FROM POLICY TO PROGRAMME

AN EMPIRICAL ASSESSMENT OF RESPONSES TO HIV/AIDS IN THE WORKPLACE

LRS
LABOUR RESEARCH SERVICE

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Hand paintings: Care for Caregiver workshop participants
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INDEX


FLOWER SYMBOL giving
SCENE THAT WOULD
INTREST PEOPLE
MURIEL

Why was this research done?

In 2007 the Labour Research Service (LRS)) conducted a research project entitled: "Practical Strategies for Mainstreaming HIV/AIDS in Collective Bargaining". The goal of this project was to promote collective bargaining as a focal point for the drafting and implementation of substantive responses to HIV/AIDS in the workplace. Rooting HIV/AIDS policies and programmes within collective agreements can make these policies and programmes more inclusive, more formal and subject to time framing, monitoring and sanction in the event of non-delivery. Trade union representatives are also encouraged to develop a better understanding of the disease; to focus existing policies and resolutions on this arena: to participate in the drafting of responses to HIV/AIDS in the workplace; and to participate in the monitoring and implementation of programmes against agreed outputs.

How was the research conducted?

Litreture Review

The review focussed on an analysis of existing HIV/AIDS legislation related to the workplace; corporate responses to HIV/AIDS; the constraints faced by small business in responding to HIV/AIDS; the sectoral variations in response to the epidemic; the gendered nature of responses to the epidemic; and what is considered as best practice in dealing with the epidemic.

Baseline Study

A baseline study of 47 bargaining councils, 421 enterprise level agreements and seven sectoral determinations was conducted.

Workshops

Trade union representatives from six private sector and four public sector unions participated in three workshops. Each

workshop had an average of 31 participants, 51 percent female and 49 percent male. In the workshops participants identified the key challenges facing unions when mainstreaming HIV/AIDS in collective bargaining, shared experiences of best practice and developed recommendations for enhancing practical strategies for mainstreaming HIV/AIDS in collective bargaining

Four workshops with an average of 22 women shop-stewards from the General Industrial Workers Union of South Africa (GIWUSA) were conducted between October 2007 and March 2008. This group acted as a reference group where particularly women workers' experience of HIV/AIDS workplace programmes was explored.

Interviews

In-depth interviews were conducted with trade union representatives from SACCAWU, NUM, SACTWU, SAMWU, FEDUSA and GIWUSA.[1] The interviews focused on an analysis of the strengths and weaknesses of workplace and trade union policies and programmes.

Telephonic interviews were conducted with 11 of the LRS member unions to establish the status of HIV/AIDS workplace interventions.

An in-depth interview was also conducted with a representative from the AIDS Law Project.

Questionnaires

As part of a more general study on gender standards in the workplace, 100 women workers filled in a questionnaire on

1 SACCAWU - South African Commercial and Catering Workers Union; NUM – National Union of Mineworkers; SACTWU – South African Clothing and Textile Workers Union, SAMWU – South African Municipal Workers Union; FEDUSA – Federation of Democratic Unions of South Africa and GIWUSA – General Industrial Workers Union of South Africa

the status of prevention and treatment programmes in their workplaces.

At the LRS 2008 Negotiators Conference 22 trade union representatives from NUM, MEWUSA[2], SACCAWU, CEPPAWU[3] and CWU[4] responded to a questionnaire. The questionnaire focussed on taking stock of HIV/AIDS demands that form part of their 2008 Collective Bargaining Strategy.

2 MEWUSA – Metal and Engineering Workers Union of South Africa
3 CEPPAWU – Chemical, Paper and Pulp Workers Union
4 CWU – Communication Workers Union


I AM A MOTHER
BUT I HAVE A PLACE FOR THEM
BUT FEW

How does the law protect us?

Using the law to protect workers affected and infected by HIV/AIDS is not easy. There is no single legislation governing HIV/AIDS in the workplace. A NEDLAC Code of Good Practice exists, but even this code has to be read in conjunction with other pieces of legislation including the Constitution.

The legislation that exists applies to everybody within a company but employers and workers have different imperatives. For employers the law is used and evaluated in relation to how it affects profits. If the law impedes profit making then some employers will find ways to circumvent the law while others will ignore it. Workers on the other hand have the imperative to protect and improve their lives, but in a context where workers are often silent about HIV/AIDS, and where using the law depends on knowledge, resources and organisational strength, the law is seldom used to protect workers who are dealing with the HIV/AIDS epidemic.

Even with the above-mentioned limitations it is important to understand some of the key features of the law that can protect workers when dealing with HIV/AIDS at the workplace.

Constitution of South Africa Act (No. 108 of 1996)
The constitution protects workers against unfair discrimination.

> *Chapter 2. Bill of Rights. Section 23. Labour relations. Everyone has the right to fair labour practices.*

Labour Relations Act (No. 66 of 1995)
The Labour Relations Act protects employees against unfair dismissal. If an employee is dismissed on the grounds of HIV/AIDS, this dismissal is based on discrimination and is automatically unfair. Dismissal is only fair if it is based on

wrongful conduct or if an employee can no longer work, but then proper dismissal procedures must be followed.

> 187. Automatically unfair dismissals
>
> (1) A dismissal is automatically unfair if the employer, in dismissing the employee, acts contrary to section 549 or, if the reason for the dismissal is - (f) that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political opinion, culture, language, marital status or family responsibility.

Employment Equity Act (No. 55 of 1998)

The Employment Equity Act provides that no person may unfairly discriminate against an employee, or an applicant for employment, in any employment policy or practice, on the basis of his or her HIV status. The Act thus prohibits medical testing to determine the HIV status of an employee, except in cases of Labour Court authorisation.

> Section 6. Prohibition of unfair discrimination.- (1) No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.
>
> (2) It is not unfair discrimination to: Take affirmative action measures consistent with the purpose of this Act; or distinguish, exclude or prefer any person on the basis of an inherent requirement of a job.
>
> Harassment of an employee is a form of unfair discrimination and is prohibited on any one, or a combination of grounds of unfair discrimination listed in subsection (1).

Section 7. Medical testing. - (1) Medical testing of an employee is prohibited, unless: Legislation permits or requires the testing; or it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job.

(2) Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined justifiable by the Labour Court in terms of section 50 (4) of this Act.

Occupational Health and Safety Act (No. 85 of 1993)

The Occupational Health and Safety Act require an employer to provide, as far as it is reasonably practicable, a safe workplace. This includes ensuring that the risk of occupational exposure to HIV is minimised.

8. General duties of employers to their employees: Every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees.

Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993)

An employee who is infected with HIV as a result of an occupational exposure to infected blood or bodily fluids may apply for benefits in terms of Section 22(1) of the Compensation for Occupational Injuries and Diseases Act.

22. Right of employee to compensation. -

(1) If an employee meets with an accident resulting in his disablement or death such employee or the dependants of such employee shall, subject to the provisions of this Act, be entitled to the benefits provided for and prescribed in this Act.

Basic Conditions of Employment Act (No. 75 of 1997)

In accordance with the Basic Conditions of Employment Act every employer is obliged to ensure that all employees receive certain

basic standards of employment, including a minimum number of days of sick and family leave. Employees are allowed to take a total of six weeks paid sick leave every 3 years. Sick employees can ask employers to have more sick leave for less pay.

> *Sick leave. 22 (2) During every sick leave cycle, an employee is entitled to an amount of paid sick leave equal to the number of days the employee would normally work during a period of six weeks.*

> *Family responsibility leave. 27 (2) An employer must grant an employee, during each annual leave cycle, at the request of the employee, three days' paid leave, which the employee is entitled to take— (a) when the employee's child is born; (b) when the employee's child is sick; or (c) in the event of the death of— (i) the employee's spouse or life partner; or (ii) the employee's parent, adoptive parent, grandparent, child, adopted child, grandchild or sibling.*

Medical Schemes Act (No. 131 of 1998)

According to the Medical Schemes Act, a registered medical aid scheme may not unfairly discriminate directly or indirectly against its members on the basis of their "state of health". All schemes must additionally offer a minimum level of benefits to their members, including treatment of HIV.

> 24 (2) No medical scheme shall be registered under this section unless the Council is satisfied that— (e) the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.

> *67 Regulations. (1) The Minister may, after consultation with the Council, make regulations relating to— (g) the prescribed scope and level of minimum benefits to which members and their registered dependants shall be entitled to under the rules of a medical scheme.*

Promotion of Equality and Prevention of Unfair Discrimination Act (No. 4 of 2000)

The Promotion of Equality and Prevention of Unfair Discrimination Act protects against discrimination. An employee with HIV/AIDS must be treated in the exact same way as all the other employees in all matters.

> *Prohibition of unfair discrimination on ground of disability.* (*9) Subject to section 6, no person may unfairly discriminate against any person on the ground of disability, including—*
>
> (a) denying or removing from any person who has a disability, any supporting or enabling facility necessary for their functioning in society;
>
> (b) contravening the code of practice or regulations of the South African Bureau of Standards that govern environmental accessibility;
>
> (c) failing to eliminate obstacles that unfairly limit or restrict persons with disabilities from enjoying equal opportunities or failing to take steps to reasonably accommodate the needs of such persons.
>
> *Directive principle on HIV& AIDS, nationality, socio-economic status and family responsibility and status. 34 (1) In view of the overwhelming evidence of the importance, impact on society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, socio-economic status, nationality, family responsibility and family status—*
>
> (a) special consideration must be given to the inclusion of these grounds in paragraph (a) of the definition of ''prohibited grounds'' by the Minister;
>
> (b) the Equality Review Committee must, within one year, investigate and make the necessary recommendations to the Minister.

Code of Good Practice: Key Aspects of HIV/AIDS and employment, 2000

Its primary objective is to set out guidelines for employers and trade unions to implement. These include:

- Creating a non-discriminatory work environment
- Dealing with HIV testing, confidentiality and disclosure
- Providing equitable employee benefits
- Dealing with dismissals, and
- Managing grievance procedures.

Its secondary objective is to provide guidelines for employers, employees and trade unions on how to manage HIV /AIDS within the workplace:

- Creating a safe working environment for all employers and employees
- Developing procedures to manage occupational incidents and claims for compensation
- Introducing measures to prevent the spread of HIV
- Developing strategies to assess and reduce the impact of the epidemic upon the workplace
- Supporting those individuals who are infected or affected by HIV/ AIDS so that they may continue to work productively for as long as possible.

How is the corporate sector respoding to HIV/AIDS?

The response of corporate South Africa to HIV/AIDS has been and continues to be very limited, varied and fragmented despite the fact that the disease is primarily infecting people of working age, leading to an increase in illness, absenteeism and death amongst the workforce.

There are a number of different workplace models with the four[5] most dominant being the following:

- The employer provides the full programme
- Employers and employees both make payments to a medical scheme
- Companies contract in a specialist HIV/AIDS organisation to manage the company treatment and care programme
- An external clinic is contracted to provide services at the workplace.

Different survey studies vary slightly in their estimates as to the number of workplaces that have implemented policies and programmes, but the general consensus is that while several large companies have actively responded to the epidemic in a variety of ways, the vast majority of smaller companies have yet to put into practice even the most basic awareness campaign. Workshop discussions[6] with shop-stewards from small companies[7] indicate a high level of intolerance on the part of management.

5 Business and Aids : sectoral challenges and opportunities in *Aids 2007 21 (supplement 3)*
6 Workshops with trade union representatives and GIWUSA reference group
7 Companies with less than 50 employees

"The bosses are very arrogant. They see infected workers as unproductive who need to be taken out of the system."

"In the workplace there is still a real fear of discrimination and the attitude is if you are sick stay at home."

"The attitude of the bosses towards HIV/AIDS is to force workers to be treated and they want to know how many workers are affected so that they can budget."

"They do not give support especially during sick leave and they further gossip or expose the employee."

"Workers are dismissed for incapacity as the law allows dismissal based on incapacity."

The 2005 SABCOHA survey (South African Business Council on HIV/AIDS survey), "The impact of HIV/AIDS on selected business sectors in South Africa", conducted among 1032 companies, shows that workplace responses to HIV/AIDS are strongly related to company size. The results suggest that around 90 percent of larger companies have implemented a HIV/AIDS policy, while less than 20 percent of smaller companies have policies in place.

There are a number of factors that influence larger companies to respond to HIV/AIDS. In some cases it can be linked to keeping a positive public image, maintaining investor confidence or responding to social pressures. [8] As harsh as it might sound, for the company there is also the skills levels of the workforce and the relative costs in production if workers become ill or die. In some cases the threat of profits declining and an increase in outflow of company benefits has seen company's invest in workplace HIV/AIDS programmes. For some of the larger companies, like Anglo American, a cost benefit analysis showed

8 CPH – HIV/Aids in the workplace symposium 2004, pg70

that the costs of investing in workplace HIV/AIDS programmes would be less than the costs of increasing loss of production due to absenteeism and illness. Anglo American has been at the forefront of encouraging workers to find out their HIV status and providing antiretroviral (ARV) treatment to all employers who test positive, as well as offering enrolment in wellness programmes to ensure ongoing monitoring and support.[9]

The mining industry has been one of the leading corporate sectors when responding to HIV/AIDS. Anglo American launched its antiretroviral therapy (ART) programme in August 2002 followed by De Beers and then AngloGold in 2003. According to the AngloGold *2006 Report to Society,* provision of ART has had positive cost benefits for the company, including a decline in deaths in service, hospital admissions, medical absenteeism and thus a decrease in the number of shifts lost.

The SABCOHA survey indicates a great deal of unevenness amongst different corporate sectors in their response to HIV/AIDS. While 60 percent of mining companies have implemented HIV/AIDS policies, and 50 percent in the manufacturing and transport sectors, in the retail, wholesale, building and construction sectors, less than a third of companies have HIV/AIDS policies in place. While our study did not explore the reasons for the variations in responses from different corporate sectors, it is a well known fact that the retail, wholesale, building and construction sectors are characterised by low skilled and outsourced forms of employment. Employees are generally not seen as critical for operations and are easily replaced. Another argument could be that with the relative mobility of the labour force, HIV/AIDS is not as visible as when employees are permanently part of a company.

It is important to note that the large companies leading the response to HIV/AIDS have in some cases extended their ART

9 Aids Foundation South Africa – www.aids.org.za

to wellness programmes focussing on general health-related issues like high blood pressure and diabetes. This, it is argued, helps to reduce the stigma attached to HIV/AIDS. There have also been shifts to include spouses into the programmes, and in some companies through corporate social responsibility programmes, extend HIV/AIDS services to community based initiatives.

This does not mean that companies are carrying all the costs related to HIV/AIDS. A key strategy has been to shift the cost burden of HIV/AIDS onto the employee by restructuring employee benefits. One example of this is to shift pension benefits from a defined benefit pension fund to a defined contribution fund. This means that the employee's spouse only receives what has been contributed by employee and employer and not a fixed lifetime annuity. A Sanlam survey of 800 South African pension funds in 2000 found that 71 percent were classified as defined contribution funds, compared to just 26 percent in 1992.[10]

In the past few years the gap between the "high profile" HIV/AIDS programmes of some large companies and the relative obscurity of any HIV/AIDS programmes for employees in small companies as well as for the more vulnerable casual or outsourced employees is growing. This is posing important challenges for the unions and for a collective bargaining strategy that needs to take into account the needs of all workers including the most vulnerable sectors.

10 George & Whiteside, 2003, p232

How is the Public Sector responding to HIV/AIDS?

The public sector is the biggest employer in South Africa, employing over one million people. Like in the private sector, HIV/AIDS has had a major impact on public sector employees. Seventy percent of government departments have HIV/AIDS programmes in place but the implementation of these programmes is weak.

In 2005 the Government introduced the Government Employee Medical Scheme (GEMS). 40 percent of public sector employees now covered by GEMS previously had no medical cover. Employees who are HIV positive register on the HIV Management Programme even before ART is necessary. ART forms part of the HIV Management Programme.

The Public Service Co-ordinating Bargaining Council (PSCBC) Resolution No 8 of 2001 commits itself to mobilise its social partners to actively engage in prevention programmes, counselling and giving support to infected and affected members and their families, and where possible to support the provision of means to speed up delivery. As from January 1 2006 medical assistance includes a comprehensive treatment and prevention programme with enrolment into GEMS.


- Beauty within me
- Growth
- Hope
- Courage
- LOVE OF
PEOPLE
- COMMUNITY
- CHILDREN
- Approachable
- Smile
- Happiness
- PLAYFUL
- CHILDHOOD

Challenges facing the union

In South Africa where HIV/AIDS has reached pandemic proportions we see very little evidence of practical measures to provide treatment in the workplace. It was surprising to note that only 1.6 percent of bargaining councils and 1 percent of enterprise level agreements show practical measures to provide treatment for HIV/AIDS. Our research revealed that where practical measures did exist, these in the vast majority of cases formed part of company policies, and did not emerge as a result of negotiated collective bargaining agreements. These policies also seldom translate into concrete programmes. HIV/AIDS policies have become, in the words of a woman shop steward: *"Good ideas on paper, but they remain in the drawer of the human resource manager as supposed proof that the company is doing something"*. What is clear though is that where HIV/AIDS programmes are in place, it is the company management who lead these programmes and not the union. And where no HIV/AIDS programmes exist, unions have been slow in placing the issue on the collective bargaining agenda. Even in the public sector, where 60 percent of public sector workers in South Africa belong to trade unions, the unions have played very little role in developing HIV/AIDS programmes or impacting on the programmes that do exist. No reference to HIV /AIDS was found in any of the sectoral determinations examined.

In our research many explanations have been given for the slow response on the part of the unions. A number of quotes from workers and union officials provide important insights into understanding this response.

Challenges inside the union:

- Nobody wants to speak about HIV; even amongst officials there is a silence
- The stigma is very strong, in both the company and the union

- Very few union leaders are prepared to reveal their HIV status
- Unions do not address the needs of their own members. Before one can push for a policy in the company, one needs to make sure the union has a policy in place
- HIV is like gender, it just gets forgotten about
- HIV is marginalised and becomes the job of the gender co-ordinator
- Very little resources are available for taking up HIV/AIDS
- It is not clear how peer educators fit in with the work of the union.

A general sentiment amongst participants in the workshops was that the union culture does not always promote talking about HIV/AIDS or encourage union members to disclose their HIV status. Stigma and discrimination continue to be key reasons for the general lack of engagement with HIV/AIDS. HIV/AIDS as a sexually transmitted disease is often still seen as private, taboo, shameful and associated with a "culture of rejection". From interviews with union officials it would seem that even where unions are negotiating HIV/AIDS-related issues in companies, there is ironically very little in place to protect union employees.

"Many of our organisers are sick and some have died, but nobody speaks openly about AIDS. We should be protecting our staff, but there is a silence and everyone is scared to discuss AIDS. How can we develop policies if we refuse to talk? There is a real denial and comrades try to find other explanations when someone gets sick."[11]

A theme emerging through all our research activities is how gender and HIV/AIDS are marginalised issues in the union. The

11 Interview with SAMWU union official (15 May 2008)

majority of HIV/AIDS co-ordinators in the union are women and many fulfil the dual function of dealing with gender and HIV/AIDS. Much has been written about the gendered nature of HIV/AIDS. Gender inequality leaves women with less control than men over their bodies and their lives. They often have less access to information about how to prevent HIV, and fewer resources to take preventative measures. They face barriers to the negotiation of safe sex due to patriarchal relations and control through violence and economic dependency. Regardless of whether they themselves are HIV positive or sick with AIDS, it is women who assume the burden of home-based care for others who are sick or dying. In the union the gendered nature of HIV/AIDS takes on a specific form. Gender and HIV/AIDS have become synonymous with the same people in the union responsible for both, with a similar sense of marginalisation from the real "bread and butter" issue of wages, with little profile in collective bargaining processes or agreements and with a sense that these are issues for the "private space" and not part of the public life of the union.

In the unions accessing resources remains a huge challenge. Very little funds are available for unions as companies have marketed themselves as being in the forefront of dealing with the epidemic in the workplace. As a result much of the existing funds have been channelled into company programmes. With the unions' lack of clear intervention strategies to address the stigma and discrimination, and with a culture of silence still very prevalent in the unions, raising resources to deal with HIV/AIDS will continue to remain a challenge.

Many company-based programmes include peer educators. Traditionally, health education information is provided by experts. Peer education in the workplace context is an attempt by workers to empower fellow workers. For peer education to be effective in a context of high levels of stigma and discrimination, communication, trust and a sense of egalitarianism, community and solidarity is necessary. For this sense of community to develop it is important for peer education programmes to work through the

formations and structures that workers see as legitimate. Many of the peer education programmes we encountered through this research are programmes initiated by company human resource management and not by the unions. In some cases the unions have been involved but usually in the implementation stage and not during the conceptualisation or planning stages. How the unions relate to the idea of peer education as part of a HIV/AIDS strategy is important, but at the moment there is a lack of synergy between peer educators and the union. Peer educators are generally not part of union structures. Many peer educators are part of company programmes and at times there is a tension between what they see as their "professional role" and their role as social actors for transformation. [12]The peer educators are not necessarily shop stewards and some union members feel that this is not necessary: *"Not everybody is comfortable spreading messages on HIV/AIDS so we cannot insist that all shop stewards do this."* [13] But in the view of a participant at the 2008 LRS Negotiators Conference the opposite is true:

"Usually the first contact for a person who is positive is through the shop steward so therefore the shop steward needs to have training and counselling skills."

The question still remains, what kind of legitimacy can these peer education programmes have, if the programmes are led by management? The challenge for the union is creating peer learning experiences that deal with HIV/AIDS while building the collective strength of the unions.

Challenges when defending workers:

"When you defend a worker for being absent you know it is about HIV but the worker will not reveal this and in the end you cannot stop the worker from getting dismissed."

A key challenge is getting workers to disclose their status. The law provides for work to be changed if the work affects the

12 D. Dickinson – Talking about Peer Educators (May 2007)

13 SACTWU presentation at 2nd Wits HIV/Aids in the Workplace Research Symposium

health of the worker but this can only apply if there is openness about the status of the health of the worker. For many workers revealing their status is to put into jeopardy their employment. Even if the law does not allow for discrimination on the basis of HIV/AIDS, workers argue that they are dismissed on the grounds of incapacity. For the union, using the law to defend workers against discrimination is very difficult if there is no openness as regards the HIV status of the worker. At the same time workers feel that because this discrimination exists even in the union there is no guarantee that the union will protect them.

Workers in the research reference group indicated that they felt very little sense of agency as regards HIV/AIDS. 95 percent of the participants indicated that they knew where they could get tested but only 30 percent have been tested. Calling on companies to provide voluntary counselling and testing was therefore not a demand they felt very strongly about. They also questioned whether they would have the power to refuse to be tested if the company did initiate such a programme. From the sentiment of the reference group it is clear that union-initiated collective bargaining demands have to be formulated through a process that includes education and awareness-raising.

Participants in the reference group and workshops indicated that while some companies had in the past taken up the challenge of making male condoms available in rest rooms, over the past year this seemed to have become less of priority.

"It was a fashion to put condoms in the toilets, but now management seems to have lost interest." [14]

For unions the challenge is to keep alive the struggle of addressing HIV/AIDS in the workplace. This in a context where some would argue there has been a saturation of the message and people are no longer listening, where company management's are

14 Reference Group participant

trying to maximise profits through outsourcing and casualisation and where employers see unions as relatively ineffective in protecting workers against HIV/AIDS discrimination.

In a context where workers feel little protection against discrimination, individual solutions are being sought.

"In our company, we have an informal agreement that if an employee dies of HIV/AIDS the company must replace him or her with a relative. In this way the family can have some financial security." [15]

"One way we are thinking about dealing with workers being absent because they are sick is to put all our sick leave together in a bank of leave that workers can access when they get sick. In this way if you are not sick you can contribute your sick leave to someone who is sick." [16]

Hearing these proposals one senses the absolute desperation on the part of workers. For the union these proposals can reverse many of the gains that have been made in protecting the rights of workers. To seek financial security through replacing a deceased worker with a relative is to return to an aspect of feudal relations where the lives of entire families are tied to the landlord, and in this case the employer. Instead of struggling for an extension of sick leave, workers sensing a weakness in their collective strength have opted to put at risk their own wellbeing by "donating" their sick leave. Sick leave is a non-negotiable right and cannot be given away. A union official provided some possible insight into this idea of a "bank of leave".

"Workers are using the idea of sharing the paid time off for shop stewards. As the union we negotiate time off for shop stewards, but not all the shop stewards are equally active.

15 View of participant in CEPPAWU workshop (September 5 2007)
16 View of HOSPERSA participant in workshop (August 14 2007)

We then pool the time off and we use it for the more active shop stewards." [17]

It is clear that in the absence of the union taking the lead in developing proposals to address HIV/AIDS in the workplace, workers will continue to find individual solutions, solutions that might seem viable in the short term but can undo many of the gains unions have won.

Challenges in responding to company-initiated HIV/AIDS programmes:

Bosses have an attitude that they own the policies

- In some companies there is a policy but no agreement on a programme
- Some companies give the appearance of caring, such as giving time off for peer educators, but there is no treatment programme
- Unions are are not involved in the planning, monitoring or evaluation of company HIV/AIDS programmes
- HIV/AIDS service providers work with the company and union members are not proactive in discussing issues with management before the service providers are brought in. Also, it would seem that this is another profit-making exercise for providers
- When voluntary counselling and testing (VCT) was first introduced, very few workers came to be tested. Then incentives, such as thermo cups, were introduced and there were queues to the clinics. The incentives did make people get tested, but workers came for the wrong reasons. This does not translate into behaviour change. If a person who comes for a thermo cup gets a positive test result, there is a great chance that person will not come back for proper treatment.

17 Interview with SACCAWU official (May 31 2008)

Unions need to engage with company policies and programmes. From the views emerging in the research it would seem that there are a number of contradictory aspects to many of the company policies and programmes. Where policies exist there is a view that the policies deal with redress and are not focused on being proactive in creating an environment for preventing discrimination. In other instances policies exist on paper and HIV/AIDS committees exist as window dressing. Even with policies and committees in place workers are not given time off for basic HIV/AIDS education and training. Companies organise events on AIDS day on December 1 and then believe that they have implemented a HIV/AIDS strategy.

Wellness programmes is a strategy used by some companies but in some cases the programmes do not allow for the provision of ART. A few of the bigger companies have clinics on site. There are different opinions on the effectiveness of this. Some see the clinics as providing a sense of security if employees get sick in the workplace. On the other hand there is a view that company clinics and doctors often collude with management in putting workers' jobs, health and lives at risk.

In our workshop in August a heated discussion about HIV-testing incentives took place. In some companies, particularly in the mining sector, incentives ranging from money to T-shirts have been introduced. NUM does not support the incentive structure and believes that the danger with incentives is that often people get tested for the incentive and they are not prepared for the results. Some comrades also argued that companies are not innocently introducing the incentives due to concern for the wellbeing of the workers, but rather because testing helps to develop a prognosis about the health and life span of the workforce and in this way they can retrench workers before they get sick.

Unions take up the challenge

From a sample of 19 unions and two federations, all have varying degrees of responses to HIV/AIDS in place. Most public sector unions, apart from DENOSA, HOSPERSA and SAMWU, have signed agreements with public sector bargaining councils.

NUM is the union with the most workplace agreements on HIV/AIDS and has made important strides in the mines. The AngloGold and labour policy agreement signed with NUM in 2002, for example, has materialised into a full scale HIV/AIDS programme. What started as a wellness programme in 1999 was expanded in 2003 to include the provision of ART. By 2005 five percent of the AngloGold workforce was on ART[18].

On the mines NUM has extended its demands beyond the provision of ARVs to access to decent housing, proper compensation, access to benefits and a call for professional health ethics[19]. Decent housing is linked to the demand for family accommodation that will ensure mineworkers who are HIV positive have a healthy and more supportive environment. NUM sees discrimination as still rife on the mines. Workers who are HIV positive and get work related illnesses are sometimes not compensated properly as the company tries to *"hide behind the HIV status of the worker"* and claim that their illness was due to HIV. Even though the mining companies claim to provide treatment, when workers are too ill to continue working and return home there is no provision made for the continuation of treatment. An important indication of NUM's ongoing monitoring of treatment and care is the call for professional health ethics. Workers indicate that nurses use discriminatory means to identify HIV positive workers. For example: *"Red stickers are put onto your folders"*.

18 AngloGold *Report to Society 2003-2006* (www.anglogold.com)
19 Presentation by NUM official at 2nd Wits HIV /Aids in the Workplace Research Symposium (29-30 May 2008)

Even where NUM has no collective bargaining agreement on HIV/AIDS like in Eskom, the union's strategy has been to engage with the existing company policy. Eskom has had an HIV/AIDS policy since 1998. The programme includes a wellness programme, VCT and ART. In the opinion of the union members interviewed, even though the existing policy was initially developed without union involvement it is seen as a good one. The union sees its role as reviewing and enhancing the existing policy. NUM sits on the HIV/AIDS committee and if there are issues to deal with, the representatives take them back to the union for discussion. An important move forward on the part of the union is the involvement of NUM representatives in the HIV/AIDS committee meetings. When the HIV/AIDS committees were first formed only corporate representatives such as medical staff, wellness managers and HR advisors participated. [20]

It is important to note though that NUM has not managed to impact on all the sectors it organises. Even with important breakthroughs in the mines and Eskom, the construction sector is still far behind. In the words of a NUM official, *"if you are sick you are just dismissed on the spot. Unlike permanent Eskom workers who are seen as skilled, construction workers are mostly casual and as a result are very vulnerable".* [21] It is not only in the construction sector that NUM faces important challenges. *"Outsourced and contract workers at Eskom also do not have the same benefits as permanent workers".* While NUM has managed to ensure that practical measures are in place in some workplaces, the challenge is now to extend these measures to all workers and workplaces.

Another union making an important contribution in the fight against HIV/AIDS is SACTWU. The SACTWU AIDS Project started in 1998 and the first phase of the project was to develop and implement an HIV/AIDS policy, followed by a comprehensive

20 Interview with NUM member at Eskom 2 August 2007
21 ibid

HIV/AIDS programme. Negotiations with the Clothing and Textile Bargaining Council also started in 1998. The aim of the negotiations was to get employers to contribute to the AIDS Project. Contributions were initially from workers' wages, but SACTWU managed to put the demand on the table and into the wage negotiations that employers contribute. Now employers contribute up to 30 cents for each worker.

The SACTWU AIDS programme centres around three main focal points: prevention, clinical and wellness management, and care and support. A variety of training programmes are offered, including management training, shop steward training and train-the-trainer programmes, as well as training for peer counselling and home based care.

Additionally, a training programme with a slightly different approach is the drama club where four retrenched factory workers have been trained to become actors and use theatre to deliver messages regarding HIV/AIDS.

Another important initiative is in respect to the establishment of public-private partnerships. Since 1999 SACTWU AIDS Project has had a public-private partnership in KwaZulu-Natal with the local health authorities where free provision of sexually transmitted infection (STI) treatment is given to SACTWU members.

In 2003, a social programme was initiated to offer psycho-social support in the form of individual and group counselling to workers and their dependents. The programme also provided skills development opportunities for workers to supplement their income and to explore their creativity, ranging from nutritional programmes to baking courses.

A home-based care partnership was launched in 2003 as a joint pilot project with a Belgian trade union to establish a network of 50 home-based carers in KwaZulu-Natal and begin a partnership

with a hospice care facility where workers are allowed to "die with dignity". In partnership with the Clothing and Textile Bargaining Council, seven clinics have been established in the Western Cape and one clinic in KwaZulu-Natal.[22]

The SACTWU initiative is important in that SACTWU organises in an industry where young, poorly paid women constitute a large majority of the workers. Also, the majority of workers are employed in small companies. All of these factors would generally imply a high risk sector with unsympathetic management. The project has introduced important innovations like the public-private partnerships, the accessing of external funding, the combining of HIV/AIDS training with other skills training and close working relations with the bargaining council.

Important steps have been taken but in the opinion of one of the trainers in the project: *"The union must initiate more discussions at the workplace level and even at the bargaining council level. What is needed in the bargaining council agreements is a framework policy, not only references to funding of the AIDS Project. Initiatives are on their way to expand the agreements from the fund to a framework. The framework for company policies must look at the circumstances in different companies. There is a great difference between small companies with five employees and bigger companies with hundreds of employees."* By demanding a framework policy the union hopes to ensure that all workers receive the same practical measures to combat HIV/AIDS.[23]

In the transport sector SATAWU's involvement in the Trucking against AIDS project is an example of how partnerships between unions, government, transport companies, industry suppliers, employers associations and funding agencies can play an important role in taking forward the fight against HIV/AIDS.

22 SACTWU AIDS Project (www.sactwuaidsproject.org.za)
23 Interview with SACTWU trainer 28 June 2007

The project was launched in 1999 under the banner of the National Bargaining Council for the Road Freight Industry. It is a targeted industry initiative focusing mainly on truck drivers and commercial sex workers. The key aim of the project is to reduce the spread of HIV/AIDS in the road freight industry and to provide assistance to people who are already infected by the disease. Services are free of charge and the project is based on establishing wellness centres along main trucking routes, particularly at transit areas or border posts where truck drivers spend hours resting or waiting.[24]

24 Matthew, P; Watson B. (2006) *Trucking against AIDS: a unique and sustainable response to HIV/AIDS by the South African road freight industry*, Presentation given at the XVI International AIDS Conference in Toronto, Canada, 13–18 August, 2006.


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Moving forward – thinking about strategy

From inside out – reworking the union culture

"Without addressing the stigma inside the union, we will not be able to move forward. There is a need for openness and dialogue." This is the view of the majority of shop stewards and union officials who participated in the research. Suggestions to address the stigma included the need for union-initiated policies and programmes; union leaders acting as role models by testing and publically declaring their status; discussions about how to create more open and compassionate relations between union employees and amongst union membership more generally; making peer education part of the union processes and training all shop stewards with an approach that sees peer education as part of social transformation.

Even though HIV/AIDS must be dealt with through programmatic intervention, it is important to recognise the role that dedicated individuals play in initiating and strengthening responses to the epidemic.

"I chose to become involved to try to make a difference, and to understand why the numbers of infections are still growing and why there is no cure. I am a peer educator, but I am also a part of the Eskom community outreach programme and visit community projects from time to time." [25]

From our research findings it would seem that brave, concerned individuals play a key role in getting HIV/AIDS to be taken seriously in the workplace. These individuals are sometimes union members, sometimes individual workers who have been trained in the workplace or in the community as peer

25 Interview with NUM member at Eskom (August 2, 2007)

educators, workers living with HIV/AIDS or directly affected, and sometimes relatively junior managers, usually from the human resource departments. It would seem that the majority of these individuals are women who have relatively limited power in the company and whose interventions are hampered by a lack of resources or limited capacity. These individuals are important as agents for change but we need to recognise that responses driven in this way are generally weak and fragmented as it is not part of a collective and organisational strategy.[26] Unions need to find ways of relating to these individuals, if they are union members, to ensure that the work they are doing is valued within the union structures and programmes. If they are not union members, unions need to find ways of recruiting these concerned individuals.

26 CPH- HIV/AIDS in the workplace symposium 2004

From the margins to the center addressing the gendered nature of HIV/AIDS

There is a general consensus amongst all the participants in the research process that the relationship between gender and HIV/AIDS must first and foremost be dealt with inside the unions.

"Before bringing an issue surrounded by discrimination and stigma to the negotiation process, these problems must be properly addressed and reflected upon within the unions." [27]

Where unions are addressing HIV/AIDS, it is usually located as part of the gender structure or is seen as a health and safety issue. A question raised in the August workshop was:

"Is the reason why we keep hitting a wall in the struggle against HIV/AIDS, when we spend millions but still the infection rate keeps rising, a reflection of unequal power relations between men and women?"

Unions are not immune to these unequal power relations. Even where resolutions, policies and structures exist, gender relations in unions are anything but equal. The experiences of women in the GIWUSA reference group in many ways reflect the experience of women in all of the trade unions involved in this research process. Comments included:

- Women have a fear of speaking in a male dominated space

27 View of participant at the "Developing strategies for mainstreaming HIV/AIDS in Collective Bargaining" Workshop – August 14, 2007

- Unions do not provide childcare so this limits participation by women
- There are no women organisers and this is a problem because men sometimes do not understand the problems that women face
- Women abuse is everywhere even in unions and women are not treated like human beings.

A key feature of this unequal power relationship relates to how the reproductive work women perform is viewed. Issues like childcare, family responsibility and caring is still seen as "women's work". From our survey of collective bargaining agreements and views of women workers, it is clear the devaluing of "women's work" is prevalent within the unions. It is therefore not surprising that the support and caring involved in HIV/AIDS work has been left to women in the workplace and in the unions.

Another key feature of the gendered nature of HIV/AIDS is how sexual relations are viewed. Macho masculine identities remain a feature of union culture and this identity is associated with multiple sexual partners and even a lack of caution in high risk sexual situations. The women shop stewards in the research process often spoke about emotional and psychological abuse in the union. In this context women seem to express a sense of fatalism about protecting their sexual health.

The union in many ways mirrors some of the relations women experience in the workplace.

"Women are treated like pre-school children. The boss does not want us to talk to each other and even though I am a leader I feel invisible."

"Men earn more money than women."

"Jobs that are done by women are valued less. If a man did a certain job before, the name of the job changes when it is given to a woman."

"The company does not consider my needs as a woman."

"There are no separate toilets or change rooms for us women especially if we are a small minority in the company. This creates problems for us as we have no privacy."

"No female condoms, only male condoms are distributed. Even in companies where the majority of the staff is female." [28]

Addressing HIV/AIDS in the workplace means dealing directly with the unequal power relations between men and women in the workplace and in the union. Throughout the research process a number of suggestions have been made: more discussions in the union on the gendered nature of HIV/AIDS; reviewing how reproductive work is valued; a more conscious focus on collective bargaining demands that takes reproductive work, particularly "caring work", into account; and practical demands like the demand for female condoms to be made available in all companies. The focus on female condoms is important not only in protecting women, but also in putting firmly on the agenda the rights of women in taking control of their own sexual health.

28 Views of women in the reference group


Children
Hope
Love
Scorpion
People
Very Soon

Using the law

From the research process there were three different views on how to engage with existing legislation. One view was that unions should have a more radical approach to the law and that it should be compulsory for all companies to have policies on HIV/AIDS with legislation to support this and penalties if companies do not comply. Another view was that the existing legislation was sufficient and that it is more important to negotiate how to enforce this existing legislation. A third view argued that the provisions of the existing legislation are too vague with reference to HIV/AIDS and that there is a great problem of adherence when the legislation is so general.

A number of suggestions for improving the legislation were proposed: that the Department of Labour should appoint inspectors to assess the levels of discrimination in companies; that the provision of family responsibility leave in the Basic Conditions of Employment Act is inadequate and that provision should be made for leave for caring of family members beyond just children; and lastly, that provision be made for long sick leave.

Keeping ahead of the employers

HIV/AIDS should be brought directly into the collective bargaining process as a strategy for protecting and advancing the interests of workers. This was the view of the majority of participants in the research process. Locating HIV/AIDS in the collective bargaining process would mean treating HIV/AIDS as not just a health issue but developing a strategy that takes into account the social conditions, gender relations and discrimination that workers experience. It will also need to be a strategy that focuses on grassroots and democratic processes to develop proposals, recommendations and demands.

From the research process the following recommendations emerged:

Collective bargaining should address matters such as medical cover, incapacity benefits, sick leave, benefits for orphans, burial benefits, and compliance of labour legislation. Also, to look at social conditions like family housing instead of hostels. The agreements should also include provisions in the workplace to assist in addressing the epidemic, for example, time off for peer education and training, practical measures to allow for voluntary counselling and testing, and wellness programmes that include the provision of antiretroviral treatment.

Agreements should be formally recognised collective bargaining agreements and not informal agreements with sympathetic management, as these are subjective and dependent on the mood and attitude of the management.

There is a need for union peer education and training for models for social transformation that are formally recognised in agreements. In this model peer educators are viewed as popular educators who see people as having the capacity to understand their rights and to organise and transform their conditions. Peer education should include not only the medical aspects of HIV/AIDS prevention, testing and treatment, but also the socio-political, socio-economic and gendered elements of the spread of the epidemic and responses to the epidemic. The peer education and training process should also focus on building co-operative and trusting relations, raise consciousness and lead to action. Action that, for example, empowers shop stewards to negotiate workplace policies.

The wellness programmes should encourage workers to disclose all chronic illnesses and provide assistance and treatment for these illnesses. Workers on company-based wellness programmes should have access to treatment even if they are temporarily based outside of the company, for example, when

on leave. Wellness programmes should be extended to family members.

Unions should engage employers using the Government's National HIV/AIDS Strategic Plan as a framework for developing collective bargaining agreements.

Moving beyond the shop floor

Building partnerships and alliances needs to be a central component of any trade union strategy addressing HIV/AIDS. The Treatment Action Campaign (TAC) has been at the forefront of developing strategies for dealing with HIV/AIDS and has a large number of activists working in a range of different contexts. A sharing of experiences between these activists and worker leaders at a local level can play an important role in strengthening union strategies.

There are also a number of existing models of workplace-community co-operation being initiated by union activists. These include workers in the retail sector (including customers) in awareness raising programmes; retrenched or retired workers in the clothing and textile industry working in home base care projects; and joint company and union-driven community projects, for example, orphanages.

Building strong partnerships that extend to the community is important in shaping alliances outside of management-driven initiatives, alliances that can be based on mutual experiences, needs, respect and compassion.

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