

An Evaluation of Staff Attitudes towards the HIV and AIDS Workplace Programme at the Baphalali Swaziland Red Cross Society

Elliot Jele

Graduate of the Regent Business School, Durban, South Africa

Nadeem Cassim

Lecturer and Manager of Institutional Research, Regent Business School, Durban, South Africa
research1@regent.ac.za

Anis Mahomed Karodia (PhD) (Corresponding author)

Professor, Senior Academic and Researcher, Regent Business School, Durban, South Africa
akarodia@regent.ac.za

ABSTRACT

The purpose of the study was to conduct an evaluation of staff attitudes towards the HIV and AIDS workplace programme at the BSRCs. Four research objectives were to establish staff attitudes towards the HIV and AIDS workplace prevention, treatment, care, support, monitoring and evaluation programmes. The problems associated with the impact of HIV/AIDS in the world of work of BSRCs, as a non-profit making organisation, were loss in break-even margins, and employees' mortality and absenteeism. Both parties accumulate an increase in costs structures.

Keywords: *Evaluation; Attitudes; AIDS / AIDS; Communication; Employees; Families; Strategies; Formal and Informal Economy; Medical Aid Premiums*

INTRODUCTION

According to the ILO (2010:2), workplace programmes addressing employees' health and other associated health problems caused by the Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS), are critical for organisational survival. It is therefore crucial for organisations to establish HIV and AIDS workplace programmes because such programmes help reduce stigma and discrimination usually based on real or perceived HIV status against employees, their families and dependants. This in turn increases workers access to awareness, treatment, care and support services through the world of work. These factors contribute to what empirical literature would call 'decent work' (ILO, 2010:1).

LITERATURE REVIEW

Global HIV/AIDS Epidemic Trends at a Glance

UNAIDS (2012:8) argued that AIDS remains one of the world's most grave health challenges. According to this UNAIDS Report, there were 34 million people who were living with HIV in 2011. About 0.8% of adults, aged 15-49 years worldwide are living with HIV. Nearly one in every twenty adults (4.9%) is living with HIV and accounting for 23.5 million people, (69%) of the 34 million people living with HIV worldwide are in Sub Sahara Africa. Globally, 2.5 million people became newly infected with HIV in 2011 (UNAIDS, 2012:1-8).

Comparatively, the Sub-Saharan regional prevalence of HIV infection is nearly 25 times higher than Asia. After sub-Saharan Africa, the Caribbean and Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011 (UNAIDS, 2012:8).

The burden of the epidemic continues to vary exceedingly between countries and regions. If HIV trends were to remain constantly unchallenged, it was projected that by 2015, people living with HIV would be 60 million (Henry, 2007:1). However, the overall growth of the global AIDS epidemic appears to have stabilized. Even though the number of new infections is declining exceedingly, levels of new infections overall are still high. The sharpest declines in the numbers of people acquiring HIV infection since 2001 have occurred in the Caribbean (42%) and (25%) in sub-Saharan Africa (UNAIDS, 2012:8).

HIV/AIDS Epidemic in Swaziland

Swaziland is a landlocked country in Southern Africa, with a land surface area of 17, 364 square kilometres. It has four administrative regions (Hhohho, Manzini, Lubombo and Shiselweni). Swaziland is furthermore subdivided into 55 constituencies into which 360 chiefdoms and towns feed. The population size is projected at 1,093,158 by 2013 (Government of Swaziland 2011:1). Swaziland has a workforce of about 453 thousand (IMF, 2012:8). It also has an estimated 40% unemployment rate (KPMG, 2012:2). The percentage of people in Swaziland living in poverty is 63% (Government of Swaziland, 2011:1).

The first HIV positive person in Swaziland was diagnosed in 1986. The Government responded by establishing a national programme, called National AIDS Prevention and Control Programme (NAPCP), and later renamed the Swaziland National AIDS/STI Programme (SNAP). The World Health Organisation Global Programme on HIV/AIDS provided resources towards these activities. In 1987, a first AIDS case was discovered. The main source of data was notified AIDS cases and there was a steady increase from the earliest AIDS case in 1987 to over 150 in 1993 (Whiteside *at al.*, 2006:6).

Research Methodology

The overall study methodology was both quantitative and qualitative. The quantitative research focused on descriptive research (Brink, 2009:104). In this regard participants were asked to rate a given situation using a Likert Scale. The qualitative research sought to determine research participants’ feelings or opinions regarding the Red Cross HIV/AIDS workplace programme (Brink, 2009:113).

Limitations of the study

The Likert scale used for data collection had not been evaluated for psychometric properties among other civil society organisations in Swaziland. Respondents’ honesty, seriousness, accurate memory, and perceptions of the employees examined in this survey are specific to the Red Cross work climate and may differ from the opinions of staff working in other civil Society organisations, and therefore, caution was considered regarding external validity.

RESULTS, DISCUSSION AND INTERPRETATION OF FINDINGS

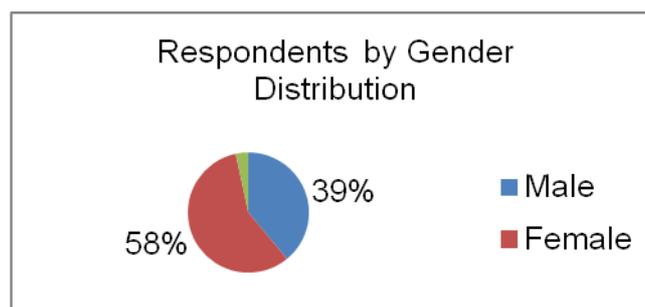
Section A: Social Demographics

Response Rate

Questionnaires distributed to work stations (Head office, 3 Clinics and 5 Divisions) were 60, and fifty-nine were returned. A 98.3% response rate was achieved. A total of Fifty-nine respondents participated in the survey. Three out of fifty-nine returned questionnaires were discarded because respondents indicated that they were not aware of the BS RCS HIV/AIDS Policy and yet, went on to respond to questions 8 to 32, and most of the responses were recorded as uncertain.

Distribution of respondents by Sex

Figure 4.1 Distributions of Respondents by Sex



The distribution of respondents by sex showed that male respondents were 39% while females had 58%. Of the respondents, only 8.5% were between 51 to 60 years and 16.9% between 21 to 30 years, majority of the respondents were between age group 31 to 50 years (74.6%) as illustrated in figure 4.4.

Respondents by workstation

Table 4.1 Work Station

		Frequency	Percent	Cumulative Percent
Valid	HQ	16	27.1	27.1
	Clinic	29	49.2	76.3
	Division	14	23.7	100.0
	Total	59	100.0	

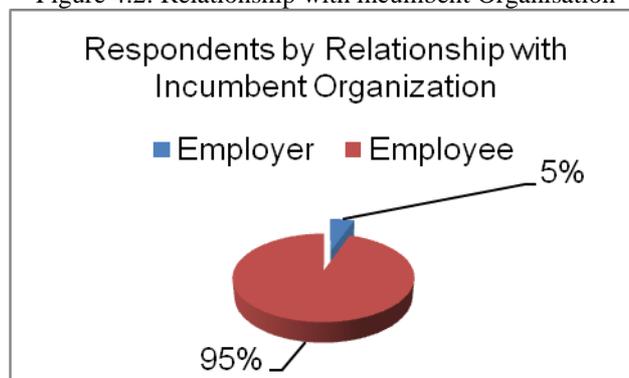
Table 4.1 shows 49.2% of the respondents are stationed at the clinics with Headquarters at 27.1% following and Divisions staggering at 23.7%. The location of employees has a direct bearing on factors regarding vulnerabilities. All divisional offices are located in towns, (i.e. 25%) while clinic employees are situated in rural settings. Commonly, poor and inequitable distribution of health infrastructure and personnel has been identified as a driver of the epidemic in Southern regions of Nigeria (Akinrimisi, Blake, and Samuels, 2012:17-19).

Occupational Level & Respondents by Relationship with Incumbent Organisation

Table 4.2 Occupational Level

Management level	Frequency	Percentage
Senior	1	1.69%
Middle	11	18.64%
Line	14	23.73%
Other	33	55.93%
Total	59	0.9999%

Figure 4.2: Relationship with incumbent Organisation



As illustrated in figure 4.2 senior management is represented by 2% while middle management is represented by 18.64%, and line management 23.73%. Figure 4.2.2 illustrates that staff regard that there is 5% and 95% ratio considering themselves as employer and employee with the incumbent organisation respectively.

Figure 4.3: Experience with BSRCS

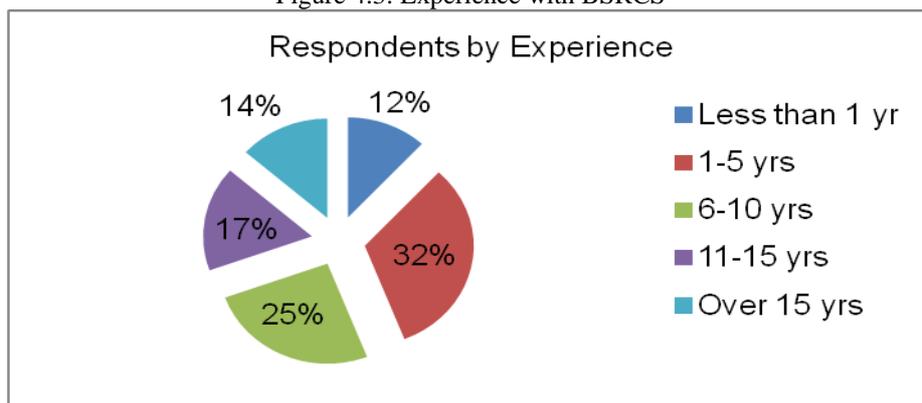
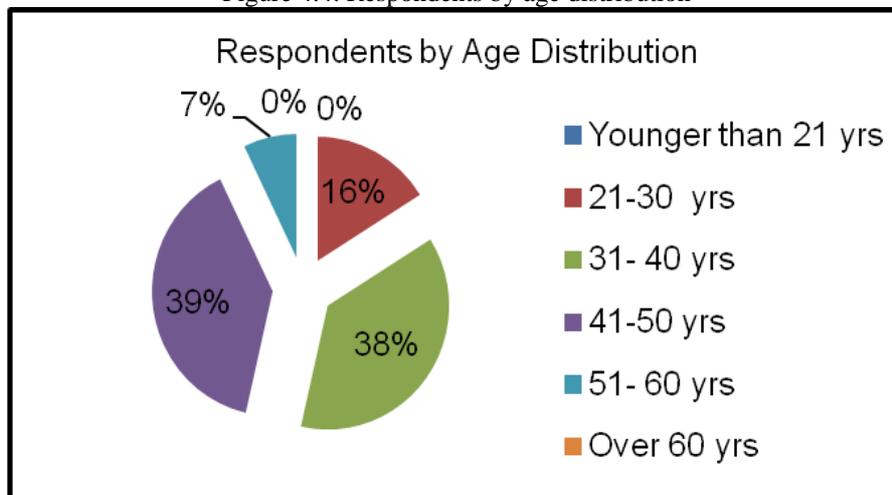


Figure 4.3 illustrates that of the respondents, 32% of them are between 1 and 5 years of service, 25% were between 6 and 10 years, 14% were over 15 years and the least was those less than one year of service who made up 12% . This indicates that 30.51% of the respondents have been with the organisation since the inception of the BSRCS HIV/AIDS policy in 2002.

Age of Respondents

Figure 4.4. Respondents by age distribution



As illustrated in figure 4.4, the majority of the respondents are between 31 and 40 years (38%) and 41 and 50 years (39%), those in the age group 21 to 30 and 51 to 60 years constitute 16% and 7% respectively.

Section B: Staff attitudes towards HIV and AIDS in the workplace

Research objective 1: to determine the response mechanisms put in place aimed at addressing HIV/AIDS in the workplace

Awareness of the BSRCS HIV/AIDS policy

Figure 4.5: Awareness of the BSRCS Workplace HIV/AIDS Policy

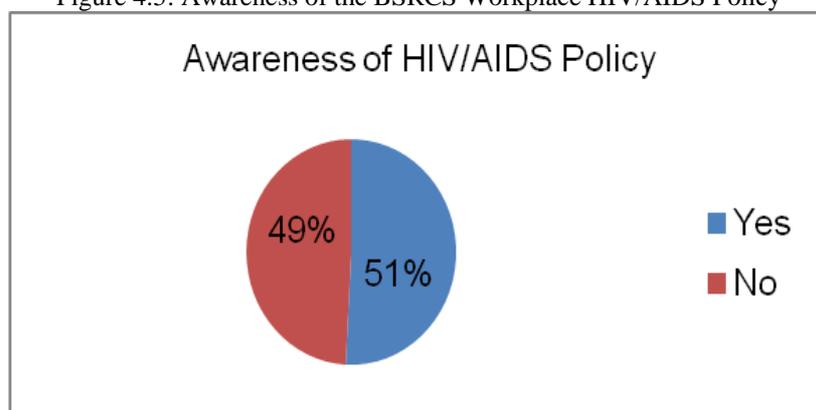
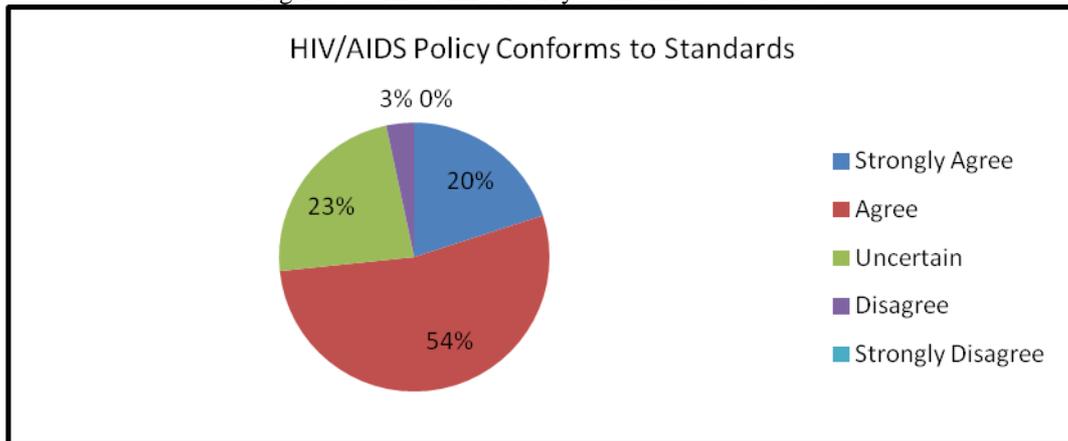


Figure 4.5 demonstrates that half (51%) of the respondents interviewed, knew of the BSRCS HIV/AIDS policy and 49% were not aware of the policy. Of the 51% who were aware of the policy, 40% were males and 60% were females. The 51% demonstrates an organisation’s commitment to the global call by the Red Cross Movement that all National Societies should have policies that established HIV/AIDS workplace programmes (IFRCS,2010:13;30).

HIV/AIDS Policy Conforms to ILO Code of Practice & the Tripartite Declaration to Combat HIV/AIDS in the World of Work in Swaziland

Figure 4.6: HIV/AIDS Policy Conforms to Standards



Roughly, 74% (54% agree and 20% strongly agree) of the respondents were in agreement that the BSRCS HIV/AIDS Policy was in conformity to the Tripartite Declaration to combat HIV/AIDS in the workplace and the ILO Code of Practice on HIV/AIDS and the World of work. However only a nominal 3.3% disagree and 23% uncertain as demonstrated in figure 4.6.

BSRCS HIV/AIDS workplace programme mainstreaming

Table 4.3 HIV/AIDS Programme Mainstreamed In All Programmes

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	2	6.7	6.7	6.7
	Disagree	3	10.0	10.0	16.7
	Uncertain	6	20.0	20.0	36.7
	Agree	14	46.7	46.7	83.3
	Strongly Agree	5	16.7	16.7	100.0
	Total	30	100.0	100.0	

Of the respondents who were aware of the HIV/AIDS policy, 46.7% of them agree that the policy was mainstreamed in all programmes through consultative process between employer, employee and other stakeholders, 16.7% strongly agree. However, 10% disagreed; with 6.7% strongly disagreed and 20% were uncertain. Mainstreaming refers to four prong concepts that refer to internal, external, developing an HIV/AIDS policy, and measuring HIV/AIDS competence.

Structures for workplace programme implementation

Table 4.4 BSRCS has established appropriate structures

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	3	10.0	10.0	10.0
	Disagree	4	13.3	13.3	23.3
	Uncertain	7	23.3	23.3	46.7
	Agree	9	30.0	30.0	76.7
	Strongly Agree	7	23.3	23.3	100.0
	Total	30	100.0	100.0	

Table 4.4 revealed that out of the respondents who were aware of the policy, 30.0% agreed that structures for workplace programme implementation were in place, while 23.3% strongly agree. About 13.3% disagree and 10.0% strongly disagreed. However, 23.3% respondents were uncertain.

HIV/AIDS Workplace Committees

Table 4.5 BSRCs has established workplace HIV/AIDS programme committees

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	3	10.0	10.0	10.0
	Disagree	9	30.0	30.0	40.0
	Uncertain	8	26.7	26.7	66.7
	Agree	7	23.3	23.3	90.0
	Strongly Agree	3	10.0	10.0	100.0
	Total	30	100.0	100.0	

According to Vass (2008:5) the powers of workplace committees are largely consultative, and employee committee members are often managed in an indirect manner to secure and extend social protective rights on HIV/AIDS to employees, and monitor their effective implementation in practice.

HIV/AIDS Workplace Peer-to-Peer dialogues

Table 4.6 Peer-to-Peer dialogues

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	4	13.3	13.3	13.3
	Disagree	3	10.0	10.0	23.3
	Uncertain	10	33.3	33.3	56.7
	Agree	7	23.3	23.3	80.0
	Strongly Agree	6	20.0	20.0	100.0
	Total	30	100.0	100.0	

Out of the 50.85% respondents who were aware of the policy, 23.3% agreed that peer-to-peer dialogues were functional, and 20.0% strongly agree. About 10.0% disagree and 13.3% strongly disagreed.

Objective 2: To establish staff attitudes towards the HIV and AIDS workplace prevention programmes put in place to address information and education gaps, voluntary testing and counselling services, and self-care practices that Reduce transmission of HIV.

Staff receive information about HIV/AIDS

Table 4.7 All Staff receive information about HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	4	13.3	13.3	13.3
	Uncertain	8	26.7	26.7	40.0
	Agree	10	33.3	33.3	73.3
	Strongly Agree	8	26.7	26.7	100.0
	Total	30	100.0	100.0	

The World Bank workplace programme recommends theme that employers should follow such as leadership and clear communication structure. Statistical findings show that 33.3% of the respondents agreed that staff receive culturally sensitive, accurate, up to date, relevant and timely information about HIV/AIDS in any of the official language in Swaziland.

Workplace Programmes and Education

Table 4.8 Workplace programmes provides comprehensive education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Disagree	6	20.0	20.0	23.3
	Uncertain	6	20.0	20.0	43.3
	Agree	10	33.3	33.3	76.7
	Strongly Agree	7	23.3	23.3	100.0
	Total	30	100.0	100.0	

As demonstrated in table 4.8, 33.3% of the respondents agree that the workplace HIV/AIDS prevention programmes provides comprehensive education to help staff, and 23.3% strongly agree. Only 3.3% strongly disagree and 20% disagree.

Access to Necessary supplies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	3	10.0	10.0	10.0
	Uncertain	1	3.3	3.3	13.3
	Agree	15	50.0	50.0	63.3
	Strongly Agree	11	36.7	36.7	100.0
	Total	30	100.0	100.0	

As illustrated in table 4.9 where 50.0% of the respondents agreed that the BSRCS has provided staff with access to supplies such as male and female condoms, and 36.7% strongly agree. Only 10% disagreed, and 3.3% were uncertain.

Staff in high risk areas have access to necessary services such as PEP

Table 4.10 Staff in high risk areas have access to necessary services such as PEP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	2	6.7	6.7	6.7
	Disagree	6	20.0	20.0	26.7
	Uncertain	6	20.0	20.0	46.7
	Agree	8	26.7	26.7	73.3
	Strongly Agree	8	26.7	26.7	100.0
	Total	30	100.0	100.0	

Post exposure prophylaxis (PEP) services are one of the measures put in place to minimize the risk of further infections to employees in high risk areas.

BSRCS HIV/AIDS Workplace Policy has a Harm reduction strategy

Table 4.11 Workplace programme has harm reduction strategy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Disagree	4	13.3	13.3	16.7
	Uncertain	11	36.7	36.7	53.3
	Agree	9	30.0	30.0	83.3
	Strongly Agree	5	16.7	16.7	100.0
	Total	30	100.0	100.0	

The table suggests that 30.0% of the respondents agreed that the workplace programme has harm reduction strategies, and 16.7% strongly agreed. Approximately 3.3% strongly disagreed and 13.3% disagreed, 36.7% were uncertain as indicated in table 4.11.

BSRCS HIV/AIDS Workplace programme Promotes Harm Reduction Measures that minimise HIV infection risk

Table 4.12 Harm Reduction Measures

		Frequency	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	3	3
	Disagree	3	10	10
	Uncertain	5	17	27
	Agree	8	27	
	Strongly Agree	13	43	100.0
	Total	30	100	

Results indicate that 43% of the respondents strongly agreed that the BSRCS does promote measures that minimize HIV infection risk, with 27% agreeing. Only 3% strongly disagreed and 10.0% disagreed, and 17% remain uncertain.

Voluntary HIV Testing

Table 4.13 Staff test for HIV voluntarily

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Uncertain	4	13.3	13.3	13.3
	Agree	9	30.0	30.0	43.3
	Strongly Agree	17	56.7	56.7	100.0
	Total	30	100.0	100.0	

As demonstrated in table 4.13 that 86.7% of the respondents affirmatively said there was voluntary HIV testing without coercion. That is 30% agreed and 56.7% strongly agreed. Only 13.3% were uncertain.

Pre-employment HIV testing and Medical screening

Table 4.14 BSRCS does not require HIV testing or medical screening

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Uncertain	4	13.3	13.3	13.3
	Agree	5	16.7	16.7	30.0
	Strongly Agree	21	70.0	70.0	100.0
	Total	30	100.0	100.0	

Respondents who on this subject, 16.7% of the respondents who are aware of the HIV/AIDS policy agreed that BSRCS does not require pre-employment HIV testing or medical screening, and 70% strongly agreed to the fact, with only the uncertain proportion making up the 13.3% as illustrated in table 4.14.

Personal data protection

Table 4.15 Staff personal data are always protected

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Disagree	2	6.7	6.7	10.0
	Uncertain	13	43.3	43.3	53.3
	Agree	6	20.0	20.0	73.3
	Strongly Agree	8	26.7	26.7	100.0
	Total	30	100.0	100.0	

In table 4.15 about 43.3% of the respondents were not sure whether staff personal data are always protected as enshrined in the ILO code of practice, and other relevant international data protection standards. A total of 46.7% were affirmative and only 10% were not.

Staff personal data are always protected * Staff who confides their HIV status not deprived access to jobs

Table 4.16 Staff personal data are always protected * Staff who confides their HIV status not deprived access to jobs

		Staff who confides their status not deprived access to jobs				Total
		Disagree	Uncertain	Agree	Strongly Agree	
Staff personal data are always protected	Strongly disagree			100.0%		100.0%
	Disagree				100.0%	100.0%
	Uncertain		15.4%	15.4%	69.2%	100.0%
	Agree		33.3%	50.0%	16.7%	100.0%
	Strongly Agree	12.5%			87.5%	100.0%
Total	3.3%	13.3%	20.0%	63.3%	100.0%	

There was 43.3% proportion of respondents who were uncertain about the protection of personal data, while 69.2% of them strongly agree that staffs who confide their HIV status to the employer are not deprived access to jobs, tenure, and 15.4% of them agree.

Conclusion to research objective 2

It can be concluded that staff have a positive attitude towards HIV/AIDS workplace prevention programme activities put in place to address information and education gap, VCT services and self-care practices that reduce transmission of HIV infection.

Objective 3: To investigate the degree of attitudes towards treatment, care and support services accessible to employees at the working-stations of the BSRCS.

Working Space sharing

Table 4.17. Staff living with HIV or those perceived share working space

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	8	26.7	26.7	26.7
	Strongly Agree	22	73.3	73.3	100.0
	Total	30	100.0	100.0	

Findings indicate that 73.3% of the respondents strongly agreed to the fact that they share working space with those staff members living or perceived to be living with HIV and another 26.7% agreed to give a 100% affirmative response as indicated in table 4.17, confirms the improved knowledge on the modes of HIV transmission, hence employees’ higher tolerance for people living with HIV.

Stigma and discrimination

Table 4.18. BSRCS who stigmatise and discriminate risk losing their jobs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	2	6.7	6.7	6.7
	Disagree	2	6.7	6.7	13.3
	Uncertain	14	46.7	46.7	60.0
	Agree	6	20.0	20.0	80.0
	Strongly Agree	6	20.0	20.0	100.0
	Total	30	100.0	100.0	

A total of 40% (20% Agree, 20% strongly agree) of the respondents who are aware of the BSRCS HIV/AIDS policy said BSRCS staff who stigmatise and discriminate risk losing their jobs.

Possibility of Carrying on with Work when Fit

Table 4.19 BSRCS policy provides the possibility of carrying on with work when fit

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Uncertain	5	16.7	16.7	20.0
	Agree	11	36.7	36.7	56.7
	Strongly Agree	13	43.3	43.3	100.0
	Total	30	100.0	100.0	

Table 4.19, indicates that 36.7% of respondents agreed that the policy has provisions for continuing on with work once fit from HIV/AIDS related sickness and 43.3% strongly agreed.

In conclusion to research objective 3

There is a high positive degree of attitudes towards treatment, care and support services accessible to employees at the working-stations of the BSRCS given their high positive affirmation on different forms of attitudes towards people living with HIV/AIDS.

Objective 4: To explore attitudes related to monitoring and evaluation of the HIV and AIDS workplace programme practices

Workers’ Representatives have right to be informed on workplace policy

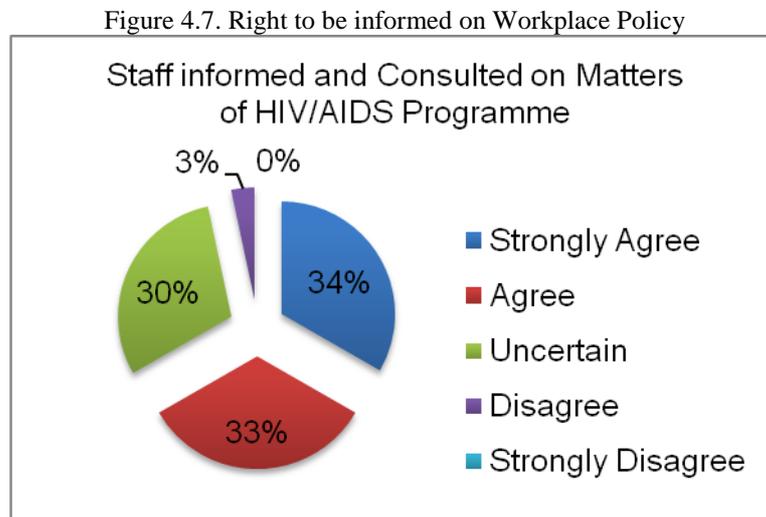


Figure 4.7 expressed that 33.3% of the respondents agreed that work representatives have the right to be informed on workplace policy and 33.3% strongly agreed with a significant number of uncertainties making the other 30%.

Workplace Inspections

Table 4.20 Workers and employers representatives participate in workplace inspections

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Disagree	4	13.3	13.3	16.7
	Uncertain	12	40.0	40.0	56.7
	Agree	10	33.3	33.3	90.0
	Strongly Agree	3	10.0	10.0	100.0
	Total	30	100.0	100.0	

The table above indicates that 33.3% of respondents agreed that employees’ and employers’ representatives participate in workplace inspections, and a further 10% strongly agree, however there was a 40% proportion that were not sure whether employer representative were participating.

BSRCS HIV/AIDS workplace programme monitoring

Table 4.21 BSRCS HIV/AIDS workplace programme is monitored closely for developments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Disagree	2	6.7	6.7	10.0
	Uncertain	11	36.7	36.7	46.7
	Agree	9	30.0	30.0	76.7
	Strongly Agree	7	23.3	23.3	100.0
	Total	30	100.0	100.0	

Table 4.21 shows that, of the respondents who are aware of the BSRCS HIV/AIDS policy 30% agreed that the workplace programme is monitored closely for developments and 23.3% strongly agreed to give an affirmative response of 53.3%. Approximately 6.7% of respondents disagreed with 3.3% strongly disagreeing.

Policy and Data collection

Table 4.22 BSRCS policy allows for collection of data about the programme for improvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	3.3	3.3	3.3
	Disagree	4	13.3	13.3	16.7
	Uncertain	8	26.7	26.7	43.3
	Agree	14	46.7	46.7	90.0
	Strongly Agree	3	10.0	10.0	100.0
	Total	30	100.0	100.0	

Collection of accurate information on HIV/AIDS programme would help organisations to set up future strategies on productivity and set realistic human resource strategies. According to the Asian Business Coalition on AIDS (2002:3-4), for any organisation to thrive, there is need to protect its economy, social and the human resource interests by providing healthy occupational settings that acknowledge the potential impact of HIV/AIDS in the workplace.

Conclusion to research objective 4

Based on the results of the analysis, it can be concluded that there is minimal monitoring and evaluation of the HIV and AIDS workplace programme practices mainly due to employer representatives not being part of the workplace inspections and also the lack of close monitoring of the programme.

CONCLUSIONS AND RECOMMENDATIONS

Findings from the study

Findings from the study were divided into literature review, and the primary research findings.

Findings from the literature review:

Prevalence of HIV infection

The global HIV prevalence rates have stabilized. However, Southern Africa has the highest adult prevalence rate record with the Asian countries recording a steady rise in the HIV prevalence rates. Swaziland, in particular is still the leading country with the highest adult HIV prevalence rate. Key drivers of the epidemic in Swaziland are poverty, multiple and concurrent sexual partnerships, low and inconsistent condom use, intergenerational sex, early sexual debut, and low HIV testing and disclosure.

Findings from the primary research

Findings from the primary research were based on the social demographics, and the four research objectives. The four research objectives had HIV/AIDS response mechanisms, staff attitudes towards HIV and AIDS workplace prevention, treatment, care, support, monitoring and evaluation themes.

Social Demographics

According to the ratio of respondents who participated in the study, the assumption drawn was that BSRCS had a higher ratio of female respondents than their male counterparts.

Research objective 1

To determine the response mechanisms put in place aimed at addressing HIV and AIDS in the workplace

BSRCS has in place mechanisms such as the policy itself, and at some extent tried to operationalize the policy. The setting of a medical scheme, initiation of savings and credit cooperatives as well a non-contributory funeral schemes were some of the policy related initiatives established by the BSRCS in response to the epidemic.

Research Objective 2

To establish staff attitudes towards the HIV and AIDS workplace prevention programmes put in place to address information and education gaps, voluntary testing and counselling services, and self-care practices that Reduce transmission of HIV.

BSRCS made use of the public sector services available to the employees, and these are information materials, access to condoms, voluntary counselling and testing services. However, respondents had a feeling the human resources department needed to ensure that personal health information was kept confidential and kept well secured. Findings also have shown that BSRCS does not conduct pre-employment HIV testing or medical screening just for the purpose of securing employment. Staffs were positive that the employer was not being discriminatory.

Research objective 3

To investigate the degree of attitudes towards treatment, care and support services accessible to employees at the working-stations of the BSRCS.

In general, staff at BSRCS on tolerant of each other. However, there is need to enforce the policy on stigma and discrimination. Areas that need attention were orientation of staff at recruitment stage, ongoing health education, through peer-to-peer and setting up a support group structure at the BSRCS workplace.

Research objective 4

To explore attitudes related to monitoring and evaluation of the HIV and AIDS workplace programme practices

BSRCS has minimal monitoring and evaluation programmes in paces that address HIV and AIDS workplace programme issues. This was partly due to employee representatives not being part of the workplace inspections and also the lack of close monitoring of the programme.

Recommendations

One of the research objectives was to recommend good practice approaches to BSRCS regarding HIV/AIDS workplace programming by May 2013

Guiding Principles on the BSRCS Workplace HIV/AIDS Programme

BSRCS recognizes HIV/AIDS as a workplace issue. However, the organisation needs to strengthen its leadership, structures, and partnerships aimed at addressing the spread of the infection, treatment, care, and support response mechanism in consultation with the staff's representatives.

Basics of an effective Workplace HIV/AIDS Programme

Besides the mechanisms, the BSRCS needs to enforce the implementation and monitoring of the policy at all work stations through all managerial levels. Monitoring systems that the BSRCS may put in place include but are not limited to personnel profiling, critical post analysis, and assessment of organisational characteristics, liabilities, productivity, and organisational context.

Development of workplace HIV/AIDS Programmes

BSRCS Workplace HIV/AIDS policy was actually crafted to address two policy areas. These are Impact of HIV/AIDS and other life threatening Illnesses on households and implications for the employer. It is recommended that BSRCS should consider conducting regular assessments to determine whether the programme has been relevant and effective in addressing those needs over time for both the impact on employees and the implications for the employer.

Workplace HIV/AIDS Prevention Programmes

There is need for education and awareness in the protection of staff personal data and also compliance on both International and National standards enshrined in the ILO Code of Good Practice on HIV/AIDS and the World of Work.

Workplace HIV/AIDS treatment, and care and support Programmes

BSRCS staffs need an orientation at recruitment stage, a continuous information, education and communication through structured peer education programme, and staffs supports group, and a HIV/AIDS committee.

Strategies aimed at managing the institutional impacts caused by HIV/AIDS

Knowledge Management

Respondents indicated that it was important that employees' personal data should be kept safely and confidential so that the trust between the employer and the employee is kept at a very high level.

Work design

As the impact of the epidemic grips the organisation, and vital skills also get lost, the organisation should ensure that job descriptions are regularly reviewed in response to the skills gap. Peer education would also help in the knowledge sharing so that the organisation is able to cope with the impact of the epidemic.

Career Development and succession planning

This involves regular identification and development of employees with high potential and ensuring that enough people are equipped to take over key positions within the BSRCS should they fall vacant.

Areas for further research

Determining the nature of the threat

The BSRCS does not have a traceable record of how the impact of HIV/AIDS has affected the organisation in the past and how the future would look like given certain scenarios. This can be achieved through personnel profiling, critical post analysis, and assessment of organisational characteristics, liabilities, productivity, and organisational context.

CONCLUSIONS

The study discussed findings from the study, recommendations, and areas for future research. Findings from the study focused on both primary research and secondary literature review. Secondary literature review looked at the trends of the HIV/AIDS epidemic at global, regional, sub-regional and country levels and the Kingdom of Swaziland.

NOTE: The principal author presented this dissertation to the Regent Business School, in 2013, in partial fulfilment for the award of the Degree of Master of Business Administration (MBA). The dissertation was supervised by Nadeem Cassim, Lecturer and Manager of Research and the dissertation was edited by Professor Anis Mahomed Karodia. Both these academics work for the Regent Business School, Durban, South Africa. Part of the bibliography is cited, pertaining to this paper. If a copy of the full dissertation is required, a request must be made furnishing reasons for the use and the organization that the request is being made from: akarodia@regent.ac.za

REFERENCES

1. Akinrimisi, B., Blake, C. and Samuels, F. (2012). *HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria*. Overseas Development Institute [Online], Available from: <http://www.odi.org.uk/resources/docs/7581.pdf>. [Accessed, 12th May 2013:1740].
2. Brink, H. (2009). *Fundamentals of Research Methodologies for Health Care Professionals* 2nd ed. Lansdowne Cape Town: Juta and Company.
3. BSRCS. (1996). *Twenty Fifth Anniversary*, Mbabane: Swaziland.
4. Government of Swaziland, (2010). *Swaziland HIV Estimates and Projections Report*. National Emergency Response Council on HIV/AIDS. [Online]. Available from: <http://www.infocenter.nercha.org.sz/sites/default/files/SwaziHIVEstimates.pdf> [Accessed, 10th January 2013:17:30].
5. Government of Swaziland. (2011). *Poverty in a decade of slow economic growth: Swaziland in the 2000's*. Ministry of Economic Planning and Development – Census Department, Mbabane: Swaziland.
6. Government of Swaziland. (2011). *Swaziland Household Income and Expenditure Survey*. Government of Swaziland, Census Department, Mbabane: Swaziland.
7. Henry, J. (2007). *The Multi-sectoral Impact of the HIV/AIDS Epidemic – A Primer*. Kaiser Family Foundation. [Online] Available from: <http://www.kff.org>. [Accessed, 12th February 2013: 18:50].
8. ILO. (2010). *Recommendations Concerning HIV/AIDS & the World of Work, 2010*. International Labour Organisation. [Online], Available from: http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_112365.pdf. [Accessed 11th March 2013:19:50].
9. IMF. (2012). *IMF Country Report No. 12/37*. International Monetary Fund, Geneva. [Online], Available from: <http://www.imf.org/external/pubs/ft/scr/2012/cr1237.pdf>. [Accessed, 12th March 2013:1805].
10. KPMG. (2012). *Swaziland Country Profile*. KPMG Cutting Through Complexity. [Online], Available from: <http://www.kpmg.com/Africa/en/KPMG-in-Africa/Documents/Swaziland.pdf> [Accessed, 26th May 2013:17:00].
11. UNAIDS. (2012). *Regional Fact Sheet: Sub Sahara Africa*. Joint United Nations Programme on HIV/AIDS. [Online], Available from: https://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012_FS_regional_ssa_en.pdf [Accessed, 10th January 2013:1755].
12. UNAIDS. (2012). *Report on the Global AIDS Epidemic*. Joint United Nations Programme on HIV/AIDS. [Online], Available from: <http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/January 2013:1700>.
13. Whiteside, A., Hickey, A., Ngcobo, N., and Tomlinson, J. (2006). *What is driving the HIV/AIDS epidemic in Swaziland, and what more can we do about it?* National Emergency Response Committee on HIV/AIDS (NERCHA) and United Nations Programme on HIV/AIDS (UNAIDS). Swaziland. [Online], Available from: <http://allafrica.com/download/resource/main/main/idadtc/00010555:08b98d36e5efddab4f9b5ccd922bf055.pdf> [Accessed, 10th January 2013:1650].