PRIVATE & CONFIDENTIAL

Final report

HIV/AIDS Pilot Project submitted to:

merSETA

MANUFACTURING, ENGINEERING AND RELATED SERVICES SETA

Project managed by:

Self Empowerment International (Pty) Ltd

Date: 31 March 2011

Contents

EXECUTIVE SUMMARY

Self Empowerment International (SEI) were appointed by MERSETA to conduct a pilot project on assisting small and medium-sized enterprises to develop an HIV/AIDS strategy for their workplace. The pilot project was conducted for 37 companies.

Key Findings:

- 48.7% (19) of the participating employers indicated that they have a policy in place but only 12.8% (5) have a strategic plan in place. Many of those with a policy in place indicated that it had not been updated in at least the past two years.

- 25.6% (10) of the participating employers indicated that they had assessed prevalence in their workforce. The prevalence estimates ranged from 3% to 15% with an average in the order of 10%.

- Approximately half the employers have some form of onsite care through a clinic service or nursing sister (visiting or permanent) and this is a good starting point for implementing general and HIV-specific wellness interventions.

- Adult Basic Education and Training, Performance Management, Remuneration review and Succession planning are the least frequently offered programmes. Funeral and Life Insurance cover are the least frequently offered employee benefits.

- We have applied a scoring system to the questions in the survey to facilitate the comparison of the results. A score closer to 1.00 indicates higher overall knowledge, attitude and practice towards HIV/AIDS. The overall score for employees that completed the surveys was 0.65 with the highest rating for knowledge of HIV/AIDS followed by awareness of risky behaviour, awareness in the workplace, attitude and finally VCT. This suggests that introducing VCT in these workplaces is an important next step.

- For the 2994 employees of participating companies for whom data was provided, it is estimated that the HIV prevalence is 10.8%($CI_{95\%}$: 9.6-11.9%). The additional cost associated with HIV for this group is R2235 per employee per annum over the next 5 years. The intervention of providing anti-retroviral therapy to employees using a treatment protocol of CD4 at 350 has the highest programme costs but also generates the highest level of savings as the Wellness programme only scenario. The net savings are expected to be in the order of 21.6% of the status quo cost. These savings are increased if some of the treatment costs are covered by the medical scheme or through the Government programme.

The following key learnings for each section were determined from the HIV/AIDS Pilot Project. These learnings will be critical to the success of the main project.

Planning:

- The reporting requirements to MERSETA were not clearly understood in terms of:
    - Project milestones – the requirements for companies to be completed individually rather than on a comprehensive project basis was not understood.
    - Reporting requirements – the documentation required from participating employers was not provided up front and this lead to additional interactions with participating employers being required (and not provided for in the project plan). This also caused confusion and irritation among participating employers.
- It is recommended that milestones and reporting requirements are defined up front and communicated to all stakeholders.

Recruitment:

- The commencement of the project was delayed because a database of eligible companies was not available.
- A comprehensive database of eligible employers is required for the recruitment process including current contacts details.
- An intensive communication process (telephonic and one-on-one) is required to persuade companies to participate.
- A printed media campaign should also be conducted in order to give impetuous and substance to the programme.
- Many companies that see the value of an HIV management programme have already established programmes and were reluctant to allocate time and resources to this project.
- Retention after recruitment is also a challenge and is very time-intensive.
- Companies need clarity up front about what is required of them from an information and time perspective and do not respond well to this being changed during the project.
- Companies require the credibility of the project to be established to commit time and resources.
- In this sector HIV is still a difficult topic to relate to between management and employees. Companies were found to have unsuccessfully attempted implementation of projects before and this led to a firm belief that this project would be no better/successful.
- More often than not, particularly in companies of this size (50-149 employees), the person (generally HR) who sees value and signs the form does not have the ultimate authority when certain components of the project are required e.g. training time and data.

Training:

- Participants were required to attend a 6 day workshop programme and complete a Portfolio of Evidence.
- The level of the training needs to be appropriate for the attendees (or the requirements made clear up front).
- It is difficult to get companies to allocate 6 days of time from key employees for training, particularly in employers of this size.

- It is also difficult to get employees to do additional work outside of the training sessions to prepare a Portfolio of Evidence and more assistance is required to guide them through this.
- Even when employers have committed to sending employees to training sessions they fail to arrive due to work pressures.
- The requirements in terms of attendance and completing a Portfolio of Evidence need to be made clear in advance.
- It has been very difficult for there to be two competitive companies providing components of the project that overlap such as training. Neither company wishes to relinquish their intellectual property (understandably) and this creates a void for the trainee.
- The training needs to be seamless and integrated with the entire project.
- It is recommended that a less intensive training process is considered.

Data collection:

- Participants were required to provide demographic data and also to provide staff with KAP surveys for completion on an anonymous basis.
- The data specification needs to be incorporated in the training process and thoroughly covered during the initial interview process.
- Data requests should be made at the beginning of the project and followed up in parallel to the other components.
- Requests for salary data within the same industry was met with much distrust. This is apparently a highly confidential area and apparently in some engineering circles it seems as though corporate espionage on this information is rife. In some cases this caused companies not to want to provide any information.
- A template of the report, or example of a previous report, will be useful to demonstrate the value of providing data in as much detail as possible.
- There was some concern that information may be referred back to the SETA which further complicated matters. Some form of legal *guarantee* must be provided in terms of confidentiality.

Knowledge, Attitude and Practices Survey (KAP):

- Some companies seemed reluctant to issue the forms to their staff because of the work involved in communicating and collecting.
- There was some concern around the confidentiality of responses, despite the use of sealed envelopes for submitting anonymous questionnaires.
- There was also concern from some employers that the KAP survey created an expectation for additional benefits to be provided.
- It may be useful to issue the forms in other languages

Economic Impact Analysis (EIA):

- Participating employers have responded positively to the information provided in the EIA reports.
- Employers who were not able to provide the full data requirements benefited from receiving the general report.

- Some of the overall prevalence estimates were close to what a small number of the companies had estimated but most had either not made an assessment, or their assessment was out of date.
- The companies found the financial quantification of costs and benefits very interesting and useful. Only one of the companies had attempted to do this previously.

Toolkit:

- Only 19 of the participating companies had a policy document and only 5 had a strategic plan. Many noted that these were out of date (more than 2 years old).
- The development of policy and strategy is a process that needs to be planned carefully and include all stakeholders, particularly labour. HIV/AIDS is a difficult issue because of the associated stigma and so a cautious approach is required. The companies thus need time to assimilate the information they have acquired through this project to develop the documents.
- The templates were well-received as it is difficult to start from scratch.
- The training DVD was particularly well-received as a way to start addressing HIV more actively in the workplace.

Overall Comments:

According to the brief that was provided this was a successful project. All companies have a manual that explains the manner and form in with which they should be dealing with HIV. They have at their fingertips a substantial resource (the manual) containing additional resource links to enable them to implement comprehensive changes within their respective organisations should they so wish. Some of the companies that did not participate in various components of the project can be drawn into the main project so that they are able to gain the benefit of having all aspects completed.

The Strategic Support Plan that the MERSETA wishes to implement will provide a good platform from which these initial pilot companies can implement their solutions and gain maximum results.

1. Introduction

In May 2010 SEI was appointed to provide assistance to MERSETA member companies with respect to HIV management in the workplace. The second King corporate governance report introduced the concept of evaluating the environmental and social bottom lines as well as the financial bottom line. This means that investors are looking for corporates to have:

- a legally sound and documented company HIV/AIDS policy;
- publication and implementation of the policy;
- measurement of the financial exposure to the disease;
- preventative initiatives provided to employees;
- management of the whole workplace with regard to health and safety in an HIV/AIDS environment.

The MERSETA Project aims to recruit MERSETA member companies and provide them with:

- An assessment of their current workplace practices with respect to HIV/AIDS
- Training on managing HIV in the workplace (provided by Redpeg)
- A survey of Knowledge Attitudes and Practice (KAP) with respect to HIV amongst employees
- An Economic Impact Analysis (EIA) of HIV on their organization
- A Toolkit for managing HIV
- Guidance on an HIV Workplace Policy
- Advice on interventions

The project has been addressed in the following phases:

- Planning
- Recruitment
- Training
- Data collection
- KAP survey analysis
- EIA survey analysis
- Toolkit and Policy development
- Company Feedback
- Reporting

The latest version of the project plan is appended to this report. The approach taken was to work sequentially through the project steps across all recruited companies so that their experience and results can be benchmarked against the project aggregate. This enabled the companies to interpret their results in both relative and absolute terms.

This report provides an update on the experience of the project and **key learning's**in each section as the project progressed. It is important to note that this is a pilot project and so the learning's will be important input into the final project design.

2. Planning

The planning process commenced in May 2010 and included:

- The recruitment of a project manager to manage the liaison with participating employers.
- The development of communication material for the recruitment process including a letter of commitment;
- The development of the data requirements including the employer questionnaire, employee questionnaire and employee data specification;
- Establishing the project plan with feasible timelines to meet the project milestones and deliverables;
- Liaison with the training providers (Redpeg) to ensure that their requirements are incorporated in the project plan.

Key learnings:

- **The reporting requirements to MERSETA were not clearly understood in terms of:**
    - **Project milestones – the requirements for companies to be completed individually rather than on a comprehensive project basis was not understood.**
    - **Reporting requirements – the documentation required from participating employers was not provided up front and this lead to additional interactions with participating employers being required (and not provided for in the project plan). This also caused confusion and irritation among participating employers.**

3. Recruitment

The commencement of the recruitment process was hindered by the time it took to obtain a database of eligible MERSETA companies with contact details. One week was allowed for in the project plan but it took almost six weeks for this data to be obtained. The data provided was also not clear as to the size of the companies and this lead to companies outside of the range of 50 to 149 employees being included.

The process of contacting employers and persuading them to participate was also very challenging. Small employers find it difficult to release their key employees for extended periods of time for training and are also reluctant to allocate time to the data collection process.

A total of 396 companies were contacted in order to recruit the final 37 companies. 4 of the originally recruited companies also dropped out of the process before completion and additional efforts were requirement to replace these. It is worth noting that 2 of the companies that dropped out did so because their initial interactions with the project manager persuaded them that it was necessary to recruit a dedicated service provider to implement their HIV/AIDS workplace programme.

The recruitment process was also hindered by the business disruption caused by the World Cup and the difficult economic circumstances facing many companies in this sector – and hence their reluctance to distract their focus from core business activities.

Key learnings:

- **A clear database of eligible employers is required for the recruitment process including current contacts details.**
- **An intensive communication process (telephonic and one-on-one) is required to persuade companies to participate.**
- **A printed media campaign should also be conducted in order to give impetuous and substance to the programme.**
- **Many companies that see the value of an HIV management programme have already established programmes and were reluctant to allocate time and resources to this project.**
- **Retention after recruitment is also a challenge and is very time-intensive.**
- **Companies need clarity up front about what is required of them from an information and time perspective and do not respond well to this being changed during the project.**
- **Companies require the credibility of the project to be established to commit time and resources.**
- **In this sector HIV is still a difficult topic to relate to between management and employees. Companies were found to have unsuccessfully attempted implementation of projects before and this led to a firm belief that this project would be no better/successful.**
- **More often than not, particularly in companies of this size (50-149 employees), the person (generally HR) who sees value and signs the form does not have the ultimate authority when certain components of the project are required e.g. training time and data.**

4. Training

The training course provided by Redpeg for the MERSETA HIV/AIDS pilot project comprised of 6 modules offered over a 6 day course. The training for groups recruited by SEI was originally scheduled in the project plan to be held across 4 sessions of 3 days each during August – October. We managed to obtain a venue on the East Rand that was central to the majority of the participating companies. Ultimately the best dates for the first round of training were found to be 1-3 September with completion 15-17 September. The second round of training was held over 4 days from 18-22 October 2010. Unfortunately, the second round could only be held over 4 days as Redpeg were unable to provide trainers for the originally planned and scheduled week of 11-15 October.

Training session 1a (Mods 1-3):
This training took place from 1 to 3 September. Training was arranged for 30 companies as we had the venue and most of the companies had replied positively to the invitations and subsequent follow ups. Unfortunately, in the week preceding the training we had 6 apologies and a further 8 failed to arrive on the day (see attached schedule). We found that many of the companies sent staff that were too junior for the level of the training that was to be provided. There is thus a chance that those individuals that were booked for training but did not arrive,did not understand the training requirements. Ultimately those that did attend seemed to have gained a degree of insight into HIV/AIDS that they did not have before. During the interviews after the training I have had positive feedback from management and employees alike.

Training session 1b (Mods 4-6):
This training took place from 15 to 17 September. The full complement of trainees from the first session returned for these mods. We had a number of queries from those that did not attend the first training session as to whether or not they could attend this one. It was deemed unwise to permit them to start in the middle of the programme and they were requested to make themselves available for the next sessions.

Training session 2 (Mods 1-6):
This training session was held between 18-22 October excluding Tuesday as the venue was not available. The confirmed tally of 11 was unfortunately whittled down substantially when we had to change the dates but in the end we still managed to ensure 5 attendees. Having learnt from some of the calibre of attendees that attended the first sessions we were adamant about who attended this session resulting in all 5 attendees being either senior management or high level HR personnel. This resulted in a much more interactive workshop but also caused it to run out of time.

We attempted to arrange a follow up day with Redpeg to provide assistance and guidance in respect of completing the Portfolios of Evidence. We were only advised by Redpeg in mid-November that there was a requirement for those attending training to submit a Portfolio of Evidence. Had this requirement been made clear initially we would have been in a better position to support the individuals attending the training to complete this.

Training session 3:

In order to ensure that the remaining companies at least have one more chance at attending a training session we issued invitations to attend a session on 18-24 February 2011. Invitations were sent out to various of the participating companies in early December 2010 to advise them of a training session that was being organised for February 2011. We had no response on this email. A second mail was sent to these companies in mid January with a follow up call before the deadline. Unfortunately, once again none of them were available to attend during those times. We did however have interest from one of the new companies (Avlock International) but in the end the venue was too far for the representative to attend.

Feedback:

Complete feedback on the training session will be provided through the feedback surveys that we will conduct on completion of the project. However, comments to date:

"I thought I knew everything there was to know about HIV/AIDS in the workplace"
"This course has highlighted many problems for our organisation as well as given insight to the solutions"
"The problem may be bigger than we thought"
"I didn't know many of the HIV facts relayed to me"
"Very Impressive"
"The food was fantastic"
"Would love to learn more"
"Looking forward to receiving the results"

Schedules:

Booked for Session 1:

Company Name	Invited	Attended
Suzuki South Africa_Pty Ltd	Johan Cloete*	No
Evapco South Africa Pty Ltd	King Ndinisa*	King Ndinisa
Specstrip (Pty) Ltd	Albert van Wyk*	ThembaMaseko
East Rand Plastics	Angela van der Holst*	JabulaniSibanyoni
Bosworth - A Div Of Hudaco Trading Ltd	Helen Naude*	No
Archie Engineering Cc	Cindy Hoffman*	No
FB Crane Builders & Repairs (Pty) Ltd	Karen Mullaney*	Karen Mullaney
Smith Capital Pty Ltd	Isaac Mergui*	ThamsanquaMseko
Actom Head Office	Dawie Oberholzer*	No
Alsthom South Africa -(Pty) Ltd	NellisaTwalo*	No
Actom Static Power	Jill Burrows*	No
Norsa Electronics	SihleNtombela*	SihleNtombela
Chi Control	Portia Safriti*	No
Meissner	Lindie Marais	No
Contact Engineering	Ernie Miller*	No
Electrical Machines	Pauline Moekoena*	Margaret Molapo
Current Electric	LebohangMaquenane*	LebohangMaquenane
Distribution Transformers	SabeloSibiya*	SabeloSibiya
Actom MV Switchgear	Garth de Kock*	Garth de Kock
Actom Power Transformers	Pat Tshoma*	ThembaMaluleke
Actom Protection & Control	NokuKhanya Zulu*	NokuKhanya Zulu
T & D High Voltage	Joy Venter*	NkosinathiMasina
Actom Industry	Amanda Terblanche*	No
Alstom Power	Rani Dhaver*	No
John Thomson Boilers	John Paul Andre (asked for Isando rep)	No
Actom Signalling	Victor Rhadeba*	Moses Shilubane
African Electroplating	Don Spooner*	No
Gordon &Posniak	Peter Posniak	No
City Packaging (Pty) Limited	Peter Gouden*	Moepi Daniel Sookoco
Canopy Hoekie	Riete Atkins*	No
Consolidated Auto (Pty) Ltd	Cindy Williams*	No
McCarthys (General Motors)	Paulina Maphuta*	No

* Booked

List of participants booked for session 2:

Company Name	Invited	Attended
Suzuki South Africa_Pty Ltd	Johan Cloete	No
Bosworth - A Div Of Hudaco Trading Ltd	Helen Naude*	No
Archie Engineering Cc	Cindy Hoffman*	Cindy Hoffman
Actom Head Office	Dawie Oberholzer*	Dawie Oberholzer
Alsthom South Africa -(Pty) Ltd	NellisaTwalo	No
Actom Static Power	Jill Burrows*	No
Chi Control	Portia Safriti*	No
Meissner	Lindie Marais*	Lindie Marais
Contact Engineering	Ernie Miller	No
Actom Industry	Amanda Terblanche*	No
Alstom Power	Rani Dhaver	No
John Thomson Boilers	John Paul Andre (asked for Isando rep)	No
African Electroplating	Don Spooner*	No
Gordon &Posniak	Peter Posniak	No
Canopy Hoekie	Riete Atkins	No
Consolidated Auto (Pty) Ltd	Cindy Williams*	No
McCarthys Training	Dudu Motswiri	Dudu Motswiri
McCarthys (General Motors)	Paulina Maphuta*	Bellindah Mello

* Booked

Key learnings:

- **The level of the training needs to be appropriate for the attendees (or the requirements made clear up front).**
- **It is difficult to get companies to allocate 6 days of time from key employees for training.**
- **It is also difficult to get employees to do additional work outside of the training sessions to prepare a Portfolio of Evidence and more assistance is required to guide them through this.**
- **Even when employers have committed to sending employees to training sessions they fail to arrive due to work pressures.**
- **The requirements in terms of attendance and completing a Portfolio of Evidence need to be made clear in advance.**
- **It has been very difficult for there to be two competitive companies providing components of the project that overlap such as training. Neither company wishes to relinquish their intellectual property (understandably) and this creates a void for the trainee.**
- **The training needs to be seamless and integrated with the entire project.**

5. Data Collection

The data collection process involved:
- Employer survey forms completed by employers (Appendix 3);
- KAP survey forms completed by employees (Appendix 4);
- Employee data requirements as specified in the employer forms.

The data collection process involved one-on-one interactions with the participating employers. During each interview the employer survey form was completed (i.e. by sitting with each company representative rather than sending it to them for completion) and the process for conducting the KAP surveys and the data requirements explained. While this was time-consuming it did lead to the collection of useful information (refer Appendix 5) and provided a good opportunity to explain the benefits of participating in the project.

Participating employers were provided with KAP survey forms for all of their staff and self-seal envelopes for employees to use for form submission to preserve confidentiality.

The initial employer interviews were conducted over an8 week period. These were followed by the collection of the KAP survey forms. 700 forms were collected from 18 employers.

The submitted KAP forms were coded with unique numbers and captured on a master spreadsheet for analysis.

The employer survey forms were captured on a spreadsheet for summary purposes and where applicable employers were asked to submit their:
- HIV policy document
- HIV strategy document

For some participating employers the information on the level and costs of their employee benefits was not immediately available and follow-ups were required to complete the process.

The collection of individual employee data for the Economic Impact Analysis proved very challenging. The data specification was simplified as far as possible but the challenges encountered included:
- employers not having data accessible in the required form (a simplified spreadsheet template was provided);
- reluctance to provide individual data (employers were able to provide this on an anonymous basis).
- Salary information is a critical stumbling block as it is apparent that the competition in this industry is intense leading to the non submission of information to *any* third party.

The data that has been submitted enabled us to provide 31 customised EIA reports and 6 general EIA reports.

Key learnings:

- **The data specification needs to be incorporated in the training process and thoroughly covered during the initial interview process.**
- **Data requests should be made at the beginning of the project and followed up in parallel to the other components.**
- **Requests for salary data within the same industry was met with much distrust. This is apparently a highly confidential area and apparently in some engineering circles it seems as though corporate espionage on this information is rife. In some cases this caused companies not to want to provide any information.**
- **A template of the report, or example of a previous report, will be useful to demonstrate the value of providing data in as much detail as possible.**
- **There was some concern that information may be referred back to the SETA which further complicated matters. Some form of legal *guarantee* must be provided in terms of confidentiality.**

6. KAP Survey Analysis

The Knowledge, Attitude and Practice (KAP) survey was conducted by means of a questionnaire (refer annexure 4) issued to employees with questions covering:

- their Knowledge of the causes of HIV/AIDS and how it is treated;
- their Attitude towards HIV risk and those who are HIV positive; and
- their Practice with regard to behaviour that is associated with a higher risk of HIV infection.

Employees were invited to complete the questionnaire on an anonymous basis. It is intended that the results of this survey will assist the employer in designing an HIV management programme that takes account of the employees' level of understanding and current practices.

734 of 3621 employees in 20 participating employers completed and submitted KAP questionnaires; this is a 20% response rate for the Group.

A scoring mechanism was used to rate each company that had submitted forms. A score closer to 1.00 indicates higher overall knowledge, attitude and practice towards HIV/AIDS which shows increased awareness which impact the risk of HIV and AIDS on individuals as well as your business activities.

KAP Score card:

Variable	Group
Knowledge of HIV/AIDS	0.79
Attitude towards HIV/AIDS	0.61
Risky behaviour (sexual)	0.65
VCT usage and awareness	0.58
HIV/AIDS awareness in the workplace	0.63
Overall Score	0.65

The overall KAP score for the Group is 0.65. Companies that completed the KAP surveys received a detailed report that benchmarked their results against the Group. The balance received the general KAP report (see Appendix 6)

The KAP survey analysis enables employers to identify where their training efforts should be focussed.

Key learnings:

- **Some companies seemed reluctant to issue the forms to their staff because of the work involved in communicating and collecting.**
- **There was some concern around the confidentiality of responses, despite the use of sealed envelopes for submitting anonymous questionnaires.**
- **There was also concern from some employers that the KAP survey created an expectation for additional benefits to be provided.**
- **It may be useful to issue the forms in other languages.**

7. Economic Impact Analysis

A key challenge in this process is the statistical credibility associated with modelling impacts on small groups. This has been addressed by:

- including confidence intervals in the reporting framework;
- combining sub-groups as far as possible;
- including benchmarking of results against the survey total.

The HIV/AIDS Economic Impact Assessment is broken down into three phases. The first phase assesses the prevalence of HIV/AIDS in the workplace status quo (under current conditions). The second phase of the project extends the assessment to a financial impact under the status quo scenario. The final phase involves assessing the financial impact of having a private HIV wellness and anti-retroviral treatment programme for all employees.

The Status Quo scenario assumes that the employee profile, knowledge of HIV, training and availability of services or treatment relating to HIV to be the same as currently available.

The HIV prevalence has been assessed with reference to an HIV assessment model based on the Actuarial Society of South Africa ASSA2003 population and select models. The results were also assessed with reference to a pre-release version of the ASSA2008 model but we are unfortunately not yet permitted to use these results.

The financial impacts were assessed with reference to the key financial assumptions derived from the data provided and a set of benefit assumptions as set out in the report (see Appendix 7).

Note that the results provided in these reports are based on a statistical analysis of the demographic information provided on the employees of the participating companies and not actual testing of individuals. The model that has been used is based on the ASSA2003 model of the Actuarial Society of South Africa. The results in this report are intended to support strategic decision making with respect to managing HIV risk and it is recommended that employees are encouraged to undergo Voluntary Counselling and Testing so that they can know their HIV status. All results should be interpreted in the context of the pilot project and the assumptions made. Estimates are based on model outputs and some variation around these should be expected. The variation of results is exacerbated by the lower number of employees.

Individual employee information for 2994 employees (29 companies) has been supplied for the Group. The information has not been audited but we have conducted reasonability checks.

The key risk factors from an HIV prevalence perspective are age; gender; race; income; region (province); employee category (management/other). The individual information supplied for the assessment is summarised as follows:

Summary of information:

	Group
Total employee count	2994
% Females	17%
Age (average)	41.3
Age (minimum)	19.0
Age (maximum)	78.0
% Employees classified as 'African' (Other employees)	63.2%
% Employees classified as 'African' (All employees)	50.6%
Average gross salary (2010 Rands per employee per month)	9,852
Average pensionable salary (2010 Rands per employee per month)	7,882
Pensionable salary/Gross salary	80%

Note:

- Where there was insufficient information (e.g. information not provided on key parameters such as salaries, date of birth, ethnic group, retirement fund cover and benefit) the general assumptions are based on the Group averages;
- Pensionable salary is assumed to be 80% of gross salary;
- All employees of the Group have been allocated to the Gauteng province.

The estimated HIV Prevalence (% HIV+ employees of total active employee count) and 95% Confidence Intervals are as follows:

Projected HIV Prevalence

Estimated prevalence	2010	2011	2012	2013	2014	2015	…	2020
Average	10.8%	10.8%	10.7%	10.7%	10.6%	10.4%		9.8%
Lower 95% CI	9.6%	9.6%	9.6%	9.5%	9.5%	9.3%		8.8%
Upper 95% CI	11.9%	11.9%	11.8%	11.8%	11.7%	11.5%		10.9%

Based on the information provided, assumptions (detailed in the Appendix 7) and methodology outlined in the report, it is estimated that the HIV prevalence for the Group in 2010 is 10.8% ($CI_{95\%}$: 9.6-11.9%) reducing to 9.8% ($CI_{95\%}$:8.8%-10.9%) in 2020. The trending reduction of prevalence into the future is primarily due to the increased number of exits (HIV related deaths and ill-health retirement). Note that

these projections have been made on a STATUS QUO scenario. The estimates are based on model outputs and some variation around these should be expected.

The infection rate is assumed to differ per employee category (management and other). This impacts both the rate of new infections and the progression of the epidemic. Any changes to the allocations to the employee categories above will therefore impact the output results. The prevalence rates may differ by employee category:

Estimated count of HIV+ employees and % prevalence for 2010:

	Group 2010		
Employee category	Count of active employees	% HIV+	95% confidence interval range
Management	712	2.1%	(1.1 - 3.2%)
Other	2,282	13.5%	(12.1 - 14.9%)
Overall	2,994	10.8%	(9.6 - 11.9%)

76% of the employees are allocated to the 'Other' employee category, where the prevalence can to be as high as 14.9%.

The quantification of the financial impact of HIV/AIDS has been assessed at a number of levels:

- **Death and disability benefit impacts**: The death and disability benefit impacts will be felt through increased premiums for these benefits.
- **Supervisory load**: increased staff replacement rates will necessitate increased allocations of supervisory time (and a higher ratio of supervisors to reporting staff).
- **Recruitment and overtime costs:** costs to replace staff lost through ill-health retirements and deaths associated with HIV/AIDS and additional staff required as a result of leave requirements and reduced productivity of HIV positive employees.

The financial impacts assessed are forecasted for a 5 year period and have been calculated with reference to the following benefit assumptions:

Summary table of assumptions:

Parameter	Group (general assumptions)
Gross salary	Group average gross salary per employee (gender and employee category specific) gives an average gross salary of R10 737 per employee per month
Pensionable salary	80% of gross salary
% Employees on retirement fund	100%
Employee category: Management Other	Where salaries were provided (23 companies) we assumed 'Management' to be all employees with salary exceeding R15 000 per month. The remaining

	employees were allocated to the other employee category. Where no or partial salary information was provided (6 companies) we used the occupational information in the data to allocate these employees.
Death benefit (GLA):	
Multiple of basic salary	3 times annual pensionable salary, or as disclosed by company
Disability benefit (PHI):	
Multiple of basic salary	75%
Waiting period	3 months general waiting period

The cost impact of HIV/AIDS is closely linked to the salary information for each employee category and is based on the projected HIV prevalence. These projections are initially prepared on the basis of a STATUS QUO scenario.

The 2010 costs reflect the estimate of current additional HIV expenditure (compared to an environment with no HIV infections). All results are in 2010 Rands (i.e. no inflation).

The Group's current additional HIV expenditure (R'000):

Group (R 000's)	2010	2011	2012	2013	2014	2015	2010 to 2015
Death and disability benefits	2,842	2,885	2,936	2,976	3,002	3,010	17,651
Supervisory	455	460	462	462	460	456	2,755
Recruitment and overtime	3,235	3,285	3,315	3,323	3,310	3,280	19,749
Total cost (R 000's)	6,531	6,631	6,713	6,761	6,771	6,746	40,154

For the Group, 44% of the estimated aggregated additional expenditure over the next five years is attributable to the Retirement Fund benefits (in terms of additional death and disability costs), 49% is attributable to Recruitment and Overtime costs and 7% is attributable to supervisory expenses.

The Group's overall current additional HIV expenditure:

	Group 2010 to 2015
Total cost (Rands per active employee per annum)	2,235
Total cost (Rands per HIV+ employee per annum)	21,001
Total cost (% of gross annual earnings)	1.89%

These expenditure effects have been assessed with reference to a number of assumptions (set out in annexure C of this report) and these results are sensitive to variations in these assumptions.

The estimated additional cost attributable to HIV/AIDS impact is expected to be approximately 1.89% of gross payroll.

The cost of running the Wellness Programme is estimated to be R1,295k for the Group over the period 2010 to 2015. This is 3.2% of the total cost associated with HIV/AIDS for this period. It is estimated that the programme will result in an additional cost of R889k over the period and so there is an increase in the net costs associated with HIV/AIDS under this scenario.

For the programme including anti-retroviral treatment, the cost of the Programme is estimated to be R3,397k over the period 2010 to 2015. This is 8.5% of the total cost associated with HIV/AIDS for this period. It is estimated that the programme will result in nett savings of R8,665k for the period so the net effect is a 21.6% reduction in the total costs associated with HIV/AIDS for the 2010 to 2015 period.

If the employees are able to access treatment through a Government-funded clinic, then the cost of treatment will be reduced proportionately and the net savings increased.

Key learnings:

- **Participating employers have responded positively to the information provided in the EIA reports.**
- **Employers who were not able to provide the full data requirements benefited from receiving the general report.**
- **Some of the overall prevalence estimates were close to what a small number of the companies had estimated but most had either not made an assessment, or their assessment was out of date.**
- **The companies found the financial quantification of costs and benefits very interesting and useful. Only one of the companies had attempted to do this previously.**

8. Toolkit and Policy Development

The participating employers have received extensive generic input on HIV management in the workplace through the training programme. The Toolkit aims to provide a reference point on key aspects under the following headings:

1) Basic Information
2) Management of HIV in the workplace:
3) Early diagnosis and treatment
4) Progression of the disease
5) Employers/Management/Human Resources
6) What an employer can do
7) What an employee can do
8) If HIV positive

This Toolkit has been compiled from the following sources:

Resources employed to design this toolkit:

http://www.avert.org/hiv-types.htm
http://health.nytimes.com/health/guides/disease/aids/overview.html?inline+nyt-classifier
ILO programme SOLVE – MicroSolve
http://aids.about.com/od/hivprevention/a/pep.htm - determining whether or not PEP is appropriate
http://hab.hrsa.gov/tools/primarycareguide/PCGchap11.htm#PCGchap1
Dr Susan Steinman

Just over half of the participating employers have indicated that they have an HIV Policy in place and this has been submitted (with strategy documents, where these are available). The policy document includes sample approaches under the following headings:

1. Policy Purpose:
2. Glossary
3. Preamble
4. Policy Principles
5. Confidentiality
6. Legal Issues
7. Termination Of Employment
8. Record Keeping
9. Human Resources Issues
10. Information
11. Application
12. Responsibility
13. Grievance Procedures
14. HIV/AIDS Assistance Resources

This has been compiled from the following sources:

SEESA – www.seesa.co.za
Dr Susan Steinman
www.hivatwork.org.za

Participating employers also receive a DVD of training material to enable them to commence an HIV/AIDS training programme if this has not already been started.

For participating employers who have made a policy submission, an evaluation will be included in their report with recommendations. For the balance of the employers, implementation recommendations will be included.

Key learnings:

- **Only 19 of the participating companies had a policy document and only 5 had a strategic plan. Many noted that these were out of date (more than 2 years old).**
- **The development of policy and strategy is a process that needs to be planned carefully and include all stakeholders, particularly labour. HIV/AIDS is a difficult issue because of the associated stigma and so a cautious approach is required. The companies thus need time to assimilate the information they have acquired through this project to develop the documents.**
- **The templates were well-received as it is difficult to start from scratch.**
- **The training DVD was particularly well-received as a way to start addressing HIV more actively in the workplace.**

9. Company Feedback

A feedback form was included to provide feedback on the process and outcomes of the pilot project. A telephonic strategic questionnaire is also being conducted to assess the plans that participating companies have for implementation of workplace HIV policies and interventions.

Project Feedback Questionnaire

Introduction

The questionnaires were included in all the files delivered to the participating employers and we requested submission within 2 weeks of the delivery of the files but extended the deadline to 18 March. 15 participating employers completed and faxed the Feedback questionnaire, in the remainder of this annexure we refer to these 15 participants as 'participants'. This report provides a high-level analysis of the responses. The questions aimed to assess the employer (contact person's) experience during the project.

A: Initial contact

The participants were asked about their initial contact experience. The responses on their initial contact experience are as follows:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
The requirements to participate in the pilot project were explained to me.	8	7	0	0	0	0
I understood the key objectives of the project.	8	7	0	0	0	0
I see the necessity of this project.	13	2	0	0	0	0
HIV/AIDS is an important workplace issue for my organisation.	13	2	0	0	0	0

Note:

- 53% of respondents 'strongly agree' and 47% 'agree' that the requirements to participate in the pilot project were explained.
- 53% of respondents 'strongly agree' and 47% 'agree' that they understand the key objectives of the project.
- 87% of respondents 'strongly agree' and 13% 'agree' that they see the necessity of this project.
- 87% of respondents 'strongly agree' and 13% 'agree' that HIV/AIDS is an important workplace issue for their organisation.

B: Training

The majority of the participants who attended training were happy with the overall structure, venue and contents of the training. 47% (7) of the participants (or one of their representatives) attended the SAQA accredited training session provided as part of this project. For these 7 participants who attended training the responses on training are as follows:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
1. It was feasible for me to attend a six day training course.	4	3	0	0	0	0
2. The training dates were convenient for me.	3	4	0	0	0	0
3. The training location was convenient for me.	6	0	0	1	0	0
4. The training location was pleasant	6	0	1	0	0	0
5. The catering was of a good quality	6	1	0	0	0	0
6. The presenter was easy to understand.	4	2	1	0	0	0
7. The material was useful.	4	3	0	0	0	0
8. The training met my expectations.	7	0	0	0	0	0
9. The training requirements were easy to fulfil.	4	3	0	0	0	0
10. The SAQA accreditation is important to me.	5	0	1	1	0	0
11. I would like to have additional training on HIV/AIDS	5	0	1	1	0	0
12. I was able to complete my PoE (if not please provide reasons why under the comments section)	3	3	0	0	0	1

50% (4) o f the participants who did not attend training did not give any feedback or recommendations to indicate whether they would have attended training should anything have been different, their responses:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
1. It was feasible for me to attend a six day training course.	3	1	1	1	0	2
2. The training dates were convenient for me.	2	2	1	1	0	2
3. The training location was convenient for me.	1	1	2	1	1	2

C: KAP survey

The majority of the participant found the information contained in the KAP Survey to be useful to developing of their training strategy that would focus on the weakness and strengths identified in the KAP survey. Two companies indicated that they still need to complete the KAP survey.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
1. I understood the objectives of the KAP survey.	9	6	0	0	0	0
2. I was able to get my employees to participate in the KAP survey.	5	5	2	1	0	2
3. My employees were able to understand the questions in the KAP survey.	6	4	2	1	0	2
4. The process of collecting the surveys was efficient.	8	3	1	0	0	3
5. The comparison of my KAP survey responses to the other participants was useful.	6	5	1	0	0	3
6. The results of the KAP survey are useful for developing my training strategy.	8	5	1	0	0	1

D: Economic Impact Evaluation

The majority of the participants found the information contained in the Economic Impact Assessment to be useful and easy to understand.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
1. I understood the objectives of the EIA.	10	5	0	0	0	0
2. The data requirements were explained to me.	8	7	0	0	0	0
3. The data requirements were feasible to fulfil.	8	6	1	0	0	0
4. The EIA report provided useful information.	9	6	0	0	0	0
5. The comparison of my EIA results to the other participants was useful.	10	5	0	0	0	0
6. The EIA report was easy to understand	9	6	0	0	0	0

E: Policy and practice

Majority of the participants found the policy and practice to be very useful not only to assess the current position but to give a way forward and tools to get there. The summaries of responses are as follows:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
1. The evaluation of my workplace practices was useful.	6	7	1	0	0	1
2. I shall be making adjustments to my workplace practices.	7	7	1	0	0	0
3. The policy evaluation provided useful feedback.	8	7	0	0	0	0
4. The toolkit will assist me with improving my workplace strategy with respect to HIV and AIDS.	10	5	0	0	0	0
5. Have perused the strategic	9	5	0	1	0	0

training DVD provided to me.						
6. I will be utilising the strategic training DVD for my company.	9	5	1	0	0	0
7. The toolkit will assist me with improving my training strategy with respect to HIV and AIDS.	8	6	0	1	0	0
8. The recommendations on interventions were useful.	5	8	2	0	0	0
9. I will be implementing interventions with respect to HIV and AIDS as a result of this project.	6	8	1	0	0	0

F: Overall

Majority of the participants had a positive overall response to the way the project was conducted and very happy with the service they received. They found the information provided to them to be comprehensive and useful.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No answer
1. I am glad I participated in the pilot project.	11	4	0	0	0	0
2. I have received adequate documentation and resources.	12	3	0	0	0	0
3. The MerSETA should be commended for this project.	12	3	0	0	0	0
4. The project manager ensured that I was aware of what was required of me and/or my organisation.	13	2	0	0	0	0
5. I was well treated by the SEI project manager (if not, please provide comment)	13	2	0	0	0	0

G List of Comments:

The following comments were received per section:

A: No comments
B: No comments
C: "2 companies commented that they need to do KAP survey"
D: No comments
E: "I want to speak to my MD and manager to get this going"
F: "I was very impressed with the service received from Erick Vischer, he was very professional and explained everything in detail. I will def recommend him to any other company who requires assistance."

Key learnings:

- **15 of the participating employers, approximately 41%, took the time to respond to the Feedback survey.**
- **Section A: Initial contact**
    - **53% of respondents 'strongly agree' and 47% 'agree' that the requirements to participate in the pilot project were explained.**
    - **53% of respondents 'strongly agree' and 47% 'agree' that they understand the key objectives of the project.**
    - **87% of respondents 'strongly agree' and 13% 'agree' that they see the necessity of this project.**
    - **87% of respondents 'strongly agree' and 13% 'agree' that HIV/AIDS is an important workplace issue for their organisation.**

- **B: Training**

  The majority of the participants who attended training were happy with the overall structure, venue and contents of the training. 47% (7) of the participants (or one of their representatives) attended the SAQA accredited training session provided as part of this project. Most interestingly is that almost all respondents would like to have additional training on HIV/AIDS.

  50% (4) o f the participants who did not attend training did not give any feedback or recommendations to indicate whether they would have attended training should anything have been different. We can therefore assume that they did not attend due to unforeseen circumstances at that particular time.

- **C: KAP survey**

  The majority of the participant found the information contained in the KAP Survey to be useful to developing of their training strategy that would focus on the weakness and strengths identified in the KAP survey

- **D: Economic Impact Evaluation**

  The majority of the participants found the information contained in the Economic Impact Assessment to be useful and easy to understand.

- **E: Policy and practice**

  Majority of the participants found the policy and practice to be very useful not only to assess the current position but to give a way forward and tools to get there.

- **F: Overall**

  Majority of the participants had a positive overall response to the way the project was conducted and very happy with the service they received. They found the information provided to them to be comprehensive and useful.

- **G List of Comments:**

  The following comments were received per section:

  A: No comments
  B: No comments
  C: "2 companies commented that they need to do KAP survey"
  D: No comments
  E: "I want to speak to my MD and manager to get this going"
  F: "I was very impressed with the service received from Erick Vischer, he was very professional and explained everything in detail. I will def recommend him to any other company who requires assistance."

10. Project Reporting

At the completion of this pilot project each participant has received a comprehensive manual of information to complement the training on HIV/AIDS in the workplace and to assist them with implementing workplace policies and strategies in this regard. They have also provided feedback on their experience which will assist in developing the next phase of the project.

In Appendix 9 the result of a survey of participants to assess their proposed actions following the project are summarised. There appears to be a strong recognition of HIV/AIDS as a workplace issue and broad intentions to implement policies over the next 12 months, particularly in the areas of:

- A formal workplace policy on HIV/AIDS;
- Information and education;
- Care and support programmes.

Key learnings:

- **It is important to note that this is a pilot project and the process should be assessed based on the experience of this project.**
- **A follow up on implementation could be conducted in six months (say) to assess how companies are using the outcomes.**
- **Consideration could be given to a more formal commitment to the project through a fee to participate even if this is a token fee.**

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APPENDIXES

Appendix 1: Project Plan

PROJECT PLAN – MERSETA HIV/AIDS PROGRAMME

Task	Description	Responsibility	% Complete	Revised Deadline/Completed
Project planning	Project plan with deliverable dates	PM	100%	Completed
	Project budget	SEI	100%	Completed
	Draft Introduction letter	PM	100%	Completed
SMME contact list	Identify initial set of SMMEs to contact preferably Gauteng. Identify based on employee numbers	SEI/PM	100%	Completed
Contact SMME's	Telephonic	PM	100%	Completed
	Identify contact point/champion/responsible person	PM	100%	Completed
	Email/fax introduction letter + agreement	PM	100%	Completed
	Obtain signed agreements	PM	100%	Completed
Employer survey	Email survey to participating SMME	PM	100%	Completed
	Email Kap survey to participants	PM	100%	Completed
Clinic survey	Schedule meetings/interviews with each participant	PM	100%	Completed
	Assess area clinics available to participating SMME	PM	100%	Completed
	Conduct employee survey and KAP survey at interview stage	PM	100%	Completed
Data requirement	Ensure all data is collected	PM	100%	Completed
	Check paper data integrity and fulfilment	PM	100%	Completed
	Capture employee data	PM	100%	Completed
	Capture KAP data	PM	100%	
	Verify and audit electronic data	PM/Actuary	100%	Completed
Training sessions (Redpeg) Employer to elect which sessions	First training session (ER*) Mods 1-3	Redpeg/PM	100%	Completed
	Second training session (ER) Mods 1-3	Redpeg/PM	100%	Completed
	Third training Session (ER) Mods 1-6	Redpeg/PM	100%	Completed
Best practice model	Draft for discussion	PM/Actuary	100%	Completed
	Final for distribution	Actuary	100%	Completed
	Disseminate to participating SMMEs with workplace audit	PM	100%	Completed
Toolkit	First draft for discussion	PM/Actuary	100%	Completed
	Final for distribution	Actuary	100%	Completed
	Disseminate to participating SMMEs with: Business Impact result; KAP results; recommendations for interventions; Feedback	PM	100%	Completed

	survey			
Project report	Draft of overall project report	PM/Actuary	100%	Completed
Feedback survey	Distribute survey via email	PM	100%	Completed
	Collect surveys from participating SMMEs	PM	100%	Completed
	Collate feedback survey results	PM	100%	Completed
Final project report	Presentation to MERSETA	SEI/Actuary	100%	Completed
Feedback SMMEs	Feedback function	SEI/PM	100%	Completed
Closure reporting	As required by MERSETA	SEI	100%	Completed

*ER – East Rand
** C - Central

Milestone 1	
Milestone 2	
Milestone 3	
Milestone 4	

Appendix 2: Company database

SUZUKI SOUTH AFRICA_PTY LTD	011 974 1200	Johan Cloete	54	L660713936	Metal Industries	Complete
EVAPCO SOUTH AFRICA PTY LTD	011 392 6630	King Ndinisa	89	L160738169	Metal Industries	Complete
SPECSTRIP (PTY) LTD	011 421 8315	Albert van Wyk	59	L040715858	Plastics	Complete
East Rand Plastics	011 817 9000	Angela van der Holst	250	L600726857	Plastics	Complete
BOSWORTH - A DIV OF HUDACO TRADING LTD	011 864 1643	Helen Naude	113	L410716387	Metal Industries	Complete
ARCHIE ENGINEERING CC	011 865 5704	Cindy Hoffman	51	L040715916	Metal Industries	Complete
FB CRANE BUILDERS & REPAIRS (PTY) LTD	011 902 3271	Karen Mullaney	68	L640715985	Metal Industries	Complete
SMITH CAPITAL PTY LTD	011 873 9830	Isaac Mergui	116	L280722614	Metal Industries	Complete
Actom Head Office	011 820 5024	Dawie Oberholzer	70	L430746117	Metal Industries	Complete
ALSTHOM SOUTH AFRICA -(PTY) LTD	011 8205214	Nellisa Twalo	141	L880716669	Metal Industries	Complete
Actom Static Power	011 397-5316	Jill Burrows*	61	L370761563	Metal Industries	Complete
Norsa Electronics	011 397-8438	Jill Burrows	51	L650771597	Metal Industries	Complete
Alkaline Batteries	011 397-5326	Jill Burrows	39	L580771592	Metal Industries	Complete
Chi Control	011 827-9124	Portia Safriti	193	L010762336	Metal Industries	Complete
Meissner	011 824-0202	Linde Marais	120	L670771593	Metal Industries	Complete
Current Electric	011 822-2300	Lebohang Maquenane	129	L920771518	Metal Industries	Complete
Distribution Transformers	011 820-5111	Sabelo Sibiya	27	L770771469	Metal Industries	Complete
Actom MV Switchgear	011 820-5111	Garth de Kock	200	L150771477	Metal Industries	Complete
Actom Power Transformers	0118205225	Pat Tshoma*	55	L590771525	Metal Industries	Complete
Actom Protection & Control	011 820-5111	NokuKhanya Zulu	99	L1707701473	Metal Industries	Complete
T & D High Voltage	011 820-5109	Joy Venter	51	L790771465	Metal Industries	Complete
Actom Industry	011 430-8700	Amanda Terblanche	129	L760771578	Metal Industries	Complete
Actom Contracting	011 430-8700	Amanda Terblanche	38	L92071575	Metal Industries	Complete
Actom Power Systems	011 430-8700	Amanda Terblanche	51	L030771580	Metal Industries	Complete
John Thomson Boilers	011 392-0900	John Paul Andre (referred by Jill)	47	L800771448	Metal Industries	Complete
Actom Signalling	011 871-6600	Victor Rhadeba	130	L510754734	Metal Industries	Complete
Repair Machines	011 871 6644	Victor Rhadeba*	153	L3607711283	Metal Industries	Complete
AFRICAN ELECTROPLATING	011 474 8767	Don Spooner	97	L940717509	Metal Industries	Complete
Gordon Posniak	011 474 8767	Peter Posniak	27	L200719385	Metal Industries	Complete
Cauldron PL	011 474 8767	Gordon Posniak	24	L920718261	Metal Industries	Complete

CITY PACKAGING (PTY) LIMITED	011 708 1110	Peter Gouden (now Mark 083 650 9302)	100	L040718266	Plastics	Complete
CANOPY HOEKIE	012 562 0251	Riete Atkins	61	L290711896	Plastics	Complete
CONSOLIDATED AUTO (PTY) LTD	011 306 2000	Cindy Williams	95	L320715958	Motor Industries	Complete
McCarthys (General Motors)	012 369 2000	Paulina Maphuta	61	L110707900	Motor Industries	Complete
Avlock International Fastening Systems Pty Ltd	011 917 2110	Jackie Erasmus/Janet Nienaber	112	L060758101	Plastics	Complete
Toolquip & Allied	011 370 2727	Helen Tonetti	170	L930764057	Metal Industries	Complete
Toneblast Engineering	011 452 6713	Helen Tonetti	23	L210717338	Metal Industries	Complete

Appendix 3: Employer Survey Form

Please return the first 3 pages and any supporting information to Vischer@mweb.co.za or 0866 843 717

Survey Form:

Self Empowerment International

MERSETA Project

This survey forms part of the MERSETA HIV/AIDS project to enable SEI to provide you with a business impact study and analysis.

Questionnaire				
What Chamber does your organisation belong to?				
1. Does your Company have an HIV/AIDS policy?	Y/N	If yes, is a copy available?		
If you do, when was it last updated?				
2. Do you have a Strategic Plan to manage the current and future impact of HIV/AIDS on your organization?	Y/N	If yes, is a copy available?		
3. Has your Company involved stakeholders (employees, suppliers, customers) in the planning and implementation of the response to HIV/AIDS?	Y/N			
4. Has your Company arrived at an HIV/AIDS prevalence rate for the workforce?	Y/N	If so, what is the figure?		
5. What is your Company's estimated HIV/AIDS costs/losses for the current year in respect of:	The cost of programmes in the following 5 questions below?		What are the estimated losses arising from HIV/AIDS?	

6. Does your Company have a VCT (Voluntary Counselling and Testing) Programme in respect of HIV/AIDS for its workforce? When was this implemented and last conducted?	Y/N	If so, who is providing the service?	
7. Does your company have confidential access to HIV referral counselling and testing?			
8. Does your Company have an HIV/AIDS awareness/education/training programme for the workforce?	Y/N	If so, who is providing the service?	
9. Does your Company have HIV/AIDS prevention interventions such as STI-treatment assistance, and a distribution programme for Condoms/Femidoms?	Y/N	If so, who is providing the service?	
10. Does your Company have programmes to assist workforce members who are HIV-positive and AIDS sick?	Y/N	If so, who is providing the service?	
11. Does your Company have a general Wellness/EAP programme or any other programme of this nature?	Y/N	If so, who is providing the service?	
12. Does your company have an HIV/AIDS champion?		Is their knowledge level updated regularly?	
13. Is there an HIV/AIDS committee within the Company?		If yes, how is it made up?	
14. Does your company have any of the following workplace policies in place?			
a. ABET	Y/N	If so, is it	

b. Access to training	Y/N	available?	
c. Confidentiality and disclosure	Y/N		
d. Disciplinary and grievance procedures	Y/N		
e. Employee Benefits	Y/N		
f. Human Capital Management (HR)	Y/N		
g. Occupational health & safety	Y/N		
h. Performance management	Y/N		
i. Protection against discrimination including Gender?	Y/N		
j. Remuneration	Y/N		
k. Succession planning	Y/N		
l. Termination / incapacity procedures	Y/N		
15. Does your company presently have a medical scheme in place?	Y/N	Name?	
16. If so, is it available to all employees?	Y/N	If not, what is the reason for this?	
17. Does it have an HIV benefit provision?	Y/N	If yes, value?	

18. Do you have disability cover?		If so who is the carrier?		Level of cover and cost?	
19. Do you have funeral insurance cover?		If so who is the carrier?		Level of cover and cost?	
20. Do you have Medical expense cover? If so, who is the carrier?		If so who is the carrier?		Benefit level?	
21. Do you have life insurance cover?		If so who is the carrier?		Level of cover and cost?	

Is there a clinic in the area?	Y/N	Address/tel no.	

Please return the above 3 pages to Vischer@mweb.co.za or 0866 843 717

********** VERY IMPORTANT **********

In order to conduct the business impact analysis the following information is required in as much detail as possible:

Data requirements (***per employee***):

Name of employee, ID number or appropriate identification code
Gender
Date of birth
Geographical area of site of employment
Ethnic group
Annual salary
Job Category (unskilled, semi-skilled, junior management/professional, middle management, top management)
Date of employment
Marital status
Number of adult dependents
Number of child dependents

Data should be provided in ASCII, comma delimited or Excel format.
May we take this opportunity to thank you in advance for your valuable time in this regard.

Appendix 4: KAP Survey form

Knowledge, Attitude and Perceptions Survey

This survey has no wrong or right answers. It is simply here to see what you know about HIV/AIDS.
The information is CONFIDENTIAL and you should answer it in private to the best of your ability.
Your employer will NOT have access to the information or to your answers.
Please phone 082 440 7670 if you have any problems.
Thank you for filling in this survey.

E nakeengweyadipatlisisotsemabapi le bohlokoba HIV Aids. Di karabotse o tlodifangmabapi le dipatlisisotsenatsa HIV Aids ha di nahorekarabo e itseng e lukilekampo e fosahetse.Hahonamothoeo a tlobontshwangdikarabotsahaohosakhathalesehe seemosahaebophelongbahao le ha ekaba (mong)mothoeo o mosebeletsang. O kopiwahore o arabedipotsotsena kaofelakamoo o kagonangkateng.
Kakoposebedisanomoroenaya mohala,0824407670, mabapi le dipotsotseo o kabang le tsona. Re lebohahonkakarolo ha haodipatlisisongtsenatsa HIV Aids.

Ucwaningongesifosengculazi(HIV/AIDS).
Sifunaukutholaukuthiwazikangakananinge HIV/AIDS.Ayikhoimpenduloenephuthaumauphendulalokhu.Izimpenduloz akhoangekezibonwemuntu,
Iphendulewedwangalolonke ulwazionalooluphelele.Nomqashiwakhoange keabonisweokubhalilelapha.
SicelaushayeleLezinombolo 082 440 7670 umauhlangabezananenkingamayelananaloku.Siyabongaukuyigcwalisalelifomu.

1. How old are you?	
2. What is your gender?	Male / female
3. What is your marital status?	☐ Married ☐ Living together ☐ Divorced ☐ Single ☐ Widowed
4. Do you have children?	☐ Yes ☐ No ☐ How many
5. What is your Ethnic group?	☐ African ☐ White ☐ Coloured ☐ Indian ☐ Other
6. Do you have a full time or part time job?	☐ Full time ☐ part time
7. What is your highest level of education?	☐ Below Matric ☐ Matric ☐ Diploma ☐ Degree ☐ Post graduate qualification
8. What kind of job do you have?	☐ Unskilled ☐ Semi-skilled ☐ Junior Management ☐ Professional ☐ Middle Management ☐ Top Management

9. What type of home do you live in?	☐ Brick ☐ Shack ☐ Hostel
10. How often do you drink alcohol?	☐ Never ☐ Every month ☐ Every week ☐ Every day
11. Have you ever taken drugs?	☐ Yes ☐ No
12. Who are you in the household?	☐ Father ☐ Mother ☐ Daughter ☐ Son ☐ Grandchild
13. Do you think you are at risk of getting HIV?	☐ YES ☐ NO
14. Have you had an HIV test?	☐ YES ☐ NO
15. How long ago did you have your most recent HIV test?	☐ Less than a year ago ☐ Between 1 and 2 years ☐ Between 2 and 3 years ☐ 3 or more years ago
16. Have you been told of the result of your test?	☐ YES ☐ NO
17. Have you ever been to a HIV/AIDS meeting in my workplace?	☐ YES ☐ NO

18. Do you think there is a cure for HIV?	☐ YES ☐ NO
19. Can healthy looking people who are HIV positive transmit the disease to others?	☐ YES ☐ NO
20. Are most HIV infections because of unprotected sexual intercourse?	☐ YES ☐ NO
21. Can babies get HIV from their mothers?	☐ YES ☐ NO
22. If you do not have sex can you still get HIV?	☐ YES ☐ NO
23. Are partners who are faithful to each other very unlikely to become infected with HIV?	☐ YES ☐ NO
24. Can having sex with a virgin cure HIV/AIDS?	☐ YES ☐ NO
25. Do you think that couples should have sex before marriage?	☐ YES ☐ NO
26. Are people who are HIV positive more likely to become sick with Tuberculosis (TB)?	☐ YES ☐ NO
27. Do you think that couples should have themselves tested for HIV before marriage?	☐ YES ☐ NO
28. Do you think that people who are HIV positive should be isolated from the rest of the population?	☐ YES ☐ NO
29. Do you think that the HIV status of an HIV positive person should not be disclosed to others?	☐ YES ☐ NO
30. Do you think that the practice of Voluntary Counselling and Testing (VCT) for HIV is necessary in the workplace?	☐ YES ☐ NO
31. Must a condom be used for every round of sex to prevent HIV?	☐ YES ☐ NO
32. Can someone reduce the risk of HIV by having fewer sexual partners?	☐ YES ☐ NO
33. Is AIDS caused by	☐ YES

witchcraft?	☐ NO
34. Does HIV cause AIDS?	☐ YES ☐ NO ☐ Maybe
35. Are you sexually active?	☐ YES ☐ NO
36. How old were you when you had sex for the first time?	☐ Age in years
37. How many people have you had sex with in the past 12 months?	
38. Did you use a condom the last time you had sex?	☐ YES ☐ NO
39. What was the age of your last sexual partner?	Age in years
40. Have you had a sexually transmitted infection (STI) in the last 12 months? 41. If so, did you receive treatment?	☐ YES ☐ NO ☐ Yes ☐ No
42. Are you pregnant?	☐ YES ☐ NO
43. Are you currently attending antenatal clinic?	☐ YES ☐ NO

44. Where have you received information on the dangers of unprotected sex?	☐ The workplace ☐ Newspapers ☐ Television ☐ My friends ☐ Signs by the road

Appendix 5: Employer Survey (audit) Analysis

Introduction

The Employer Survey includes responses from 39 (2 subsequently lapsed) participating employers. This report provides a high-level analysis of the data provided. The questionnaires were completed via an interview process with the project manager so all the questions were fully explained and the information was collected and collated in a consistent manner. The questions aimed to assess the employer's current practice with respect to HIV management in the workplace and to collect some of the overall data required for the Economic Impact Analysis (EIA).

The participating employers indicated their affiliation as follows:

What Chamber does your organisation belong to?	Metal	Motor	Plastics	
Count	32	4	3	39

HIV Policy and Strategy

The participating employers were asked to indicate whether they had HIV policies and strategies in place and, where this was the case, how these were compiled.

The responses were as follows:

	Yes	No	Total
Does your Company have an HIV/AIDS policy?	19	20	39
If yes, is a copy available?	17		
Do you have a Strategic Plan to manage the current and future impact of HIV/AIDS on your organization?	5	34	39
If yes, is a copy available?	4		
Has your Company involved stakeholders (employees, suppliers, customers) in the planning and implementation of the response to HIV/AIDS?	5	34	39

48.7% (19) of the participating employers indicated that they have a policy in place and 89.5% of these were willing to provide it. Only 12.8% (5) have a strategic plan in place. 12.8% indicated that stakeholders were involved in the process. Employers that provided an existing policy received an evaluation in the form of a checklist and all participating employers received a policy template and guidelines on how to establish a legally compliant policy. It is notable that only a minority of employers had included wider stakeholders in policy development.

Prevalence and Cost

25.6% (10) of the participating employers indicated that they had assessed prevalence in their workforce. The prevalence estimates ranged from 3% to 15% with an average in the order of 10%.

Only one of the participating employers appeared to have translated this prevalence into anticipated operational costs.

It appears that prevalence has previously been assessed via VCT with modelling used in only a few cases. VCT programmes were provided by external providers including medical schemes (particularly Discovery).

Programmes

The participating employers were asked to indicate the HIV related programmes currently in place in their workplaces. The responses were as follows:

	Yes	No	Blank	Total
VCT (Voluntary Counselling and Testing) Programme	12	27	0	39
Confidential access to HIV referral counselling and testing	23	16	0	39
HIV/AIDS awareness/education/training programme for the workforce	15	24	0	39
HIV/AIDS prevention interventions such as STI-treatment assistance, and a distribution programme for Condoms/ Femidoms	18	21	0	39
Programmes to assist workforce members who are HIV-positive and AIDS sick	15	24	0	39
General Wellness/EAP programme or any other programme of this nature	14	25	0	39
An HIV/AIDS champion	7	32	0	39
An HIV/AIDS committee within the Company	5	34	0	39

The participating employers who have programmes in place seem to rely largely on external parties (including the medical scheme) to provide these services. Only a minority appear to have established formal structures within the organisation to manage the HIV strategy.

Approximately half the employers have some form of onsite care through a clinic service or nursing sister (visiting or permanent) and this is a good starting point for implementing general and HIV-specific wellness interventions.

The participating employers were also asked to indicate other workplace programmes they had in place. Their responses were as follows:

	Yes	No	Blank	Total
Adult Basic Education and Training	18	21	0	39
Access to training	37	2	0	39
Confidentiality and disclosure	29	10	0	39
Disciplinary and grievance procedures	38	1	0	39
Employee Benefits	36	3	0	39
Human Capital Management (HR)	36	3	0	39
Occupational health & safety	39	0	0	39
Performance management	23	15	1	39
Protection against discrimination including Gender	37	2	0	39
Remuneration	25	14	0	39
Succession planning	22	17	0	39
Termination / incapacity procedures	35	4	0	39
Medical scheme	35	4	0	39
Disability cover	35	3	1	39
Funeral insurance cover	17	21	1	39
Life insurance cover	23	15	1	39

Adult Basic Education and Training, Performance Management, Remuneration review and Succession planning are the least frequently offered programmes. Funeral and Life Insurance cover are the least frequently offered employee benefits.

It is of concern that as many as 10 employers surveyed did not have a formal strategy to manage confidentiality.

It appears that HR requirements are well covered but access to employee benefits is not as extensive. Disability and Life insurance cover appear to be offered through Retirement Funds and funeral insurance cover (offered by the employer) has a surprisingly low prevalence. There seems to be extensive use of industry funds where individual employers would have less influence on the benefits offered.

While many employers offer medical scheme cover, not all of them make it available to all staff (4 of the 34 offering cover). The medical schemes mentioned were Discovery, Sizwe, Fedhealth and MotoHealth. The reporting to the employers highlighted that the Prescribed Minimum Benefits include HIV treatment (including antiretrovirals) for all covered beneficiaries.

Appendix 6: General KAP Report

MERSETA HIV/AIDS PROJECT

KNOWLEDGE, ATTITUDE AND PRACTICE SURVEY

GENERAL

1) Introduction

In this section we summarise the responses to the Knowledge, Attitude and Practice (KAP) survey. 20 companies participated in the KAP survey, participation rates ranged from 9% to 84%. A response rate of less than 20% means that the company specific results are less likely to be a good indication of the knowledge, attitude and practices of all employees and so the results should be interpreted with caution.

The consolidated results of the 20 companies are referred to as the Group.

The Knowledge, Attitude and Practice (KAP) survey was conducted by means of a questionnaire issued to employees with questions covering:

- their Knowledge of the causes of HIV/AIDS and how it is treated;
- their Attitude towards HIV risk and those who are HIV positive; and
- their Practice with regard to behaviour that is associated with a higher risk of HIV infection.

Employees were invited to complete the questionnaire on an anonymous basis. It is intended that the results of this survey will assist the employer in designing an HIV management programme that takes account of the employees' level of understanding and current practices.

We have not included any multi-dimensional analyses in this report due to the fact that in some cases the few numbers may lead to identification and individual respondents.

2) Level of participation and sample

734 of 3621 employees completed and submitted KAP questionnaires; this is a 20% response rate for the Group. No employees of your company have completed and submitted KAP surveys.

3) Profile of respondents

The profile of respondents that completed the questionnaire is summarised in table 2:

Table 2: Summary of profile:

	Group	
	Count	**%**
Gender (74% of the participating employees are male)		
Male	540	74%
Female	185	25%
Not answered	9	1%
Age (The average age of the participating employees is 37 years. Note that the average age profile may be distorted due to 65 (=9%) respondents who have not supplied their date of birth.)		
0-24	74	10%
25-34	244	33%
35-44	187	25%
45-54	102	15%
55+	62	8%
Not answered	65	9%
Current marital status (almost half of the participating employees are married,)		
Married	353	48%
Living together	115	16%
Divorced	26	4%
Single	209	28%
Widowed	20	3%
Not answered	11	1%
Ethnic group (64% of the participating employees are allocated to 'African')		
African	468	64%
White	203	28%
Coloured	30	4%
Indian	17	2%
Other	6	1%
Not answered	10	1%
Number of children (An average of 2 children per respondent)		
0	131	18%
1	105	14%
2	166	23%
3	72	10%
4+	72	10%

Not answered	188	25%
Full time or part time employed (90% of the participating employees are employed full time)		
Full time	659	90%
Part time	52	7%
Not answered	23	3%
Level of education (a third of the participating employees have not matriculated)		
Below Matric	240	33%
Matric	318	43%
Diploma	115	15%
Degree	12	2%
Post graduate qualification	21	3%
Not answered	28	4%
Occupational category (Approximately a third of the participating employees are at management level)		
Management	237	32%
Other	449	61%
Not answered	48	7%
Lifestyle		
Brick	593	81%
Shack	89	12%
Hostel	40	5%
Not answered	12	2%
Role in household (75% of the participating employees are the 'parent-figure' (i.e. father or mother of their household))		
Father	402	54%
Mother	153	21%
Daughter	34	5%
Son	118	16%
Grandchild	8	1%
Not answered	19	3%

Two of the questions in the survey were based on pregnancy. The following table excludes male respondents. The responses may be distorted by the high percentage of employees who did not answer the relevant questions.

Table 3: Pregnancy (excludes male):

	Group	
	Count	**%**
Pregnancy		
Female, Not pregnant	151	78%
Female, pregnant and attended antenatal clinic	4	2%
Female, pregnant and did not attended antenatal clinic	4	2%
Not answered (respondents who did not specify gender or answer)	35	18%

4) Substance abuse

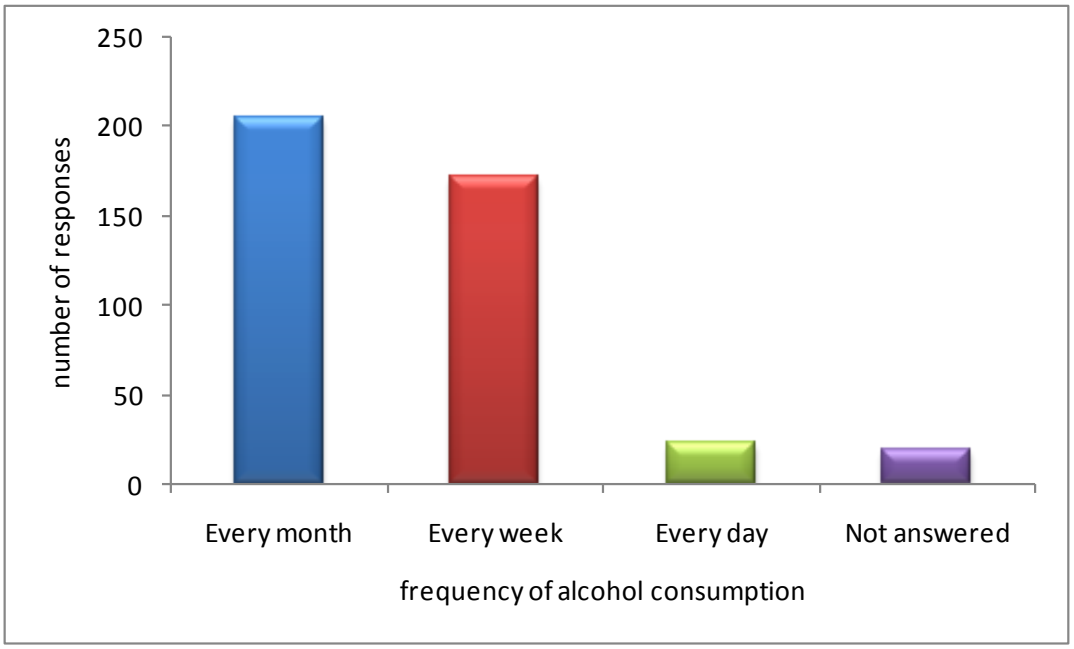
Alcohol is the most commonly used psychoactive substance in the world, and its use is among the most prevalent behaviours associated with sexual risk taking (Kalichman et al 2007).

Table 4: Substance abuse:

	Group	
	Count	**%**
Substance abuse		
Alcohol		
Never	315	43%
Every month	205	28%
Every week	172	23%
Every day	23	3%
Not answered	19	3%
Drugs		
Yes	79	11%
No	633	86%
Not answered	22	3%

54% of respondents consume alcohol to varying degrees as indicated in the chart below:

CHART 1: Frequency of alcohol consumption:



Drugs commonly used in South Africa include dagga (cannabis), which has not been linked to sexual risk of HIV and STIs unlike methamphetamine (tik) and injected drugs e.g. heroin which are associated with sexual risk of HIV infection (DOH 2007; Simbayi et al. 2006). 11% of the respondents have indicated that they have used drugs.

5) Overall KAP Score

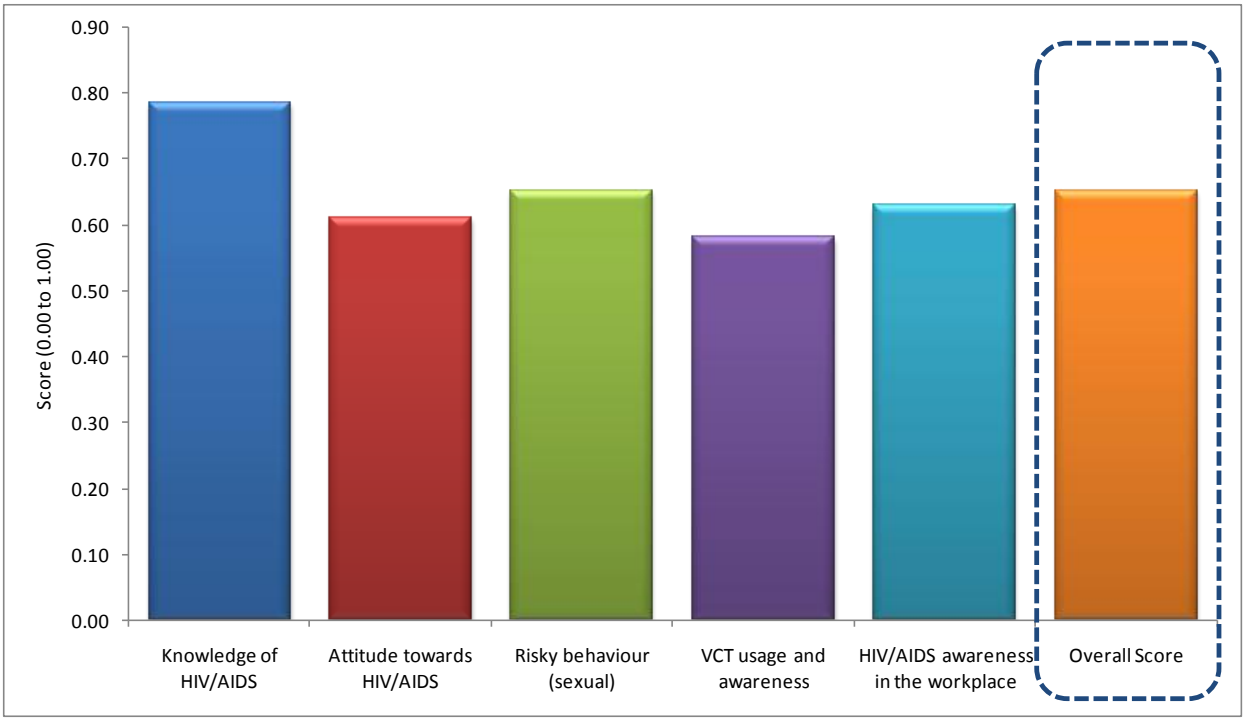
We have applied a scoring system to the questions in the survey to facilitate the comparison of the results. The scores are between 0.00 and 1.00. A score closer to 1.00 indicates higher overall knowledge, attitude and practice towards HIV/AIDS which shows increased awareness which impact the risk of HIV and AIDS on individuals as well as your business activities.

Table 5: KAP Score card:

Variable	Group
Knowledge of HIV/AIDS	0.79
Attitude towards HIV/AIDS	0.61
Risky behaviour (sexual)	0.65
VCT usage and awareness	0.58
HIV/AIDS awareness in the workplace	0.63
Overall Score	**0.65**

The overall KAP score is for the Group is 0.65.

Chart 2: KAP scores for the Group



The score of each variable is detailed in sections 5.1 to 5.5.

5.1 Knowledge:

Knowledge of HIV transmission and methods of preventing transmission is necessary to change behaviour and reduce risk of HIV. The Group scored 0.79 for knowledge.

Questions 18-24, 26, 31-34 in the questionnaire were used to determine the respondents' knowledge of HIV/AIDS. Table 6 is a summary of the responses:

Table 6: Knowledge responses:

Question	Yes (%)	No (%)	No answer (%)
18. Do you think there is a cure for HIV?	34%	63%	3%
19. Can healthy looking people who are HIV positive transmit the disease to others?	77%	17%	6%
20. Are most HIV infections because of unprotected sexual intercourse?	82%	15%	3%
21. Can babies get HIV from their mothers?	82%	15%	3%
22. If you do not have sex can you still get HIV?	75%	21%	4%
23. Are partners who are faithful to each other very unlikely to become infected with HIV?	64%	30%	6%
24. Can having sex with a virgin cure HIV/AIDS?	10%	86%	4%
26. Are people who are HIV positive more likely to become sick with Tuberculosis (TB)?	90%	8%	2%
31. Must a condom be used for every round of sex to prevent HIV?	86%	10%	4%
32. Can someone reduce the risk of HIV by having fewer sexual partners?	64%	30%	6%
33. Is AIDS caused by witchcraft?	7%	86%	7%
34. Does HIV cause AIDS?	88%	5%	7%

5.2 Attitude towards HIV/AIDS

HIV/AIDS is possibly the most stigmatised medical condition in the world. The stigma, exclusion and discrimination surrounding HIV/AIDS have forced people who are potentially infected or already infected to go into denial or hide their status. They become reluctant to seek diagnosis, treatment and could even continue to engage in high risk behaviour. The Group's Attitude score is 0.61.

Questions 13, 25, 27-29 give an indication of the respondent's attitude to HIV/AIDS. A summary of the responses are displayed in table 7:

Table 7: Summary of Attitude responses:

Question	Yes (%)	No (%)	No answer (%)
13. Do you think you are at risk of getting HIV?	30%	66%	4%
25. Do you think that couples should have sex before marriage?	40%	56%	4%
27. Do you think that couples should have themselves tested for HIV before marriage?	90%	8%	2%
28. Do you think that people who are HIV positive should be isolated from the rest of the population?	17%	79%	4%
29. Do you think that the HIV status of an HIV positive person should not be disclosed to others?	47%	50%	3%

5.3 Risky behaviour (sexual) score

The major route of HIV transmission in sub-Saharan Africa including South Africa is through heterosexual sex (SADC 2006; UNAIDS2006). The Group's Risky behaviour (sexual) score is 0.65. Table 8 gives a summary of the responses to risky behaviour (sexual behaviour questions):

Table 8: Sexual behaviour

	% responses
35. Are you sexually active?	
Yes	72%
No	20%
No answer	8%
36. How old were you when you had sex for the first time?	
Younger than 18 years	38%
18 years or older	46%
No answer	16%
37. How many people have you had sex with in the past 12 months?	
None	5%
One	53%
Multiple	23%
No answer	19%
38. Did you use a condom the last time you had sex?	
Yes	42%
No	50%
No answer	8%

39. Age difference of most recent sexual partner (in years)	
0-5	41%
6-10	17%
10+	12%
No answer	30%
40. Have you had a sexually transmitted infection (STI) in the last 12 months?	
No	84%
Yes, treatment received	3%
Yes, no treatment received	2%
Yes, no treatment information received	0%
No answer	11%

5.4 VCT usage and awareness Score

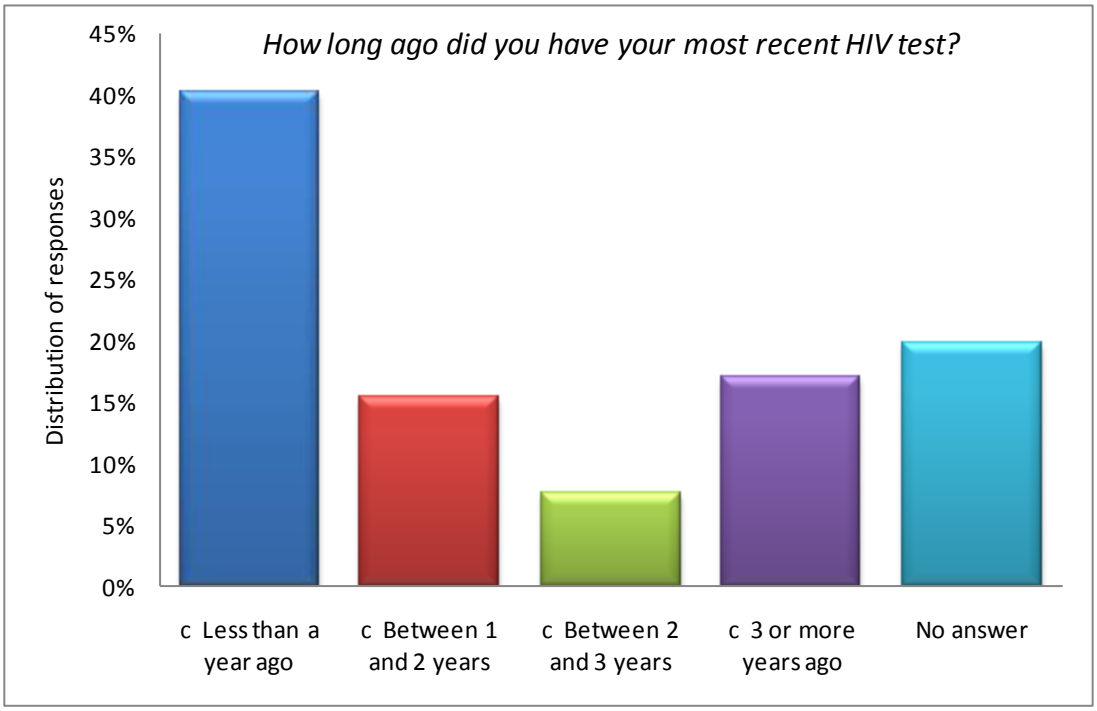
One of the cornerstones of HIV prevention campaign is to encourage people to undergo HIV testing, in order to determine their HIV status and their needs in terms of prevention, treatment and care. Going through the entire VCT procedure has many benefits including behavioural change to prevent HIV infection. VCT services are easily accessible in South Africa. The VCT usage and awareness score takes into account the respondents' awareness and use of VCT services as well as their awareness of their HIV status.

The VCT usage and awareness score is 0.58 for the Group.

Table 9: VCT usage and awareness:

	Yes (%)	No (%)	No answer (%)
14. Have you had an HIV test?	69%	30%	1%
16. Have you been told of the result of your test?	69%	17%	14%

Chart 3: 15. How long ago did you have your most recent HIV test?



69% of the Group have been tested for HIV. The national VCT participation rate for South African was estimated to be 30% in 2005 (Shisana et al. 2005a) and this has increased due to campaigns driven by Government and other organisations.

5.5 HIV/AIDS awareness in the workplace score

Various questions were asked to establish the knowledge levels of the respondents on issues related to HIV and AIDS in the workplace. Employers have an important role to play in ensuring that employees have a good understanding of HIV risk and can benefit from improved productivity associated with managing HIV risk.

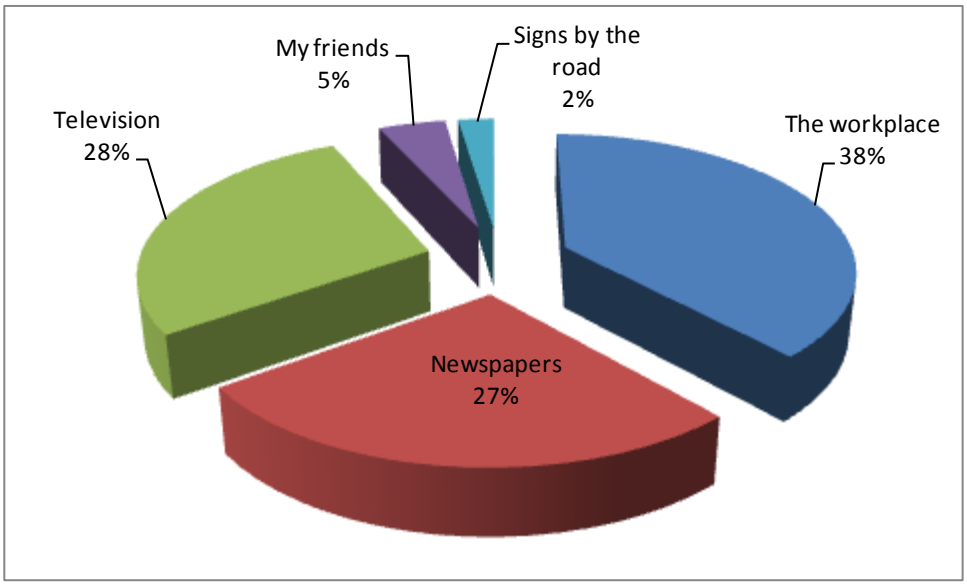
The Groups' HIV/AIDS awareness in the workplace score is 0.63.

Table 10: Workplace HIV related Score

	Yes (%)	No (%)	No Answer (%)
17. Have you ever been to a HIV/AIDS meeting in my workplace?	41%	54%	5%
30. Do you think that the practice of Voluntary Counselling and Testing (VCT) for HIV is necessary in the workplace?	85%	10%	5%

5.6 Where have you received information on the dangers of unprotected sex?

38% of the responses indicated that they are informed of the dangers of unprotected sex though information received from the workplace. These statistics strengthen the need for an effective workplace policy, training and strategic plan to keep employees constantly informed and aware of the impact of HIV and AIDS in their lives, their community, their workplace and their nation.



Further to this is the 55% dissemination of information through the media (television and newspaper) which should be utilised more effectively. The low percentage (5%) of answers to 'My friends' indicates that there is a great need for education

6) Comments and recommendations

Overall the Group KAP score is 0.65. The scores are between 0.00 and 1.00. A score closer to 1.00 indicates higher overall knowledge, attitude and practice towards HIV/AIDS which shows increased awareness which impact the risk of HIV and AIDS on individuals as well as your business activities.

The current workplace practice survey indicated that 49% of the participating companies have an HIV/AIDS policy and 13% a Strategic plan in place.

- There is a need to establish a targeted HIV/AIDS workplace programme. This programme should target gaps identified in this assessment.

- Note that HIV/AIDS cover is part of the Prescribed Minimum Benefits for all medical schemes and so covered employees will be able to access these benefits in the medical scheme. Your organization appears to have a range of workplace programmes available but further development of HIV/AIDS strategy and policy and ensuring that employees know how to access treatment is recommended. Targeted awareness campaigns should take account of the age, gender, social and job-category structure of the workforce.

- Stakeholder involvement and participation should be increased to ensure successful implementation of the targeted HIV/AIDS workplace programme and to further raise awareness of the impact and risk of HIV and AIDS on the business activities of your company.

The information included in this file will assist in establishing these.

7) References

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Appendix 7: General EIA Report

HIV/AIDS impact assessment Report

For

MERSETA

General report

Table of Contents

1) Introduction

In this section we summarise the HIV/AIDS Economic Impact of the 29 companies who have provided individual employee information hereafter referred to as 'the Group'.

The HIV/AIDS Economic Impact Assessment is broken down into three phases. The first phase assesses the prevalence of HIV/AIDS in the workplace status quo (under current conditions). The second phase of the project extends the assessment to a financial impact under the status quo scenario. The final phase involves assessing the financial impact of having a private HIV wellness and anti-retroviral treatment programme for all employees.

The Status Quo scenario assumes that the employee profile, knowledge of HIV, training and availability of services or treatment relating to HIV to be the same as currently available.

The need for HIV/AIDS impact assessments has become a key element of good corporate governance in South Africa. The second King corporate governance report introduced the concept of evaluating the environmental and social bottom lines as well as the financial bottom line. This means that investors are looking for corporates to have:

- a legally sound and documented company HIV/AIDS policy;
- publication and implementation of the policy;
- measurement of the financial exposure to the disease;
- preventative initiatives provided to employees;
- management of the whole workplace with regard to health and safety in an HIV/AIDS environment.

Research conducted by the Harvard Centre for International Health on two South African companies indicated that HIV may cost companies between 2% and 6% of salaries per year. Direct costs to companies include costs of health care and other employee benefits. However, as lower income earners who are more affected, have lower benefits, the impact is dampened. The most significant costs for most companies are likely to be the indirect costs including absenteeism (illness and funerals), lost skills, training and recruitment costs, reduced work performance and lower productivity.

There has been ongoing debate surrounding the issue of disclosure in financial statements. It is widely agreed that the policy and strategy for the assessment and management of HIV risk should be included in financial statements but the disclosure of actual or estimated prevalence will require further debate. The Actuarial Society of South Africa (ASSA), the South African Institute of Chartered Accountants (SAICA) and the Johannesburg Securities Exchange (JSE) have established a working party to debate this issue.

Stipp[1] has identified the following risks as most important for stakeholders to understand (from a materiality perspective):

- Operational risk
- Absenteeism risk
- Cost of employment risk

[1] "Corporate Governance and HIV/AIDS" presented to ASSA, October 2002

- Credit risk
- Target market risk
- Supplier/business partner risk
- Legal risk
- Health risk

The Global Reporting Initiative[2] has identified the following criteria for the purposes of meaningful disclosure:

- transparency
- inclusiveness
- auditability
- completeness
- relevance
- sustainability
- accuracy
- neutrality
- comparability
- clarity
- timeliness

This suggests that it is important for responsible employers to assess the extent of HIV risk in their workplace and to take steps to quantify and mitigate this impact while ensuring that stakeholders are appropriately informed, These stakeholders include management, shareholders, employees (and labour organisations), government, regulators, industry bodies and customers.

Note that the results presented in this section are based on a statistical analysis of the demographic information provided on the employees of the organisation and not actual testing of individuals. The model that has been used is based on the ASSA2003 model of the Actuarial Society of South Africa. The results in this report are intended to support strategic decision making with respect to managing HIV risk and it is recommended that employees are encouraged to undergo Voluntary Counselling and Testing so that they can know their HIV status. All results should be interpreted in the context of the pilot project and the assumptions made. Estimates are based on model outputs and some variation around these should be expected. The variation of results is exacerbated by the lower number of employees.

2) Summary of information received:

Individual employee information for 2994 employees (29 companies) has been supplied for the Group. The information has not been audited but we have conducted reasonability checks.

[2] www.globalreporting.org

The key risk factors from an HIV prevalence perspective are age; gender; race; income; region (province); employee category (management/other). The individual information supplied for the assessment is summarised as follows:

Summary of information:

	Group
Total employee count	2994
% Females	17%
Age (average)	41.3
Age (minimum)	19.0
Age (maximum)	78.0
% Employees classified as 'African' (Other employees)	63.2%
% Employees classified as 'African' (All employees)	50.6%
Average gross salary (2010 Rands per employee per month)	9,852
Average pensionable salary (2010 Rands per employee per month)	7,882
Pensionable salary/Gross salary	80%

Note:

- Where there was insufficient information (e.g. information not provided on key parameters such as salaries, date of birth, ethnic group, retirement fund cover and benefit) the general assumptions are based on the Group averages;
- Pensionable salary is assumed to be 80% of gross salary;
- All employees of the Group have been allocated to the Gauteng province.

Note that these are estimates based on model outputs and some variation around these should be expected.

3) Estimated HIV Prevalence:

The objectives of the prevalence assessment are:

i. To estimate the current prevalence of HIV among staff with reference to the demographics and a statistical model.
ii. To project the prevalence by disease stage over a ten year period to 2020.
iii. To project the impact on ill-health retirement, deaths and staffing requirements to 2020.

The estimated HIV Prevalence (% HIV+ employees of total active employee count) and 95% Confidence Intervals are as follows:

TABLE 2: Projected HIV Prevalence

Estimated prevalence	2010	2011	2012	2013	2014	2015	…	2020
Average	10.8%	10.8%	10.7%	10.7%	10.6%	10.4%		9.8%
Lower 95% CI	9.6%	9.6%	9.6%	9.5%	9.5%	9.3%		8.8%
Upper 95% CI	11.9%	11.9%	11.8%	11.8%	11.7%	11.5%		10.9%

Based on the information provided, assumptions (detailed in the Appendix 7) and methodology outlined in the report, it is estimated that the HIV prevalence for the Group in 2010 is 10.8% ($CI_{95\%}$: 9.6-11.9%) reducing to 9.8% ($CI_{95\%}$:8.8%-10.9%) in 2020. The trending reduction of prevalence into the future is primarily due to the increased number of exits (HIV related deaths and ill-health retirement). Note that these projections have been made on a STATUS QUO scenario. The estimates are based on model outputs and some variation around these should be expected.

The progression of the infection is measured in terms of the CD4 count, and the viral load (the amount of virus in the blood) generally determines the rate of deterioration. For the purposes of our model, we have distinguished four stages as follows:

	Clinical Indicator	**Average Duration**	**Symptom**
Stage 1	CD4 > 500	4 to 6 years	Asymptomatic
Stage 2	CD4 between 350 and 500	2 to 3 years	Some opportunistic infections
Stage 3	CD4 between 200 and 350	2 to 3 years	Opportunistic infections
Stage 4	CD4 < 200	6 months to 1 year	AIDS

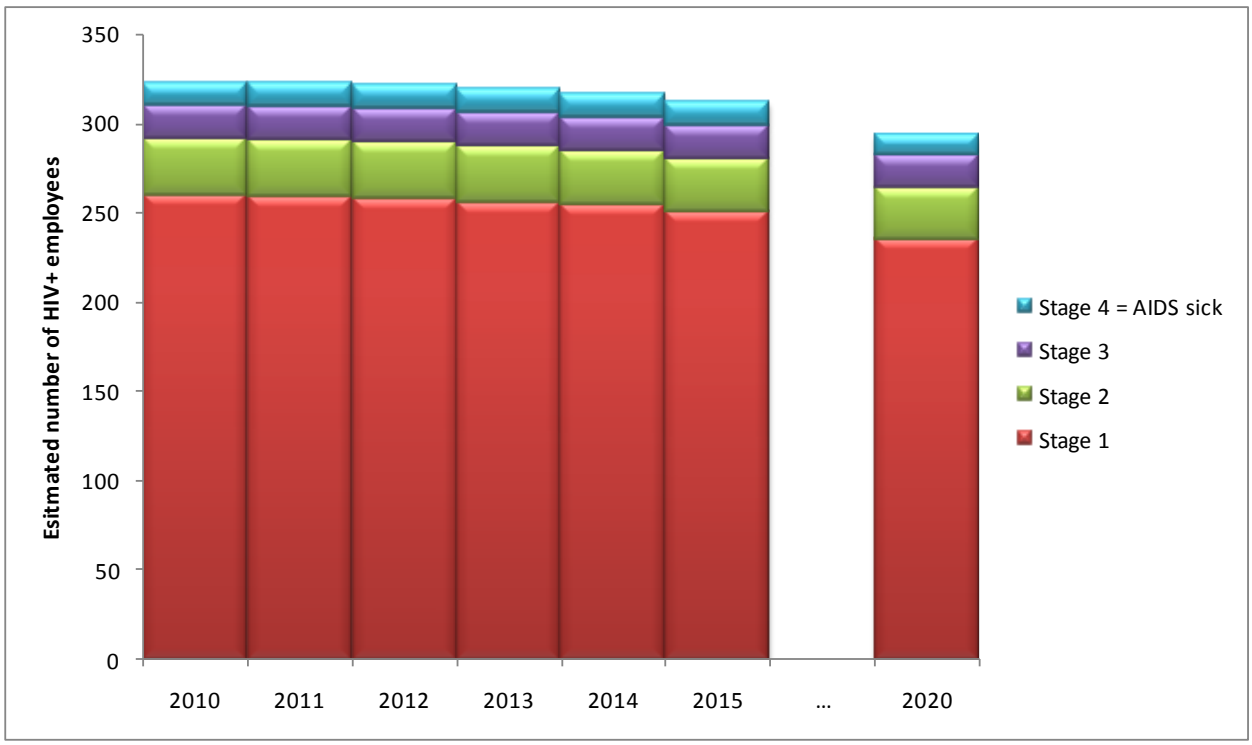
These are generalised stages and the infection may affect some patients differently.

Employees in the later stages of infection are more likely to be affected as a result of the deterioration in their health. It is estimated that in 2010 there are between 289 and 355 employees who are HIV positive. Of these employees there are possibly 12 employees who are in stage 4 (AIDS stage).

TABLE 3: Prevalence by Stage

Company	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**...**	**2020**
Stage 1	260	259	258	256	254	250		235
Stage 2	31	31	31	31	30	30		29
Stage 3	19	19	19	19	19	19		18
Stage 4 = AIDS sick	12	13	13	13	13	13		12
HIV+(% of all employees)	10.8%	10.8%	10.7%	10.7%	10.6%	10.4%		9.8%
AIDS sick (% of all employees)	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%		0.4%
AIDS sick (% of HIV+ employees)	3.7%	4.0%	4.0%	4.1%	4.1%	4.2%		4.1%

CHART 1: Prevalence by stage:



We allocated each individual employee in the data provided to one of two employee categories (management or other). Where salaries were provided (23companies) we assumed 'Management' to be all employees with salary exceeding R15000 per month. The remaining employees were allocated to the 'Other' employee category. Where no or partial salary information was provided (6 companies) we used the occupational information in the data to allocate these employees.

The infection rate is assumed to differ per employee category (management and other). This impacts both the rate of new infections and the progression of the epidemic. Any changes to the allocations to the employee categories above will therefore impact the output results. The prevalence rates may differ by employee category:

TABLE 4: Estimated count of HIV+ employees and % prevalence for 2010:

	Group 2010		
Employee category	Count of active employees	% HIV+	95% confidence interval range
Management	712	2.1%	(1.1 - 3.2%)
Other	2,282	13.5%	(12.1 - 14.9%)
Overall	2,994	10.8%	(9.6 - 11.9%)

76% of the employees are allocated to the 'Other' employee category, where the prevalence can to be as high as 14.9%.

Based on the information provided, assumptions and methodology outlined in this report, it is estimated that between 6 and 19 employees in 2010 may leave employment due to HIV related deaths and HIV related ill-health retirement, assuming no interventions.

4) Financial impact:

The quantification of the financial impact of HIV/AIDS has been assessed at a number of levels:

1. ***Death and disability benefit impacts***: The death and disability benefit impacts will be felt through increased premiums for these benefits.
2. ***Supervisory load***: increased staff replacement rates will necessitate increased allocations of supervisory time (and a higher ratio of supervisors to reporting staff).
3. ***Recruitment and overtime costs***: costs to replace staff lost through ill-health retirements and deaths associated with HIV/AIDS and additional staff required as a result of leave requirements and reduced productivity of HIV positive employees.

The financial impacts assessed are forecasted for a 5 year period and have been calculated with reference to the following benefit assumptions:

Table 5: Summary table of assumptions:

Parameter	**Group (general assumptions)**
Gross salary	Group average gross salary per employee (gender and employee category specific) gives an average gross salary of R10 737 per employee per month
Pensionable salary	80% of gross salary
% Employees on retirement fund	100%
Employee category: Management Other	Where salaries were provided (23 companies) we assumed 'Management' to be all employees with salary exceeding R15 000 per month. The remaining employees were allocated to the other employee category. Where no or partial salary information was provided (6 companies) we used the occupational information in the data to allocate these employees.
Death benefit (GLA):	
Multiple of basic salary	3 times annual pensionable salary, or as disclosed by company
Disability benefit (PHI):	
Multiple of basic salary	75%
Waiting period	3 months general waiting period

The cost impact of HIV/AIDS is closely linked to the salary information for each employee category and is based on the projected HIV prevalence. These projections are initially prepared on the basis of a **STATUS QUO scenario.**

The 2010 costs reflect the estimate of current additional HIV expenditure (compared to an environment with no HIV infections). All results are in 2010 Rands (i.e. no inflation).

TABLE 6: The Group's current additional HIV expenditure (R'000)

Group (R 000's)	2010	2011	2012	2013	2014	2015	2010 to 2015
Death and disability benefits	2,842	2,885	2,936	2,976	3,002	3,010	17,651
Supervisory	455	460	462	462	460	456	2,755
Recruitment and overtime	3,235	3,285	3,315	3,323	3,310	3,280	19,749
Total cost (R 000's)	**6,531**	**6,631**	**6,713**	**6,761**	**6,771**	**6,746**	**40,154**

For the Group, 44% of the estimated aggregated additional expenditure over the next five years is attributable to the Retirement Fund benefits (in terms of additional death and disability costs), 49% is attributable to Recruitment and Overtime costs and 7% is attributable to supervisory expenses.

TABLE 7: The Group's overall current additional HIV expenditure

	Group 2010
Total cost (Rands per active employee per annum)	2,235
Total cost (Rands per HIV+ employee per annum)	21,001
Total cost (% of gross annual earnings)	1.89%

These expenditure effects have been assessed with reference to a number of assumptions (set out in annexure C of this report) and these results are sensitive to variations in these assumptions.

The estimated additional cost attributable to HIV/AIDS impact is expected to be approximately 1.89% of gross payroll.

5) Interventions

The results presented above are on a **STATUS QUO scenario**. We have analysed the impact of two intervention scenarios on the financial implications of HIV. The first scenario is a wellness management scenario (treatment costs and assumptions are detailed in annexure A of this report) and the second one considers the introduction of anti-retroviral therapy and costs (in addition to the benefits under the first scenario), treatment costs and assumptions are detailed in annexure D of this report. Note that the results presented here are sensitive to changes in the assumptions, particularly the cost of treatment. On 15 December 2010, the Minister of Health announced a significant reduction on the cost at which anti-retrovirals will be purchased by the Government. The assumptions in this report are based on private sector experience available at the date of preparation of this report.

The costs associated with each intervention programme include:

- a management fee per patient;
- doctor consultations;
- pathology;
- medication

Costs related to HIV testing as well as HIV Service Provider premium charged to run the wellness programme (eg setup costs, training and awareness tools etc) have not been included in this analysis due to the variation of the contracts that each company has with their service provider.

The costs associated with the intervention including antiretroviral therapy from a CD4 count of 350 are much higher than the wellness only scenario but the potential gross savings are 30.0% of the Status quo cost compared to 1.0% on the other wellness only programme thus yielding a much greater return on investment.

TABLE 8: Effect of interventions (consolidated 2010 to 2015)

Company	Costs in 2010 R' 000s (consolidated 2010 to 2015)	% of nil intervention expenditure
Scenario 1: Wellness management and Sexually Transmitted Infection (STI) treatment		
Status quo - additional HIV/AIDS expenditure	40,154	
Cost of wellness programme	1,295	3.2%
Wellness programme - nett savings	(889)	-2.2%
Wellness programme - gross savings	406	1.0%
Wellness programme–**reduced** additional HIV/AIDS expenditure	41,043	
Scenario 2: Wellness programme + Anti-retroviral treatment commencing at CD4 of 350		
Status quo - additional HIV/AIDs expenditure	40,154	
Cost of wellness + ART programme (CD4 of 350)	3,397	8.5%
Wellness + ART programme (CD4 of 350) nett savings	8,665	21.6%
Wellness + ART programme (CD4 of 350) gross savings	12,062	30.0%
Wellness + ART programme (CD4 of 350) - **reduced** HIV/AIDS additional expenditure	31,490	

The results in table 9 show that the cost of running the Wellness Programme is estimated to be R1,295k over the period 2010 to 2015. This is 3.2% of the total cost associated with HIV/AIDS for this period. It is estimated that the programme will result in an additional cost of R889k over the period and so there is an increase in the net costs associated with HIV/AIDS under this scenario.

For the programme including anti-retroviral treatment, the cost of the Programme is estimated to be R3,397k over the period 2010 to 2015. This is 8.5% of the total cost associated with HIV/AIDS for this period. It is estimated that the programme will result in nett savings of R8,665k for the period so the net effect is a 21.6% reduction in the total costs associated with HIV/AIDS for the 2010 to 2015 period.

If the employees are able to access treatment through a Government-funded clinic, then the cost of treatment will be reduced proportionately and the net savings increased.

This is graphically represented in the following chart:

CHART 2: HIV/AIDS related costs in 2010 R' 000s (consolidated 2010 to 2015)

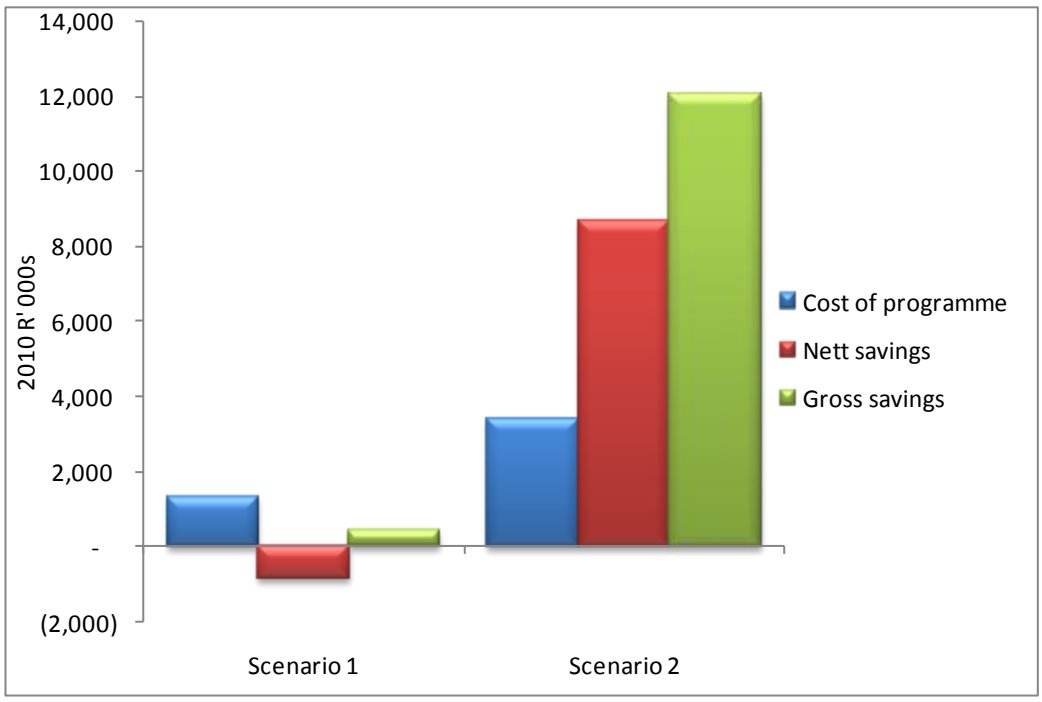
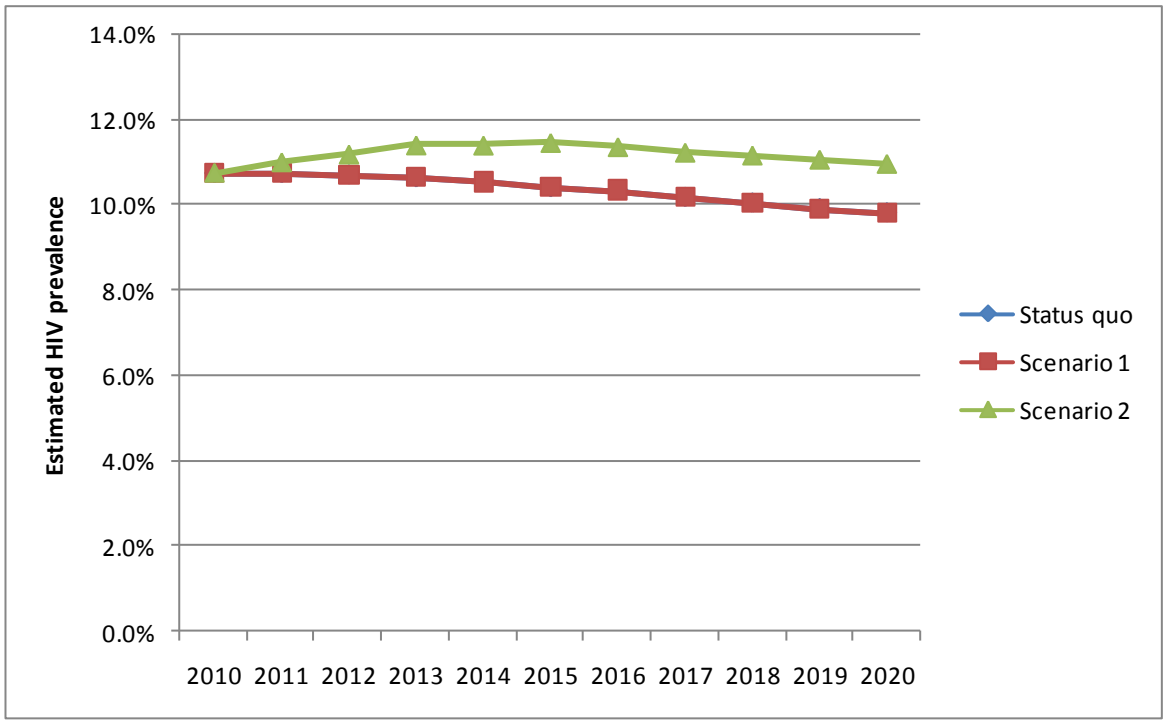


CHART 3: Projected prevalence with and without interventions



The impact of an ARV treatment is to increase projected prevalence since HIV positive employees are kept alive and productive for longer.

A further issue that needs to be considered in implementing an ARV treatment is the moral dilemma of retrenching or firing an individual whose life depends on access to such a treatment. Including

dependants in the ARV treatment will have the effect of a proportional increase in costs but a negligible impact on savings. The key benefit of this approach is improved compliance.

It is important to note that the effective management of HIV can lead to an increase in prevalence if new infections are not addressed due to the deaths being deferred.

6) Comments and Recommendations for the Group:

The most accurate way to determine the prevalence of a group of people would be if testing is compulsory for all people within the group. However it is difficult to get all people to agree to be tested. The most common approach is undertaking a Voluntary Counselling and Testing (VCT) however the participation rate and profile of the participants is key to understanding the VCT results. A further benefit to the testing approach is that each person gets to know their status and, if necessary, is able to seek treatment and modify their behaviour.

An alternate to testing is to use the group specific information to estimate HIV prevalence, i.e. HIV economic impact analyses similar to what was undertaken to develop this section of the report. The information included in such an assessment provides valuable information of estimated prevalence, not only at a specific point in time, but also projecting the impact into the future based on the progression of the disease. The assessment also adds further value in estimating the financial impact of HIV on your bottom line, projected into the future. This information could lead to a more customised intervention programme design and planning which is more appropriate for a group. The downfall of any statistical data modelling is that it highly dependent on the information provided as well as the size of the group. Estimates are based on model outputs and some variation around these should be expected. The variation of results is exacerbated by the lower number of employees.

Assuming the current profile and treatment, the information provided, assumptions (detailed in annexure C) and methodology outlined in this report, it is estimated that the HIV prevalence for employees of the Group in 2010 is 10.8%($CI_{95\%}$: 9.6-11.9%). The HIV prevalence in 2020 is projected to reduce to 9.8% ($CI_{95\%}$:8.8%-10.9%).

A key risk area is the high HIV prevalence amongst 'Other' employees, where 76% of the employees are allocated and the HIV prevalence is estimated to be in the order of around 13.5%($CI_{95\%}$: 12.1%-14.9%).

The financial effects of HIV over the period 2010 to 2015 are in the order of 1.89% of payroll (R2 235 per employee per annum). The financial consequences are compounded by the training requirements to replace employees in this area. There is also a concern around finding alternative positions for employees not well enough to perform their duties. The financial effects may also felt in the Management group where finding resources can be even more challenging.

The intervention of providing anti-retroviral therapy to employees using a treatment protocol of CD4 at 350 has the highest programme costs but also generates the highest level of savings as the Wellness programme only scenario. The nett savings are expected to be in the order of 21.6% of the status quo cost. These savings are increased if some of the treatment costs are covered by the medical scheme.

The results presented in this report are indicative and are sensitive to variations in the assumptions. We suggest that the assumptions set out in the report and annexure are reviewed for appropriateness and that a revision of this exercise is conducted on at least a biannual basis or should the circumstances of the company change significantly.

Appendix 8: Feedback Survey

This feedback questionnaire will be utilised for reporting to the MerSETA on this project. Your opinions and answers are considered highly valuable and all information will be held confidentially.

Please either fax back to 0866 843 717 or access from the CD and submit electronically to Vischer@mweb.co.za

A: Initial contact

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. The requirements to participate in the pilot project were explained to me.					
2. I understood the key objectives of the project.					
3. I see the necessity of this project.					
4. HIV/AIDS is an important workplace issue for my organisation.					

Comments:

B: Training

Did you or one of your employees attend the SAQA accredited training session provided as part of this project?	Yes	No

If yes:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
13. It was feasible for me to attend a six day training course.					
14. The training dates were convenient for me.					
15. The training location was convenient for me.					
16. The training location was pleasant					

17. The catering was of a good quality					
18. The presenter was easy to understand.					
19. The material was useful.					
20. The training met my expectations.					
21. The training requirements were easy to fulfil.					
22. The SAQA accreditation is important to me.					
23. I would like to have additional training on HIV/AIDS					
24. I was able to complete my PoE (if not please provide reasons why under the comments section)					

Comments:

If no:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
4. It was feasible for me to attend a six day training course.					
5. The training dates were convenient for me.					
6. The training location was convenient for me.					

Comments/reasons for not attending:

C: KAP survey

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
7. I understood the objectives of the KAP survey.					
8. I was able to get my employees to participate in the KAP survey.					
9. My employees were able to understand the questions in the KAP survey.					
10. The process of collecting the surveys was efficient.					
11. The comparison of my KAP survey responses to the other participants was useful.					
12. The results of the KAP survey are useful for developing my training strategy.					

Comments:

D: Economic Impact Evaluation

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
7. I understood the objectives of the EIA.					
8. The data requirements were explained to me.					
9. The data requirements were feasible to fulfil.					
10. The EIA report provided useful information.					

11. The comparison of my EIA results to the other participants was useful.					
12. The EIA report was easy to understand					

Comments:

E: Policy and practice

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
10. The evaluation of my workplace practices was useful.					
11. I shall be making adjustments to my workplace practices.					
12. The policy evaluation provided useful feedback.					
13. The toolkit will assist me with improving my workplace strategy with respect to HIV and AIDS.					
14. have perused the strategic training DVD provided to me.					
15. I will be utilising the strategic training DVD for my company.					
16. The toolkit will assist me with improving my training strategy with respect to HIV and AIDS.					
17. The recommendations on interventions were useful.					
18. I will be implementing interventions with respect to HIV and AIDS as a result of this project.					

Comments:

F: Overall

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
6. I am glad I participated in the pilot project.					
7. I have received adequate documentation and resources.					
8. The MerSETA should be commended for this project.					
9. The project manager ensured that I was aware of what was required of me and/or my organisation.					
10. I was well treated by the SEI project manager (if not, please provide comment)					

Comments:

Appendix 9: Rationale for a Strategic Support Plan (SSP)

I. Introduction

The MerSETA has committed to implementing assistance programmes for the participating companies and in terms of this intends to provide ongoing support to in the implementation of the strategic HIV/AIDS plan, Each participating company received a manual as part of their participation in the project, there were various recommendations and interventions discussed. These were put to each individual organization after they had been audited and were specific to their circumstances. The manual contains all of the interventions recommended by the Code of Good Practice supplemented by interventions from the International Labour Organisation. The manual also contains a CD with a toolkit and a list of resources to assist with implementation.

In order assist the MerSETA with budgeting, a Strategic Support Plan (SSP) questionnaire was given to all participants. The SSP questionnaire listed each intervention covered in the project and requested feedback on which of the interventions are proposed to be implemented during the next 3, 6 and 12 months.

II. Summary of responses:

12 Strategic Support Plan questionnaires were received by the 23 March 2011. For reporting purposes, the responses are split into two:

i. Already implemented, Unlikely to implement and No response
ii. For those participants who are planning to implement the indication of which of the interventions you intend implementing in the next 3, 6 and 12 months

i. Already implemented, Unlikely to implement and No response

Chart 1 provides a graphical count of participants who have selected:

- 'Already implemented',
- 'Unlikely to implement' or
- Did not respond to the question

Chart 1: Count Of participants, who selected '*Already implemented*', '*Unlikely to implement*' and '*No answer*:

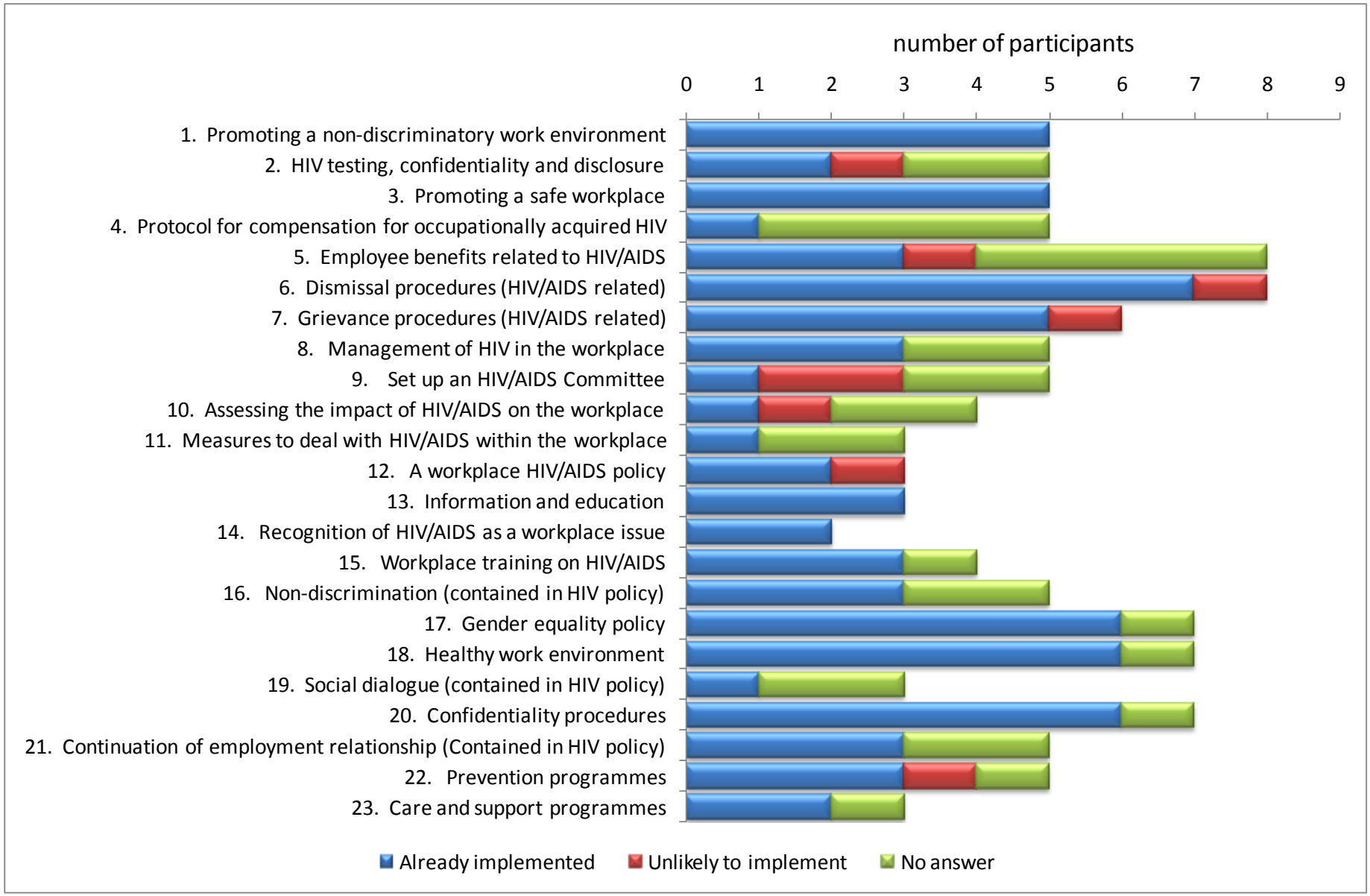
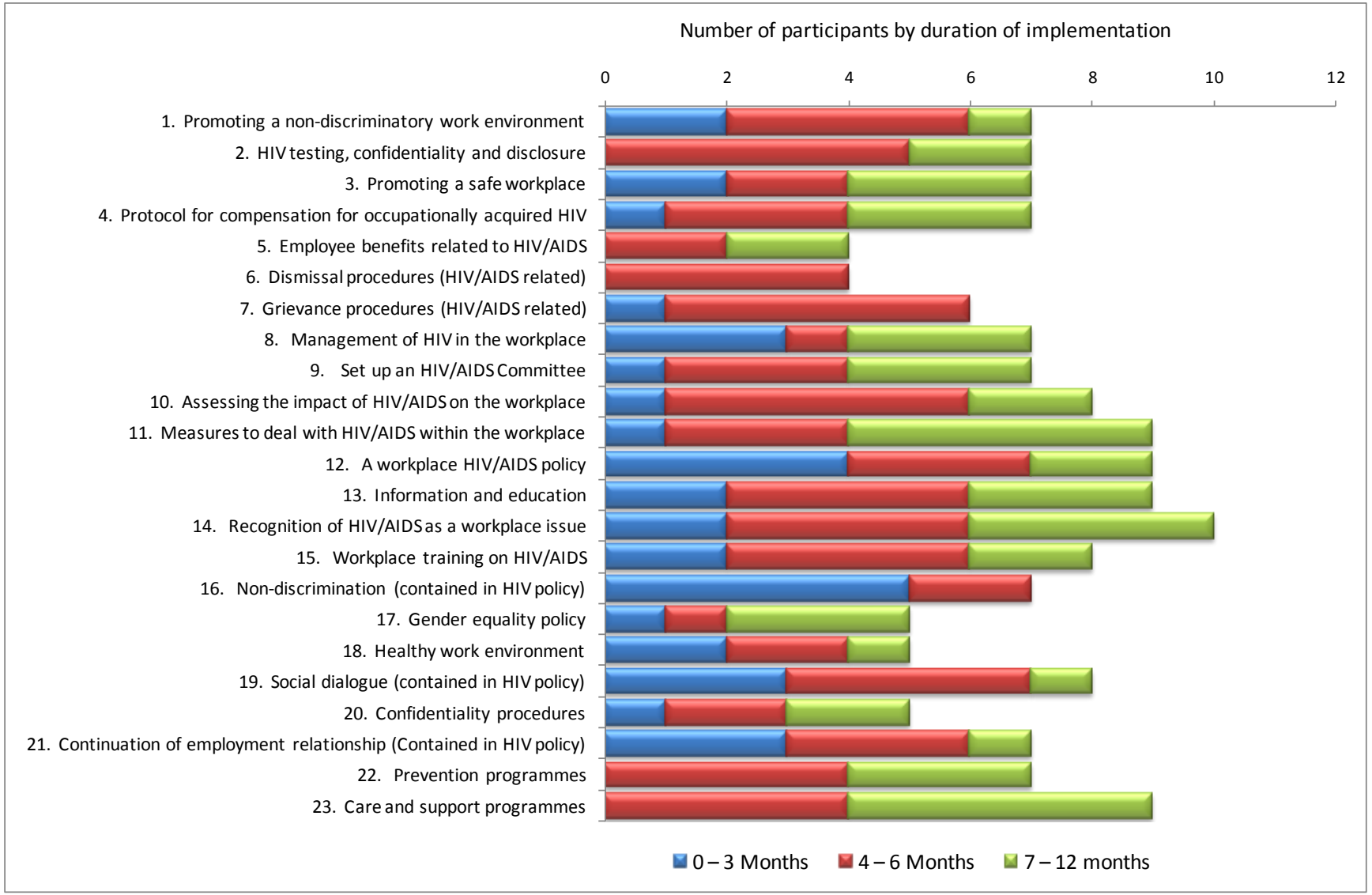


Chart 2: Count of participants who are planning to implement the indication of which of the interventions you intend implementing in the next 3, 6 and 12 months



1. Promoting a non-discriminatory work environment:
    - 42% participants have already implemented
    - 58% intending to implement is split 17% within the next 3 months, 33% within 6 months and 8% within 12 months
2. HIV testing, confidentiality and disclosure:
    - 17% participants have already implemented
    - 8% are unlikely to implement
    - 17% did not answer the question
    - 58% intending to implement is split 42% within 6 months and 16% within 12 months
3. Promoting a safe workplace
    - 42% participants have already implemented
    - 58% intending to implement is split 17% within the next 3 months, 17% within 6 months and 24% within 12 months
4. Protocol for compensation for occupationally acquired HIV
    - 9% participants have already implemented
    - 33% did not answer the question
    - 58% intending to implement is split 8% within the next 3 months, 25% within 6 months and 25% within 12 months
5. Employee benefits related to HIV/AIDS
    - 25% participants have already implemented
    - 8% are unlikely to implement
    - 33% did not answer the question
    - 34% intending to implement is split 17% within 6 months and 17% within 12 months
6. Dismissal procedures (HIV/AIDS related)
    - 58% participants have already implemented
    - 8% are unlikely to implement
    - The remaining 34% is intending to implement within the next 3 months
7. Grievance procedures (HIV/AIDS related)
    - 42% participants have already implemented
    - 8% are unlikely to implement
    - 50% intending to implement is split 8% within the next 3 months, 42% within 6 months
8. Management of HIV in the workplace
    - 25% participants have already implemented
    - 17% did not answer the question
    - 58% intending to implement is split 25% within the next 3 months, 8% within 6 months and 25% within 12 months
9. Set up an HIV/AIDS Committee
    - 8% participants have already implemented
    - 17% are unlikely to implement
    - 17% did not answer the question
    - 58% intending to implement is split 8% within the next 3 months, 25% within 6 months and 25% within 12 months

10. Assessing the impact of HIV/AIDS on the workplace
    - 8% participants have already implemented
    - 8% are unlikely to implement
    - 17% did not answer the question
    - 67% to implement is split 8% within the next 3 months, 42% within 6 months and 17% within 12 months
11. Measures to deal with HIV/AIDS within the workplace
    - 8% participants have already implemented
    - 0% are unlikely to implement
    - 17% did not answer the question
    - 75% to implement is split 8% within the next 3 months, 25% within 6 months and 42% within 12 months
12. A workplace HIV/AIDS policy
    - 17% participants have already implemented
    - 8% are unlikely to implement
    - 75% to implement is split 33% within the next 3 months, 25% within 6 months and the remaining 17% within 12 months
13. Information and education
    - 25% participants have already implemented
    - 75% to implement is split 17% within the next 3 months, 33% within 6 months and the remaining 25% within 12 months
14. Recognition of HIV/AIDS as a workplace issue
    - 17% participants have already implemented
    - 83% to implement is split 17% within the next 3 months, 33% within 6 months and the remaining 33% within 12 months
15. Workplace training on HIV/AIDS
    - 25% participants have already implemented
    - 8% did not answer the question
    - 67% to implement is split, 17% to implement within the next 3 months, 33% within 6 months and the remaining 17% within 12 months
16. Non-discrimination (contained in HIV policy)
    - 25% participants have already implemented
    - 17% did not answer the question
    - 58% to implement is split, 42% within the next 3 months and 16% within 6 months
17. Gender equality policy
    - 50% participants have already implemented
    - 8% did not answer the question
    - 42% to implement is split, 8% within the next 3 months, 8% within 6 months and the remaining 26% within 12 months
18. Healthy work environment
    - 50% participants have already implemented
    - 8% did not answer the question

- 42% to implement is split, 17% within the next 3 months, 17% within 6 months and the remaining 8% within 12 months

19. Social dialogue (contained in HIV policy
    - 9% participants have already implemented
    - 18% did not answer the question
    - 73% to implement is split, 27% within the next 3 months, 36% within 6 months and the remaining 10% within 12 months
20. Confidentiality procedures
    - 50% participants have already implemented
    - 8% did not answer the question
    - 42%, 8% within the next 3 months, 17% within 6 months and 17% within 12 months
21. Continuation of employment relationship (Contained in HIV policy)
    - 25% participants have already implemented
    - 17% did not answer the question
    - 58% to implement is split, 25% within the next 3 months, 25% within 6 months and 8% within 12 months
22. Prevention programmes
    - 25% participants have already implemented
    - 8% are unlikely to implement
    - 8% did not answer the question
    - 59% to implement is split, 0% within the next 3 months, 34% within 6 months and the remaining 25% within 12 months
23. Care and support programmes
    - 17% participants have already implemented
    - 8% did not answer the question
    - 75% to implement is split 0% within the next 3 months, 33% within 6 months and 42% within 12 months