frame, design and carry out HIV-related social science research. Increasingly over the last 10 years, we have seen a trend from conceptualising medical approaches to HIV-disease management to accepting that understanding the social and cultural aspects of HIV are equally important. This is a notable shift.

With HIV-related studies fundamentally rooted in ‘the social,’ we (as colleagues and students) in the social sciences have embraced interdisciplinary methods that draw on anthropology, psychology, sociology, development, economics, public health, ethics, and medicine. Perhaps without realising it, HIV/AIDS researchers have become hybrids — cross-breeds who use various disciplines, tools and approaches to engage with vulnerable or marginalised groups, to understand their lived experiences and to mount interventions in response. However, the challenges of conducting such work remain ever-present.

Ongoing challenges

HIV/AIDS researchers in Africa have regularly faced the difficulties of gaining access to company sites and data; participants’ fears of breaching a firm’s confidentiality; a lack of commitment to change at the operational level, particularly by leadership at the middle-tier or higher; lack of funding to implement changes associated with the research; and HIV/AIDS programming fatigue (i.e. exhaustion from multiple workplace HIV-related activities and responses mounted over time). While there is an emphasis on linking research to improved workplace practices, the researchers themselves often balance competing demands and so must move on to other projects; they may lack commitment to change in the workplace; they might be able to research but not implement; and, the recommendations resulting from the research may not be sufficiently robust.

Few researchers are also implementing agents, though a certain number of such units do exist in South Africa and elsewhere. Our generalised HIV epidemics raise the stakes of using research to change conditions on the ground, and perhaps the students of social science research need be equipped with more technical skills.

Reflections on HIV/AIDS-related research and practice

Tying research to practice

A large challenge involves the interface between HIV/AIDS-related research and practice, essentially the translation of research findings into effective workplace policies and practices. Herein, as ever, many opportunities remain. As indicated in the previous special issue on this theme (see AJAR, 2008), the topic of HIV in the workplace remains under-researched and poorly defined. The traditional boundaries of workplaces are less clearly drawn than ever before. Identifying the ‘formal’ world of work has been made more nebulous with the increasing matrix or network structures of organisations (and global offices), indeterminate industry boundaries, swiftly changing markets and evolving global services. In Africa, there is the added complication of informal workplaces and markets (Prahalad, 1998). However, the growing demand for responses to HIV in companies has clearly led to sizeable activity in the world of work in sub-Saharan Africa. What is less evident is the quality and impact of these programmes.

To that end, a common call made by all stakeholders is for greater documentation and evaluation. The lack of national monitoring of workplace programmes in general (and specifically their reach and progress) is a significant gap in the system. On the one hand, there may be no need (nor desire, arguably) to review companies’ policies and programmes where robust monitoring and evaluation exist. On the other hand, there is inadequate information to support certain analyses, such as the segmentation of workforces by sector, gender or job grade, which would assist in identifying target-specific HIV-prevention interventions. Moreover, to suggest that national strategic plans are the principal reference for workplace HIV/AIDS programmes would be a misrepresentation. For instance, the development of best practices in South Africa is more closely aligned to the development of the South African National Standard on HIV and AIDS Management Systems (SANS 160001:2007), which is driven by a division of the South African Bureau of Standards. Experimentation with practical HIV/AIDS interventions alongside the continuous evolution of workplace programmes, particularly in the private sector, are in step with SANS. This is very much the case in relation to programmes that incorporate ART. In short, ‘best practice’ remains elusive, and the private sector in Africa does not yet look to national policies for its organising principles and purpose.
Workplace HIV programming exists, but does protection of employees?

Despite the body of literature on managing HIV in the world of work, combined with growing knowledge of actual HIV-related practices, an assessment of the role of labour in tackling HIV and AIDS prepared by the National Labour and Economic Development Institute (NALEDI) (Guliwe, 2007), found that in spite of the proliferation of workplace programmes in South Africa, the majority of workers in all sectors were not adequately protected by workplace HIV/AIDS policies. Moreover, in spite of pressure from labour unions, most sector bargaining councils still did not have an HIV/AIDS policy in place, there was poor compliance with legislation, and workers risked discrimination or dismissal on the grounds of their HIV status. Furthermore, organisations that employ predominantly casual labour were less likely to have policies than those that employed formally contracted staff.

As part of a literature review of best-practice company workplace HIV/AIDS programmes, Whelan (2007) found that 14 major codes and guidelines govern the activity and reporting of South African firms: with nine components emerging as activities required by or recommended by these codes. Research by Ellis & Terwin (2005) reported that most large South African companies had already implemented the following five main components of workplace programmes by 2005: HIV awareness, VCT, ART, care and support, and programme monitoring. The obstacles that continue to plague workplace practitioners include buy-in and support at the middle-management level; lack of common standards and regulations to enforce them (the codes and guidelines are voluntary); managing the logistical complexities of healthcare provision; managing the sometimes sprawling company operations in different regions of Africa; and the ongoing difficulties of addressing HIV stigma and behaviour change (Dickinson, 2003; Dickinson & Stevens, 2005; Whelan, 2007; Whelan, Dickinson & Murray, 2008).

Such findings highlight the disjunction that surrounds workplace programmes and the existing work that remains: on the one hand, the standards for and the form of workplace programmes have evolved rapidly yet do not reach the majority of the population that should be served by them; on the other hand, national public health policy is still being developed, but seemingly with little reference to the experience and progressive ethos of existing policies and programmes in the workplace.

For all its resources and power, the private sector has yet to assume a unified voice in the HIV/AIDS response, even in the realm of HIV prevention. And it has yet to define its leadership role as a sector in Africa. It is largely made up of organisations that may think and act similarly, but are driven by individual agendas. For HIV prevention to constitute a major change in HIV-related workplace practice, employers need to go further towards truly recognising and utilising the workplace as a site of behaviour change: it already exists in a de facto sense, but not as an organised, explicit, change-making, strategic-programming vehicle.

A call to action

This collection of articles demonstrates that there is a large body of research evidence to inform concerted efforts to make workplaces (whether formal or informal) sites of HIV-related behaviour change. This is founded on the acknowledgement of the importance and necessity of interventions centred on HIV prevention. Building on this foundation requires recognition of the key challenges and opportunities to elaborate workplace HIV/AIDS programmes. Summarising the messages of this collection of articles, the challenges centre on improving the reach of public health messages and the access of workers to information, protection and advice; the opportunities relate to perceiving where and how to intervene. Notably, the research presented here identifies ideas that are not difficult to translate into practice — for example, engaging with gender and sexuality, developing couples’ therapy and family approaches to wellness, refining the skills of peer educators, and applying the employment continuum to mitigate HIV stigma and employment discrimination. These and other evidence-based ideas intimate what we believe will be the next fundamental shift in workplace HIV/AIDS programmes. Private-sector managers have guided the evolution of workplace HIV/AIDS programmes in Africa; but it is becoming apparent that workforces themselves, particularly employees living with HIV, can and should play a larger role in shaping the content of workplace HIV/AIDS programmes.

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