Women’s health, HIV/AIDS and the workplace in South Africa

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This work explores the connections between gender inequality, HIV/AIDS and women’s health in the world of work in South Africa. These connections are located within a context of significant reversals in development, specifically declining life expectancy and premature mortality for South Africans — particularly for women. By relying on the existing literature and interviews with 33 key informants, the paper examines the extent to which South African workplaces are recognising women’s social and biological vulnerability to HIV. In particular, the paper considers the potential role of the workplace in responding to growing evidence that links gender and health by establishing targeted HIV/AIDS interventions. The findings suggest that the vast majority of company representatives do not recognise women’s social and biological vulnerability and related social norms vis-à-vis HIV and AIDS. Importantly, most workplaces are not initiating programmes that specifically address women’s or men’s health. The author briefly identifies factors that may help explain the current state of knowledge and practice in the realm of HIV and women’s health in the workplace, and puts forward suggestions for future research.

Keywords: developing countries, equity, gender issues, health promotion, occupational health, sex-specific interventions, social conditions, women and work, women’s health

Introduction

Over the last five decades, health outcomes across regions of the world have revealed spectacular gains in life expectancy, with significant reductions in maternal and infant mortality. The global health revolution can be measured as increased life expectancy — an additional four months added each calendar year over the last thirty years (World Health Organization [WHO], 2000 and 2003; Médecins Sans Frontières, 2001). But these gains have not been evenly distributed. In parts of the developing world, there has been a marked decline among the same indicators and even a reversal in life expectancy for some countries in sub-Saharan Africa (Chen & Berlinger, 2001; Evans, Whitehead, Diderichsen, Bhuiya & Wirth, 2001).

Recent health outcomes — specifically, declining life expectancy and rising mortality rates — eviscerate patterns of premature illness and death for South African women (Groenewald, Bradshaw, Dorrington, Bourne, Laubscher & Nannan, 2005; Dorrington, Bradshaw, Johnson, Budlender & Daniel, 2006). In South Africa, life expectancy was 60 years of age in 1997, but dropped to 49 years by 2003 (WHO, 2003 and 2005; Cornia & Menchini, 2005). Such inequalities in health achievements become more magnified when looking through a ‘gender lens.’ Many women worldwide, like men, have benefited from improvements in medical services, access to education, and improvements in living and working conditions. More than 10 years have been added to women’s life expectancy in some countries as a result (see Doyal, 2001; Grown, Rao Gupta & Pande, 2005; Doyal, 2006; Bernstein & Juul Hansen, 2006). But South African women are not enjoying these health achievements: women of reproductive age are disproportionately affected by HIV, with women in younger age groups four times more likely to be HIV-infected than men. South African women in the 25–29-year-old age group are the worst affected, with an HIV prevalence of 33%. In contrast, for men in the same age group, prevalence is 12% (Department of Health, 2006; Pattinson, 2007). Among the 20–24-year-old age group, HIV prevalence is roughly 24% for women and 6% for men (Department of Health, 2007).

UNAIDS (2008a) notes that HIV-related deaths in South Africa have increased significantly over the period 1997 to 2004, with mortality more than tripling among women aged 20 to 39. Despite problems with the data collection and variation among an estimated six data sources, the trend in maternal deaths in South Africa is clearly an upward trend (Department of Health, 2006; Pattinson, 2007). Since 1999, non-pregnancy-related infections have become the main cause of maternal mortality in South Africa (33.7%), with HIV and AIDS the single leading cause (Department of Health, 2006; Jackson, Loveday, Doherty, Mbombo, Wigton & Matzigrofa, 2006; Shung-King, Mhlanga & De Pinho, 2007).
Through increasing mortality, morbidity and related impacts, the global HIV pandemic is illustrating the myriad ways in which gender inequalities impact negatively on women's health. The evidence reveals that women's unequal status and position in society is often at the centre of such health inequalities in South Africa. In South Africa, sexual risk behaviour is associated with interpersonal relationships, which includes an inability to negotiate condom use, peer pressure to have sex, and 'coercive male-dominated relationships' (Matthews, 2005). Studies have demonstrated that social context and position in South Africa, as well as cultural factors and norms, have been significant in increasing HIV transmission among women (Department of Health, 2007; UNAIDS, 2008b).

Biologically, women are more susceptible to contracting sexually transmitted infections (STIs), including HIV, due to the greater area of mucous membrane exposed during sex (particularly young women whose genital tracts are not fully developed), the larger quantity of fluids that are transferred from men to women, as well as the higher viral content in male sexual fluids. Micro-tears can also easily occur in women's vaginal tissue as a result of sex. Individuals with untreated STIs are more than six times more likely than other individuals to pass on or acquire HIV during sex, and a genital sore caused by an STI increases the risk of becoming infected with HIV from a single exposure by 10 to 300 times (UNAIDS, 2004; WHO, 2008). The low socio-economic status of many South African women predisposes them to higher-risk behaviours that place them at greater risk for contracting STIs, including HIV (Matthews, 2005).

Against this background, Goal 3 of the Millennium Development Goals (MDGs) aims to promote gender equality and empower women, while Goal 6 seeks to halt and begin to reverse the spread of HIV by 2015. South Africa is a signatory to the MDGs, and a core value of the South African Constitution is gender equality. On a national level, gender equality is 'an end in itself' and the Constitution articulates certain rights that are essential for the 'exercise of such equality' (Government of South Africa, 1996; Klugman, 1999; Albertyn, 2007). Since the formal demise of apartheid in 1994, the African National Congress has implemented fundamental constitutional changes to ensure equity and equal treatment of women across sectors and spheres of society, including in the labour market. Subsequently, more women are entering the South African workforce than ever before (Casale & Posel, 2002; Ntuli, 2007). But South Africa remains at the bottom of the United Nations' gender-related development index (GDI) global ranking, behind countries such as Iran, Syria and Saudi Arabia (Hassim, 2007; United Nations Development Programme (UNDP), 2008). It is well documented that women in South Africa face a particular disadvantage when it comes to accessing information about HIV transmission, prevention and care, negotiating safer sex, and accessing treatment and support for HIV/AIDS (Birdsall, Nkosi, Hajiyanni & Parker, 2004; Smit, Bekinkel, Ramkisson, Kunene & Penn-Kekana, 2004; Bekinkel, Mullick & Kunene, 2006; Ramkisson, Coutsoudis, Coovadia, Mthembu, Hlazo & Smit, 2007). And, gender-based violence and gender inequality are increasingly cited as important determinants of women's risk for contracting HIV in South Africa (Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004; Department of Health, 2007).

At the same time, South African companies have implemented workplace policies and programmes on an unprecedented scale to address, mitigate, prevent and treat HIV infection among the workforce (Ellis & Terwin, 2005). Significantly, the most recent national coordinated response to the pandemic, embodied in the national HIV & AIDS and STI Strategic Plan for South Africa 2007–2011 (NSP) (Department of Health, 2007), recognises the importance of the workplace as a site for ongoing HIV prevention and for introducing programmes that will educate men and empower women in order to reduce women's vulnerability to HIV infection.

Given the national trends of declining life expectancy and increasing mortality — especially premature mortality for women of reproductive age — it is reasonable to ask whether or not those South African companies that have established large-scale HIV/AIDS workplace programmes are acknowledging women's particular health needs and their vulnerability to HIV infection. Do they design and deploy programmes that address women's and men's different biological and socially dependent realities? And, do they consider the socio-cultural and behavioural norms that play a leading role in HIV transmission?

**Aims and methods**

This research is exploratory; it is concerned with bringing the connections of gender inequality, HIV/AIDS, and women's health and empowerment to bear on the workplace as a site of possible intervention to address women's health needs generally and HIV particularly. The study examines the potential role of the workplace in recognising women's social and biological vulnerability vis-à-vis HIV, and the extent to which an increasing evidence base is used to inform interventions in the world of work. To this end, I review the limited amount of literature on these linkages in relation to the workplace in South Africa, and supplement the literature review with interviews with 33 key informants — 10 from large firms, and 23 from other institutions. Using these methods, the paper considers the state of knowledge concerning these linkages, and offers insight into some workplace HIV/AIDS interventions being mounted in response. The companies studied were mainly large firms (in excess of 500 employees) with established HIV policies and programmes. I briefly discuss those factors that appear to underpin the dearth of knowledge and attendant action in the workplace. In response to the identified gaps, I put forward a set of recommendations for future research.

The literature review on the topics of women, work, and health in South Africa was situated within the broader international literature. The focus was on women's health in the workplace, women's occupational health, and HIV/AIDS. Coupled with this, a semi-structured questionnaire was used as a starting point for discussions with respondents. The sampling type was purposive and focused on key principals: heads of departments with strategic knowledge of company programmes, human resources officers, and heads of research entities and lead researchers well aware of the knowledge base and activities in this area.
individuals from large companies were interviewed as one component of the study. Most of these individuals spoke only on condition of anonymity and thus the companies and individuals that participated on the whole remain unnamed in the article. Twenty-three additional key informants from organisations in South Africa supplied information on various research, studies or literature in this area and on developments within South African workplaces; these individuals were researchers or academic-practitioners, some of whom were providing HIV/AIDS consulting services to South African companies and organisations.

Interviews were conducted from January to May 2008. A range of companies and industries, NGOs, and research entities were part of the sample. Company documents were collected and reviewed, including HIV policies, workplace codes of conduct and employment equity policies, as well as other legislative and industry documents. In addition, national legislation and white papers relating to HIV, health, women’s health, and occupational health were reviewed. International guidelines published by the International Labour Organization (ILO) and various other United Nations’ agencies, relating to HIV/AIDS and women, workplace codes and gender mainstreaming, were also utilised.

Prior to discussing the key findings of the interviews, the article charts critical information from the literature linking gender inequalities, illness and HIV with biological and social factors and norms, and with social inequalities in health.

Findings of the literature review

Gender is a primary way of stratifying individuals and societies. As Diaz (1994) notes, ‘sex’ is defined ‘by chromosomes or biological functions’ but ‘gender’ is a social construction. Gender divisions persist in all countries of the world. Men and women are “assigned different duties and responsibilities as well as different entitlements” (Artazcoz, Borrell, Cortés, Escribá-Agüir & Cascant, 2007, p. ii39). Stacey & Olesen (1993, p. 4) observe that gender is emerging “as a critical problematic in understanding women’s and men’s participation in social and cultural systems...[and] in studies of health and illness, care and cure.” A large body of literature captures the relationships between women’s health and gender divisions: a range of economic, social, and cultural factors have been documented by researchers, demonstrating their links with physical and mental wellbeing for women (Waldrin, 1983; Garenne & Lafon, 1998; Annandale & Clark, 2000; Doyal, 2006). Research targeted at exploring the inequalities between women’s and men’s health has increased in the last few decades, with renewed interest by the social and medical sciences in understanding the social and biological determinants of gender inequalities in health (Doyal, 1979, 2000 and 2001; Colomer-Revuelta, Peiró-Pérez, López-Rodriguez, Espiga-López Sáiz-Martínez-Acitores & Soriano-Villarroel, 2007; Garcia, Bartley & Alvarez-Dardet, 2007). Biological and social factors continue to influence and shape determinants and patterns of disease which may be sex-specific. For example, men have a much greater biological propensity to develop heart disease early in life compared to women. In contrast, women report depression and anxiety more frequently, although there is no biological explanation for this (Doyal, 2001).

It is the norm that the average weight of newborn babies who are female is lower than that of males. At the same time, life expectancy for women is higher than for men, but women’s morbidity is also higher (Verbrugge, 1985; Evans et al., 2001; Braveman & Gruskin, 2003). These are biological differences that lead to inequalities in health — but they are not unjust or avoidable.

Health inequalities can be viewed as inequities when they are avoidable, unnecessary, and unfair (Whitehead, 1990 and 1992). Clear patterns of difference in health outcomes between groups by sex — which show evidence of systematic, unfair and avoidable health inequity — lead to questions about whether there are equal and sufficient opportunities for women to be healthy. These patterns raise questions about the systematic distribution of resources, as well as other processes that drive structured inequalities (Evans et al., 2001; Sen, 2001a and 2004; Braveman & Gruskin, 2003).3 Siegrist & Marmot (2004, p. 1464) state that social inequalities in health “are not acceptable” because they are capable of being changed and “because they contradict the basic principle of ‘fair equality of opportunity’ of fundamental human life chances” which should be afforded to each person.

Women’s biological vulnerability to HIV infection

Research conducted in South Africa and elsewhere has shown that biological differences between the sexes (i.e. in reproductive systems) play a significant role in influencing patterns of morbidity and mortality, and in the delivery of healthcare (Doyal, 2001; Bernstein & Juul Hansen, 2006). In particular, women are more susceptible to STIs because of the “greater mucosal surface exposed to pathogens during sexual intercourse,” which is particularly true for young girls whose genital tracts are not fully developed (Ackermann & De Klerk, 2002; UNAIDS, 2004; Pan American Health Organization [PAHO], 2006). Women are also at greater risk of contracting HIV than men; research shows that men pass on the virus more efficiently than women, and that a woman is twice as likely to be infected by an HIV-positive man as is a man by an HIV-positive woman. There is also convincing evidence that people with untreated STIs are six- to ten-times more likely to pass on or acquire HIV during sex because there is a greater chance of broken skin (or torn membranes) if an STI is present, which facilitates the virus entering or leaving the body. The risk of becoming infected with HIV from a single exposure is increased even further (10- to 300-fold) in the presence of a genital ulcer. Likewise, untreated STIs have been identified by researchers as a factor fuelling the HIV epidemic in South Africa (Williams & Gouws, 2001; see also Chabikuli, Schneider, Blaauw, Zwi & Brugha, 2002; UNAIDS, 2004). Again, women’s greater susceptibility to STI acquisition, including HIV, is biologically dependent.

Women’s social vulnerability and HIV

The position of women in society has also been investigated in order to uncover the “social dynamics that increase their vulnerability to disease” (Ackermann & De Klerk, 2002, p. 1464).
reinforcing relationship. As Sen (2001b, p. 2) emphasises: As Sen (2001b, p. 2) emphasises: lower levels of education and income, “placing women in Soweto, South Africa, illustrated that gender is linked to 2006; Epstein & Kim, 2007). microfinance conducted in rural South Africa have shed light limited.” Other studies on HIV, economic empowerment and yet empirical research on possible connections remains gender-based violence and gender inequality are “increas-
cate about gender power relations” (see also Jewkes, 2002; Dunkle, Jewkes, Levin & Penn-Kekana, 2002). Wool, Maforah & Jewkes (1998) found that South African girls’ first sexual experience was often forced — and this pattern was repeated, in that men continued to exert control over young women. The same young women continued to have sex with the men because they were beaten if they refused. Thus, the onset of the pattern of abuse began with girls’ very first sexual experience. Jewkes, Penn-Kekana & Rose-Junius (2005, p. 1809) assert: “Patriarchal ideas render girls vulnerable to abuse through legitimising on some level displays of male power… which serve to manufacture gender hierarchy and communi-
cate about gender power relations” (see also Jewkes, 2002; Jewkes, Levin & Penn-Kekana, 2002). Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow (2004, p. 1416) note that gender-based violence and gender inequality are “increasingly cited as important determinants of women’s HIV risk; yet empirical research on possible connections remains limited.” Other studies on HIV, economic empowerment and microfinance conducted in rural South Africa have shed light on the interplay between these factors (see RADAR, 2002; Prynnick, Hargreaves, Kim, Morison, Phetla, Watts et al., 2006; Epstein & Kim, 2007).

Research conducted in the south-western townships (Soweto), South Africa, illustrated that gender is linked to lower levels of education and income, “placing women in disadvantaged social positions and rendering them more vulnerable to disease” (Gilbert & Soskolne, 2003, p. 202) (see also Veenstra, 2000; Gilbert & Walker, 2002). HIV and ill health for women thus becomes a bi-directional, mutually reinforcing relationship. As Sen (2001b, p. 2) emphasises: “Gender inequality is not one homogenous phenomenon, but a collection of disparate but interlinked problems.”

Against the context of a high burden of HIV infection among women of reproductive age, women’s increased biological and social vulnerability, gender inequality and pernicious gender norms, the practical question is whether companies mounting large-scale programmes to address HIV prevention, care, treatment and support recognise these factors and link them to their programming. The greater question is whether there are equal opportunities for women to be healthy in South Africa (in the places where they live and work). Thus, in this study, the workplace serves as a microcosm of South African society.

The workplace as a site of intervention

To improve the quality and efficacy of HIV management programmes, the importance of incorporating a gender dimension into workplace policies and programmes has been increasingly recognised. At an international level, the ILO and other UN agencies, such as UNIFEM, UNDP and UNAIDS, have long called for gender-sensitive approaches and gender-specific programmes in relation to HIV (see ILO, 2001; UNFPA & UNIFEM, 2006; UNAIDS, 2008c; UNDP, 2008). Gender equality is a key principle of the ILO’s Code of Practice on HIV/AIDS and the World of Work (ILO, 2001). The code notes that workplace programmes should emphasise the special vulnerability of women to HIV/AIDS and so mount prevention strategies that can lessen this vulnerability. The ILO (2001) also recommends several explicit gender-specific dimensions to be included in workplace HIV/AIDS programmes. A new momentum around gender and HIV has emerged in the last five to eight years, with expanding awareness and increasing knowledge of the effects of HIV on women, and increased documentation of the links between gender inequality, economic empowerment, and HIV. As Fauci (2008, p. 289) notes, “25 years of HIV has resulted in an unprecedented scientific and public health response to the disease, with welcome attention to some of the problems endemic in populations severely afflicted with HIV/AIDS, such as gender inequality.”

The ‘feminisation’ of HIV has become a global phenomenon. Now, 41% of the HIV-infected labour force is female (World Economic Forum, 2004). In recognition of these developments, the Global Business Coalition on HIV/AIDS, TB and Malaria (GBC) (one of most powerful lobby groups advancing action on HIV/AIDS in the corporate sector) has recently declared two key initiatives, both with a gender focus (GBC, 2008). However, these international developments are in sharp contrast to workplace programmes in South Africa.

Findings

Sex-specific interventions to address women’s or men’s health are not occurring in a systematic way. To date, the vast majority of companies are not initiating programmes that acknowledge or address women’s (or men’s) health specifically, or women’s special social and physiological vulnerability in relation to HIV infection. Alongside the evidence base that connects gender inequality, prevailing
social norms, and female biology to increased risk of HIV transmission, the discussions with key informants revealed the following.

**Little recognition of women’s physiological and social vulnerability to HIV infection**

At the outset, the function of this study was met with caution by those interviewed. Most company representatives agreed to speak only on condition of anonymity. In many cases, individuals expressed surprise at the nature of the research, and, with few exceptions, these individuals seemed generally not aware of or had failed to consider the linkages under study. In many cases human resources officers are charged with managing company HIV programmes; however, they are not health specialists, nor are they meant to be. A mismatch of job portfolio with skills appears to prevail, as human resources officers usually lack the specialised knowledge needed to consider how health promotion, education and related programming can best serve employees wellbeing. In short, most respondents were not adequately aware of the connections between biological and social aspects predisposing women to HIV infection, nor what response might be made by the workplace.

**The irony of policies based on non-discrimination and gender neutrality**

Among a survey of 1 008 South African companies conducted by Ellis & Terwin (2005), 81% of financial services firms, 50% of manufacturing and transport companies, and 60% of mining companies had HIV/AIDS policies in place, but the range and quality of the responses and activities varied. HIV/AIDS-programming activity is therefore widespread in South Africa but the depth and scope of the activities (including the size of the financial investment) tend to correlate closely with firm size. Among companies with fewer than 100 employees, 13% had formulated an HIV/AIDS policy while 29% offered an HIV-awareness programme (Ellis & Terwin, 2005). Such policies provide a basis for understanding subsequent company approaches to HIV, as company interventions are based closely on HIV policies.

The policies reviewed over the course of this study appear to share two common characteristics: they take non-discrimination in the workplace as their fundamental origin and starting point, and they generally tend to be gender-neutral. Organisational policies are rooted in particular contexts. South African HIV policies in the post-apartheid era take a clear affirmative-action position while ensuring that individuals are not discriminated against on the basis of race, gender, sexual orientation or other characteristics. Unwittingly, the language of the policies emphasises ‘sameness’: treating people similarly while ignoring differences — in this instance, sex-specific differences related to health and HIV. This focus is in keeping with legal norms but may impede traction on introducing sex-specific HIV-related programming.

**The demands of standards and reporting**

Another obstacle to targeted or more sophisticated workplace HIV interventions aimed either at men or women which emerged from this study concerns South African companies’ heavy burden of reporting on legal and industry standards (from industry-sector benchmarks and other requirements) to reporting in line with the listing requirements of the Johannesburg Stock Exchange (JSE). In the competitive environment in which companies are placed they must be seen as having responsible corporate governance and following the law in terms of employment equity, black economic empowerment, and industry codes and standards.

One example from the mining industry is illustrative: The Minerals and Petroleum Resources Development Act, and the Broad-Based Socio-Economic Charter for the Mining Industry, were developed in joint consultation between government and the mining and minerals industry. The goal of the charter is to “create a mining industry that will proudly reflect the promise of a non-racial South Africa” (Department of Minerals and Energy, 2008). The government then produced measures for assessing the progress of mining companies with respect to a number of key areas as they relate to socio-economic goals. This document, known as the ‘Mining Scorecard,’ has nine elements, and each element has sub-requirements. Hence, this single charter requires large-scale monitoring and reporting by mining companies, and it is only one legislative requirement that faces companies (see Department of Minerals and Energy, 2002 and 2008). International and national standards are also fluid and evolving. The regulatory, standards and reporting environment reflects the increasing demands of corporate governance in a globalising world where South Africa seeks to compete internationally. And, this environment reflects the intended social transformations in business, in keeping with the goals of a democratic society.

There are an estimated 14 major national and international HIV/AIDS workplace guidelines and codes confronting managers in South Africa, observed Whelan (2007). In his study of best-practice HIV programming, Whelan (2007) found that those 14 are the regional, national and international codes or standards most likely to be applied by companies in South Africa. This observation was born out in conversations with the respondents (see Table 1). Chief among these guidelines is the **King II – Report on Corporate Governance for South Africa** (Institute of Directors in Southern Africa [IoDSA], 2002), which calls for integrated sustainability reporting, including reporting on HIV/AIDS. Although King-II-type reporting is voluntary, listing on the JSE requires companies to comply with the King II Report, as well as with the Global Reporting Initiative (see http://www.globalreporting.org/Home). The pressure for companies to report is high. Du Bruyn (2006, p. 25) writes: “Disclosure of HIV/AIDS information by South African companies in their annual reports still remains voluntary. Recent developments in this regard are however increasing company awareness of the issue, and...companies are increasingly under pressure to disclose their HIV/AIDS policies and practices.” HIV/AIDS codes of conduct and policies therefore often seem viewed as an administrative requirement (or hurdle), rather than a vehicle for managing and safeguarding the health of valued employees.
Table 1: Workplace HIV/AIDS guidelines and codes commonly used by South African companies

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<th>International</th>
<th>Regional and national</th>
<th>Business</th>
<th>Corporate</th>
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**HIV-programming fatigue**

In many cases, a great deal of fatigue has attached itself to company’s workplace HIV/AIDS programmes. A feeling of general tiredness was repeatedly expressed by the respondents in this study, as well as by people in other forums, such as at the Wits HIV/AIDS in the Workplace Research Symposium, University of the Witwatersrand (Johannesburg, 29–30 May 2008). Such fatigue has resulted in companies cutting back on voluntary counselling and testing (VCT) drives or placing their HIV testing within a larger wellness programme (such as where blood pressure and HIV tests are conducted as part of a holistic approach to health). (Anglo American, Sasol and DeBeers are examples of companies that have opted for this course.) Many respondents expressed weariness (on the part of company stakeholders and employees) concerning HIV-programme activities more generally. However, the integration of HIV testing into routine healthcare has many advantages, also helping to thwart concerns about HIV/AIDS ‘exceptionalism’ and a focus on a single disease (England, 2008; *The Lancet*, 2008).

**Weak transfer of knowledge to practice**

The knowledge-base associated with HIV/AIDS in the workplace is a recent and emerging one, with the results of new research continually reported. Even when information is evident, some respondents expressed the difficulty of using research results to inform company practice — deciding, for example, what is relevant to the goals of a particular workplace, what is implementable, and what makes economic sense. For example, the medical officer of the Anglo Group (Dr Brian Brink, presentation to the Wits HIV/AIDS in the Workplace Research Symposium on 29 May 2008, University of the Witwatersrand) stated: ‘HIV/AIDS exploits the power imbalance of human gender…women of reproductive age are bearing the brunt of the epidemic’ and there is a ‘need to integrate women’s health and HIV/AIDS.’ However, that awareness of the connections between gender, health and HIV is not reflected in Anglo’s HIV-related programming at this stage. There also seems little attention paid to monitoring and evaluation, or to communicating and disseminating promising practices. Appropriate forums to exchange information within companies and between organisations are few. Existing ones, such as the South African Business Coalition on HIV/AIDS (SABCOHA), are understandably biased towards large firms. Even though such a forum is useful for sharing information, it does not teach individuals how to harness research results to shape workplace programming. Such skills-based training is perhaps beyond its remit. The natural home for such training would be tertiary educational institutions in South Africa. Such training is not occurring on the scale required.

**Gender stereotyping**

Historically, the mining sector has maintained the largest sustained workplace response to HIV in South Africa (notwithstanding early progress by individual companies in other sectors, such as the parastatal utilities company Eskom, whose innovative efforts have since waned). The mining sector has also historically employed a majority of men, although the South African Mining Charter now requires that by 2009 at least 10% of the mining workforce be women (Department of Minerals and Energy, 2008). Thus, gender-specific interventions utilised thus far have normally been targeted to men — and sometimes to men’s masculinity. For example, Anglo American used the slogan ‘Are you man enough to test?’ to encourage men to participate in VCT campaigns. Such approaches appear to reinforce negative stereotypes of ‘expected’ male behaviour and even machismo.
Emerging initiatives to benefit women

The sex-specific interventions that are being employed and initiated by employers mainly take the form of leadership development and mentorship for women. These are typically targeted towards capacitating women to learn a skill that was previously performed solely by men. For example, women are now operating heavy equipment in the mines. DeBeers has published a Women in the Workplace Newsletter, since 2007, which seeks to communicate to women across the company, to increase the number of women in the mining ranks, and to empower women in the responsibilities they discharge. DeBeers (2008) has also instituted a ‘Women in the Workplace Mentoring Circle’ where women are invited to share thoughts on their workplace challenges, experiences and successes. The issues that arise from this circle may very well be gendered. On a needs-driven basis, the company provides coaching and other developmental interventions for women. The objective of the mentoring circle is to enhance professional development through effective personal relationships, the sharing and appreciation of experiences of peers, and the provision of guidance and advice on organisational matters and competence development (Coral Baldwin, pers. comm., 26 May 2008). Whether or not such initiatives become institutionalised and standardised beyond the enthusiasm of one human resources director, or whether they take the form of informal and erratic initiatives, will affect the greater success and impact of such activities. At the same time, such initiatives may take place on the periphery of the workplace but may prove significant in addressing a range of women’s needs relative to skills development, health and HIV.

Some savvy South African NGOs are lending their expertise to companies and other organisations on an ad-hoc basis. Gender Links, for instance, is providing training to women in media and newsrooms on HIV/AIDS-related issues (Gender Links, 2008); and Sonke Gender Justice has launched the ‘One Man Can’ campaign to address violence against women; the ‘One Man Can Action Kit’ provides men with educational resources to act on their concerns about domestic and sexual violence. Based on research conducted by the organisation, this particular public health and social justice campaign recognises that many men are concerned about widespread domestic and sexual violence ‘and want it to stop’ (Sonke Gender Justice, 2008).

The majority of company representatives interviewed did not recognise women’s special social and biological vulnerability to HIV, and it appears that the companies in this sample are not initiating programmes that address women’s health specifically. However, opportunities for bringing these connections to the attention of institutional workplace environments remain. Thus, pilot initiatives may provide fertile ground for women’s health issues to be addressed and discussed; and these initiatives may become routine, serving as regular opportunities for women to share experiences and to seek information and support on a multiplicity of issues related to women’s health, including fertility choices and reproductive health, which are so often neglected (see Stevens, 2008). On the other hand, particular initiatives may also fail to develop or may simply continue in the same form.

Explanatory factors

Given the burden of HIV infection and the associated social impacts, the connections between gender, health and HIV cannot be dismissed. To date, the number of documented activities is small compared to the need. Two chief factors that appear to underpin the lack of knowledge and action in the workplace are identified below.

A health paradigm for women in South Africa

The dominant health paradigm for women in South Africa is not women’s health, but maternal and child health. Over the last three decades, health policy development, and subsequent reforms surrounding access to healthcare and health services, has largely focused on equality and equity (Klugman, 1999). For instance, for black South African women, a number of health problems were identified by women’s organisations and activists during the 1980s, such as the physical impact of poverty and the psychological impact of gender and race-based inequality. While occupational health was on the trade unions’ agendas in general, it lacked a gender-specific drive (Klugman, Stevens & Arends, 1995; Klugman, 1999). With a new government expected, and a new policy agenda in sight, health activism was located in an already crowded policy process (Fonn, Xaba, Tint, Conco & Varkey, 1998; Klugman, 1999; Cooper, Morrone, Orner, Moodley, Harries, Cullingworth & Hoffman, 2004). While the issues of gender equity and the social and economic status of women were extremely complex, the dominant discourse was “of national struggle and, within this, of women’s roles and responsibilities as mothers.” In May 1990, the African National Congress (ANC) issued a statement recognising ‘women’s oppression,’ yet asserted that this could only be solved by a campaign ‘in its own right’ (Klugman, 1999).

Subsequent ANC policies and plans for health culminated in the 1997 White Paper for the Transformation of the Health System (Department of Health, 1997). The new policy framework included some essential elements (such as the provision of free healthcare for pregnant or lactating women and children under age 6). Thus, these measures could be seen as a significant step for equity and gender equality, given that women and children are the most frequent users of the South African health system and that healthcare would better meet women’s health needs in a more tangible way. Beyond the general commitment to equity, however, the White Paper fails to mention occupational health issues, including reproductive health; and, as Klugman (1999, p. 57) notes, how health issues impact differently on men and women and “the need for substantial research and targeted interventions in this regard” (see also Klugman et al., 1995; Cooper et al., 2004). Thus the dominant medical and public health paradigm in South Africa has become concern for maternal and child health — not women’s health. Hassim (2007) observes that social policy gains have been effective in South Africa when women’s needs are clear and definable and do not infringe on men’s interests.
The social construction of gender

Workplaces often mirror and replicate the same social realities that exist outside the world of work. One’s sex refers to biologically recognised differences between men and women, including chromosomes, internal and external sex organs, hormonal makeup and secondary sex characteristics, such as breasts (Östlin, George & Sen, 2001); gender, however, is a social construction. It includes the different behaviours, roles, expectations and responsibilities that women and men learn within the context of their culture or society. As a social category, gender (and the power relations associated with it) has the potential to confer upon men and women different societal, family, peer and even personal norms and expectations with regard to appropriate conduct. In this way, gender norms and ideals govern attitudes and behaviour and also serve as an important mediating factor in sexual and reproductive experiences (Bates, Fenton, Gruber, Lalloo, Medina Lara, Squire et al., 2004). Moynhian (1998) suggests that while society views these categories as ‘fixed’ they vary tremendously across cultures and between individuals and are mutable. Lorber (2004) affirms that gender, like culture, is a human creation, dependent on individuals and social systems to repeat or rebuild these notions.

How does the social construction of gender play out? There is evidence that women are treated more poorly by doctors, nurses or hospital staff than men, internationally (Doyal, 2001). In South Africa, in studies of maternal health services provided in the public health sector, health-care workers described themselves as being insensitive, ‘rude, uncaring’ to women because they are women. They acknowledged that they treated clients selectively, showing more respect for men and discriminating against poor and illiterate women. They attributed these attitudes to their socialisation in a society stratified by class, race and gender (Fonn et al., 1998). A study by Jewkes, Abrahams & Mvo (1998) uncovered an environment replete with physical abuse and humiliation of female patients by nurses.

Likewise, are South African workplaces gender-neutral? Are they gender-blind or sexist? Do they simply replicate and reinforce some of the social norms discussed in this paper? The workplaces studied here appear to ignore sex-specific differences and realities surrounding health and HIV, at least on the surface. There is insufficient depth of evidence to suggest that they do or do not reinforce existing gender inequalities. Nevertheless, if they mirror a society where gender inequality is the norm, this would partly explain the lack of companies’ attention to women and their health. Accordingly, the workplace would merely reflect existing social constructions of gender.

Suggestions for further research

While there have been many studies conducted in and by the mining industry, there is not a large body of literature on occupational health in South Africa. And while current scientific (e.g. epidemiological) literature has become more attentive to gender issues, Goldman & Hatch (in Panelli & Gallagher, 2003, p. 96) state: “What seems essential is to look at women’s health separately from that of men — not simply combining the data or adjusting for sex in the analysis — and to use a gender-specific approach.” Yet there are few empirical studies in South Africa that focus on the world of work and gender differences in relation to contracting, preventing or treating HIV, as well as sexual and reproductive health more broadly (see London, 1998; Gender Medicine, 2006; Cooper, Harries, Myer, Orner, Bracken & Zweigenthal, 2007). Consequently, additional research in South Africa is needed. South African universities and research entities could engage students and academic staff in studies that examine these connections and so document and evaluate responses to HIV interventions employed. Academic schools of public health, sociology and other departments could engage in applied social research that examines important occupational and workplace health issues in order to strengthen and expand the knowledge base. Research results should also be published in the public domain instead of resting only with company representatives as private, commissioned research.

The following areas merit investigation that emphasises applied social research, tying knowledge to action:

1) Additional research on theories of masculinity and gender in the context of the South African workplace is warranted. For instance, how is masculinity perceived by employees across the ranks in the workplace? Are these identities and related behaviours changeable — through behavioural interventions focused on sexual risk behaviour, sexual norms and preferences?

2) Stigma or discrimination that women face in the workplace is under-studied yet is important in identifying and shaping appropriate interventions aimed at women, including pregnant women. What are the perceptions of stigma among women in the world of work? How does stigma manifest? And, what are the coping mechanisms and strategies employed to manage stigma by individuals and by managers?

3) What are the missed opportunities for meeting women’s sexual-health and reproductive-health needs and choices in the workplace in an integrated fashion, and how can these opportunities be exploited? This includes the provision of integrated HIV/sexual and reproductive health and rights services within an occupational setting, while also exploring HIV-related services for dependants and children (see Berer, 2003).

4) Additional research and reporting is necessary in the following areas: violence against women and the workplace, maternal and postnatal depression, women and mental health, and prescribed contraception as a minimum medical-aid benefit in the private sector.

5) Various research and policy forums in South Africa have called for female condoms to be made more widely available, allowing women more control over contraception as a female condom can be inserted many hours prior to sex (Hoffman, Smit & Adams-Skinner, 2008; see also UNAIDS, 1997). Hence, research is warranted in the following areas: social marketing of the female condom and its acceptability; and, as a business case, a feasibility study that explores whether the expanded subsidy of the female condom by private-sector...
companies could occur to achieve greater availability and uptake of female condoms by women.

6) Available research on communication for behaviour change for men and women demonstrates that highly targeted messaging that is grounded in a true understanding of the target (e.g. man, woman, youth, child) can be effectual in terms of HIV prevention and education and behaviour change in the workplace and other settings such as schools (Sprague, 2002). Effective education can contribute to the capacity of workers to protect themselves against HIV infection. It can significantly reduce HIV-related anxiety and stigmatisation, minimise disruption at the workplace and bring about attitudinal and behavioural change (ILO & Family Health International [FHI], no date). Therefore, more research is needed to evaluate targeted, sophisticated messages and HIV interventions (especially in regard to their acceptability and effectiveness). In particular, new research could explore the communication of sex-specific messaging to employees by peer educators working in companies. The perceptions and knowledge of peer educators regarding sex-specific biological and social vulnerability to HIV should be investigated (for example, what do peer educators believe regarding gender-norms and behaviour, and what advice do they provide to their peers?). Furthermore, existing interventions should be examined with a view to documenting both their limitations and efficacy.

Conclusions

In response to a growing public health crisis, business leaders in South Africa have been recognised as being the vanguard “among the global leaders in addressing AIDS” (The Economist, 2004). This is primarily attributed to their physical location at the epicentre of the epidemic. Nonetheless, companies opted to provide education, HIV testing and treatment to employees, voluntarily and on an unprecedented scale — before treatment was available in the public health sector. However, rarely are workplace health programmes sex-specific, even though men and women have different anatomies, and women have a greater biological and social vulnerability to HIV. Despite being progressive, workplace programmes and policies in South Africa have yet to develop customised, sophisticated programmes that address the special needs of women and men vis-à-vis health generally and HIV particularly. The findings of the interviews, together with the literature relating to South Africa, suggest that the workplace is not being used as a platform for addressing women’s or men’s health issues broadly, or especially for contradicting social norms in relation to HIV infection.

Clearly, the implementation of equal opportunities in the allocation of resources for health cannot mean treating men and women in exactly the same manner (Doyal, 2000). Gender neutrality has its limits: both men and women have a range of specific needs if they are to reach their development potential and flourish. Doyal (2000, p. 932) suggests: “The only practicable strategy for reducing unfair and avoidable inequalities in health outcomes between men and women is to ensure that the two groups have equal access to those resources which they need to realise their potential for health. However, this still leaves questions about how such a strategy should be carried out.”

How women’s and men’s health needs are met within a workplace context remains to be decided. Given the disproportionate burden of HIV infection facing South African women (at the levels of society and the workplace), we must question whether there are equal opportunities for women to be healthy. Improving the status and position of women in South Africa — through the workplace — has been identified as a priority by government, as has addressing equity. If we are concerned with women’s quality of life and development in our society we must attend to the treatment of women, their vulnerability to HIV, and social constructions of gender. In the context of increasing mortality and declining life expectancy, particularly for South African women of reproductive age, the question remains: What is the role of the workplace in challenging and re-constructing existing gender norms in South Africa, for the sake of workers’ health? The results of this exploratory research suggest the need for stakeholders’ increased understanding of connections between gender and health, and how the workplace can be effectively harnessed to promote health, respond to HIV/AIDS, and empower women.

Notes

1 For specific mention of the role of the private sector in the National Strategic Plan viz. national HIV/AIDS goals, objectives, targets (dates) and indicators, see in particular the Department of Health, 2007, pp. 61–64, 66, 70–72, 74, 78, 82–135. Available at: http://www.doh.gov.za [Accessed 22 August 2008].
2 Key informants included 10 company officials and 23 individuals from the following organisations: McKinsey & Co., Health Systems Trust; AIDS Law Project; AIDS Legal Network; Centre for AIDS Development, Research and Evaluation (CADRE); Africa Gender Institute, University of Cape Town; HIV Management Solutions, University of the Witwatersrand (Wits); the South African Business Coalition on HIV/AIDS (SABCOHA); Centre for Health Policy, University of the Witwatersrand; Centre for Human Rights, University of Pretoria; Sonke Gender Justice; Wits Law School, Wits School of Public Health; Women’s Health Research Unit, School of Public Health & Family Medicine, University of Cape Town; Wits Centre for Applied Legal Studies; GenderLinks; Wits Reproductive Health and HIV Research Unit; Steve Biko Centre for Bio-Ethics, Wits School of Medicine; Global Business Coalition on HIV/AIDS, TB and Malaria; School of Public Health and Family Medicine, University of Cape Town; Health and Development Africa.
3 Investigating the ways in which inequities result from and perpetuate social discrimination has been important in allowing policy to effectively address gender inequities. Östlin, George & Sen (2001) note that such inequities can be measured as the ‘health gap’ between men and women. For instance, the internationally observed higher rates of male mortality are assumed a product of biology, as women’s survival advantage has been evinced in various countries. But this survival advantage for females is relatively new, and most developing countries are defined by excess female mortality (Östlin et al., 2001; see also Hunt & Annandale, 1999). Östlin et al. (2001, p. 179) also note that the high rates of maternal mortality in developing countries “are symptomatic of more profound global gender inequities.”
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