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CHALLENGES TO IMPROVING UPTAKE LEVELS OF HIVAND AIDS SERVICES IN THE WORKPLACE: A LITERATURE REVIEW PERSPECTIVE FROM SOUTH AFRICA

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Abstract
This paper explores existing research findings on factors impacting on the efforts to improve uptake of Human Immunodeficiency Virus and Acquired Immunodeficiency Deficiency Syndrome (hereinafter HIV and AIDS) services in the workplace. Relevant literature for review is collected through desk and internet research. The paper begin with an evaluation of the rationale for upscaling the use of HIV and AIDS services in the workplace. Literature survey identify the desire to minimise the negative impact of the epidemic to business viability emerge as the prime employer motive for encouraging high use levels. It is also found employees face social, behavioural, infrastructural barriers in the workplace, which discourage them to use the available services. In conclusion, literature findings suggest coming up with programs to make the services readily available and reduce the presence of barriers to uptake such as stigma and discrimination.

Keywords: Employee uptake, HIV and AIDS, workplace, business, testing

INTRODUCTION

Research conducted in workplaces over the years explored uptake and utilisation level of HIV and AIDS services with key focus on barriers and challenges to accessibility of these services to employees (Weihs & Meyer-Weitz, 2016). While businesses have conceded to implement policies to manage the epidemic in these workplace and mitigate its negative impact on business viability (van Der Borght, Schim, der Loe et al. 2010), the results of such interventions

have not yielded different results from public health HIV efforts to the general population. Employee uptake and utilisation levels remain low as has also been observed in non-work related settings (Malla, Middelkoop, Mark, Wood & Bekker 2013; Johnson, Rehle, Jooste & Bekker, 2015). Public health figures assert one in five individuals opt to test for HIV in South Africa (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2012; Sishana & Simbayi, 2002). This situation prevails despite evidence of improved in individuals' knowledge levels about the epidemic and available services (Kassile, Kukula, Anicetus & Mmbando, 2014:2). There is also evidence to show infrastructure and resource support has upscaled to combat the epidemic (Musheke, Ntalasha, Gari et al, 2013), but positive behavioural response to utilisation exhibits a lethargic pattern. HIV and AIDS incidence rates remain high (Zaidi, Grapsa, Tanser & Newell 2013) because of a high number of people who have not tested and are unaware of their HIV status. Even where workplaces and other social environments have been transformed to provide HIV counselling and testing (HCT), treatment and care services as complementary to public health service provisions, this resistance to utilisation remain evident (Bor, Rosen & Chimbindi, 2015; Wight, Leblanc & Aneshensel, 1995). The desire to uncover reasons that explain low utilisation levels accordingly become important if corrective action can be put in place. This paper reviews literature findings of scholarly and empirical studies shedding light on patterns of HIV and AIDS in the workplace and the rationalisation of business contribution to the epidemic management. Insight will also be taken of structural and social determinants of uptake levels of HIV and AIDS services experienced in the workplace and communities.

APPROACH OF THE STUDY

This literature review exercise used desk and internet research to gather information. Desk research was used to access data from published academic books while internet search collected much of the published journal literature reviewed. This approach is consistent with literature review based research.

Rationale for upscaling HIV and AIDS services uptake in the workplace

Focus on the workplace as part of targeted epidemic intervention strategies aims to expand the framework of HIV and AIDS control efforts and improve access to HIV prevention, treatment, care and support (International Labour Organisation, 2010:1). HIV and AIDS in the workplace is also a production and welfare cost that the business sector is interested in because of its direct impact on viability, profitability and long term competitiveness (Udeh, Smith & Shava 2014:245). The epidemic increase national death and morbidity rates (Chen, Rhodes, Hall et al, 2012; Giese, 2002), worsen poverty in poor resource corners of the globe, leads to problems of

orphans and social instability in communities among other negative social impacts (Ramjee & Daniels, 2013). In the corporate sector economic models have been developed to aggregate business losses as a result of low employee morale and high stress incidences, high employee turnover and employment costs, loss of productive capacity, increase in employee benefit pay-outs and decline in labours supplies (Booysen, Geldenhuys & Marinkov, 2003; Pillay & Terblance, 2012). A study in Botswana (Jefferis, Kinghorn, Siphambe & Thurlow, 2008) correlates the use of economic modelling to express how loss of income in households and government coffers because of HIV and AIDS drive poverty levels up and consequently drop the product consumption capacity of communities to the detriment of business survival. In context HIV and AIDS creates poor communities which threaten the survival of business and promotes the proliferation of social ills such theft, unemployment, dissolution of families, proliferation of sex work and general instability (Seeley, Dercon & Barnett, 2010). The diseases has also been associated with reduced national economic growth potential (Natrass, 2004:150; Ostergard & Rubin, 2007:115). While individual employees lose earnings because of AIDS-induced redundancy, recurrent funeral costs in households' increase indebtedness and poverty (Verma, 2015; Collins & Liebbrandt, 1997). As a result of these evident negative impact which directly affect business, it was hoped socially responsible companies could see HIV and AIDS asan opportunity to invest employee targeted corporate social responsibility programs. However, the extent to which this opportunity has been utilised is in this regard is not clear. As Rosen, Feely, Connelly and Simon (2007) observe the role of the private businesses in creating a sustainable response to the epidemic is still an open question in most African countries, if not throughout the whole world.

Accordingly, despite enthusiasm towards eliciting business support to tackle the epidemic some doubt still exist as to the extent of actual contribution by big companies to tackling HIV and AIDS in the South African workplace and the affected global community. As far back as the previous decade, Connelly and Rosen (2005:10) argued "the notion that business will play a significant role in meeting national and international treatment goals is uncertain" and what they have actually contributed to attainment of national treatment goals has been exaggerated by media coverage. Large companies have been observed to trend shifting the economic burden of action to control the epidemic to governments, non-governmental organisations (NGOs) and households (Reddy & Swanepoel, 2006). Globally it has been observed that as donor funds to tackle the epidemic increased the contribution of business to fund HIV programs decrease (Fultz & Francis 2011:4). Discreet business practices such as pre-employments testing, restructuring contracts of employment, firing salaried employees covered by company health cover and replacing them with contract employee and substituting human

labour with machinery being exercised (Sehovic, 2015; Rosen & Simon, 2003; De Waal, 2003). In recent times South African employers have restructured employment contracts to part-time, short term, outsourced and casual, further alienating employees engaged under these terms because they are unable to qualify for company sponsored employment welfare schemes tailored to cover permanent employees. Kironde and Lukwago (2002) also observed this phenomenon in Uganda and did cast doubt on the magnitude of large business contribution towards responses to the epidemic. Results of their pilot study within large companies in that country concluded few had comprehensive schemes directed specifically at addressing HIV and AIDS. This effectively throws much of the burden towards the already strained government capacity to meet health care demand (Mahal & Rao, 2005). From a pragmatic view such corporate behaviour give the merit to innovative contributory schemes such as the AIDS levy introduced in Zimbabwe (Vassal, Remme, Watts, et. al, 2013; Bhat, Kilmarx, Dube, et. al, 2016) to avoid a bandwagon externalisation of the HIV and burden by both business and individuals. Whiteside (2008:265) argues these cost related HIV-risk aversion practices are prevalent poorly regulated economies where companies “offer little in the way of benefits, will rarely be called to account for violation of whatever legislation exist, and will be able to sack workers who are likely to be expensive or disruptive”.

Merits of workplace based HIV and AIDSinterventions

Results of a multi-country study conducted across Africa reveal evidence suggesting the workplace has an effect of reinforcing treatment adherence behaviour among employees living with the virus (Phaswana-Mafuya, Kose, Davids, Zahn et al, 2015). Obermeyer and Osborn (2007) assert that provision of voluntary counselling and testing (VCT) at convenient locations such as workplaces increase utilisation potential for individuals.Beyond the desire to satisfy employee welfare needs in the workplace such as extending the working lifespan of employees (Walensky, Wolf, Wood, et al., 2009), business is also motivated to provide epidemic control service as part of corporate contribution to achieving public health goals (Sturchio, 2008). Historically the much expectation has been placed on big business to respond to the epidemic (Sharma, 2015; Brown & Knudsen, 2013) but other evidence (Fraser, Grant, Mwanza et al. 2002) show even informal small business have been drawing up and implementing interventions to assist employees, though at a smaller scale. Informal business society is also challenged to develop HIV and AIDS programs because the epidemics’ impact pause similar challenges on them as it does with big business. However high labour mobility patterns in and out of informal enterprises present practical challenges for the informal economy to develop sustainable HIV and AIDS management programs beneficial to employees (McKay & Romm, 2008). According

to Bowen, Allen, Edwards et al., (2014) the informal economy also experience weak regulatory policing which does not exert pressure on employers to provide HIV and AIDS services to their employees. Survey results from Kenya reveal informal business locate themselves outside government focus and do not provide HCT services to employees. (The East African Magazine, 2008). This observation is also true for other working groups such as domestic and farm workers. In South Africa, domestic employers do not exhibit corporate behaviours to HIV and AIDS(Mills & Govender, 2014) because the home is treated not as a workplace but a household and both employers and employees act primarily as disengaged entities. Even as government have pioneered alliances with other non-state entities such as private companies and non-governmental organisations, the recognition of a domestic work environment has been neglected. There is no evidence of current institutional efforts to initiate the participation of domestic employers in HIV and AIDS programs from a corporate sense, neither are there specific programs directed at them to encourage their domestic employees to utilise public health services for the epidemic related services such as HIV testing, counselling and enrolment into antiretroviral treatment (ART)programs. According to the IOM Domestic Work Sector Report (2010:12) "their scattered and isolated working situations make them difficult to target with HIV-prevention interventions and consequently there are limited HIV interventions (including social support) for domestic workers". The proposal by Dyk (2013) to introduce self-testing can provide a meaningful solution to strategy designs aimed at increasing HIV testing uptake levels within hard-to-reach target groups such as domestic workers.

For employees in the sex industry, for examples in brothels, workplace based interventions are a giant step to securing improvement in accessing HIV and AIDS prevention resources such as condoms and antiretroviral medication. According to the Sex Workers Education and Advocacy Taskforce (ASIJIKI, Fact Sheet 2015: Sex Work and HIV), "sex workers are often judged and treated badly by service providers, including health workers, which can make it difficult to get condoms and HIV tests [and] it also make it difficult to get treatment for other STIs (sexually transmitted diseases), which can result in increased HIV". In other workplace situations, Mdunge (2012), found employees have limited access public health services because they rarely are allocated time-off from work to visit public health centres. Access outside working hours is also denied because most of these health facilities close at night after employees knock-off. (van Rooyen, McGrath, Chirowodza, Joseph, et al, 2012). In South Africa the historical narrative of how migrant labour flocking to mining towns facilitated the spread of HIV and AIDS earmarks the legitimate burden mining companies assume in providing workplace based intervention mechanism to redress, minimise and contribute to public health efforts to contain the epidemic Hirsch (2013). Brooks (2016:3) assert, "in many ways, the mining

industry created a labour climate congenial to the rapid transmission of HIV and AIDS through its migrant labour system, single-sex hostels and dangerous working conditions". Times have indeed moved on from those apartheid historical times, but the fertility of mining work environments as conducive to higher HIV and AIDS incidence levels persist hence the need for workplace based interventions. It can also be argued that the historical tenure of repatriating black employees suffering from tuberculosis (TB) back to homelands and migrant reserves in the 1940s, (Horwitz 2009:10; Nelson Mandela Foundation n.d.) as a strategy to externalise employee health and welfare responsibilities no longer has legal and moral ground in the face of a new dispensation of political and corporate governance. Lurie and Williams (2014) assert migration by repatriation of sick black employees to rural areas had the effect of helping the spread of tuberculosis, as it will do for HIV and AIDS, increasing the moral culpability of mining companies. In the relative case of South Africa, it would not be a far-fetched conclusion so suggest HIV and AIDS management forms part of how race relations between black and white people are trying to mend from the errors of apartheid. The desirability of workplace based interventions therefore go beyond serving self-motivated business goals such as preservation of highly skilled and scarce labour but also serve to communicate sensitivity to interests of other stakeholders such as governments, employees and trade unions (George, 2006; Guarnieri & Kao, 2008).

Another view extant in research support an idea that costs of inaction to control the epidemic in the workplace lack business purpose. For example, Bloom, Mahal and River Path Associates (2001) attest sick employees reduce economic productivity, staff turnover rises as individuals die and replacing professional labour is problematic. In Dlamini, Masuku and Kirsten's (2014), a study of the agribusiness sector in Swaziland, findings conclude it may take a lead time up to twenty four weeks to find suitable replacement. For companies with the initiative to bury their employees, funeral costs are ever rising as frequent deaths due to HIV-related occur. The loss of profits and competiveness in markets are other common conclusions arrived at by researchers to highlight the impact of HIV and AIDS to business. (Bollinger, Stover, Kerkhoven et al. 1999:7; Rajaraman, Russell &Heymann, 2006).

The fact that the epidemic is concentrated within the 15 to 45 years age group (UNICEF, 2002:9; Shisana, Rehle, Simbayi et. al, 2012) aids to validate the business sense of workplace based interventions. This age group make up the majority of employees found in the workplace and exhibit high sexual and reproductive activity compared to other age groups. Efforts to upscale the epidemic intervention services in the workplace will incidentally improve reach and access levels of this group, and increase the proportion of adults above 50 years living with HIV and AIDSin the near future (Hontelez, Vlas, Baltussen et al, 2012). This gives companies the

impetus to retain skilled staff and extend the length of their working life (Bor, Tanser, Newell & Barnighausen, 2012), enabling them to postpone paying out employee death associated costs such as pension, redundancy pay-out, or funeral costs (Meyer-Rath, Pienaar, Brink et. al, 2015). A longer working life for employees reduces employment costs and maintains market competiveness.

However, in the course of advocating for greater prioritisation of HIV and AIDS in the workplace, the question of economic value of such investments supported by higher utilisation levels has been paused. Even in the face of moral and political pressure to invest in social services, all business costs have to meet the threshold of economic justification. HIV and AIDSis no different. Data from various studies in South Africa lean towards a cross-sectional conclusion on the uptake levels as generally low, (Weihs &Meyer-Weitz, 2016; Lim, Dowdeswell, Murray et. al, 2012; Sieberhagen, Pienaar, & Els, 2011; Connelly & Rosen, 2005) although others do contrast this position, for example, Bhagwanjee Petersen, Akintola, &George (2008) and Charalambous, Innes, Muirhead et. al,(2007). Findings reflecting low utilisation levels in the workplace are consistent with the general population use patterns of VCT testing services in the country and the fact that workplace behaviours generally tend to replicate and reflect community behaviours is clamant in this regard. The real threat therefore is such low utilisation levels for workplace based intervention services will inadvertently promote business apathy towards investment commitment to HIV and AIDS. Resources used to pay for hired service providers who provide mobile testing services or employer contributions to medical aid schemes to enable employees to access HTC services and medication at external clinics need to be justified by evidence of high utilisation figures if their economic necessity can demonstrated.

Trends and influences of HCT access to treatment in the workplace:

Existing literature has been able to identify structural, personal and social influences on HIV and AIDS testing behaviours in the workplace in the sub-Saharan region. A survey carried out in Kenya, Irungu, Varkey, Cha and Patterson (2008) found there was a positive correlation between convenience and accessibility of VCT to an individual's willingness to test. A greater likelihood ensue employee's uptake and use of the VCT facilities rises because of ease of accessibility and convenience. However, Mahajan, Colvin, Rudatsikira and Ettl (2007:s35) offer a different thought and argue where onsite VCT services are promoted in the workplace "one among many factors limiting the success of voluntary HIV testing is distrust of an employers' motivation to conduct testing". They go further to highlight the negative impact of workplace social practices such as stigma and discrimination on health seeking behaviour of employees in

the workplace resulting in low uptake of VCT and ART programs. Mahajan et.al., (2007) are able to underline that perceptions towards employee VCT in the workplace testing and uptake of employer initiated programs can emanate from factors such as fear of retrenchment and perceived legality of the testing program. These observations reflect conclusions also drawn in Feeley, Collier, Richards, Van Der Borght, De Wit (2007) suggesting the overriding effect of stigma and employer mistrust on testing behaviour above costs and convenience as well as on how the employees drew a connection between impending retrenchment and the high HAART programme running in the company. In Holzemer and Uys (2003) stigma was pointed out as one of the greatest threats people living with HIV and AIDS(PLWHA) faced as they attempt to access HIV and AIDS support services.

Further, in Zambia, Fylkesnes and Siziya (2004) established the general perception of the individual employee of the health services on offer acted as a barrier to testing. They found because 'people seem to place high value on privacy' [570], an assurance of confidentiality plays a bigger role in influencing individuals to accept to be tested. Mundy and Dickinson (2004:174) reason employees are not willing to be tested in the workplace as a result of perceived hostility emanating from other employees, supervisors or the employer. Observations in Makwara, (2015:37) suggest low utilisation is risk avoidance behaviour in relationship strained workplaces. For employees"the life time loss of social value employees hold towards each other and the potential threat to job security should the employer discover one's positive HIV status cannot be sacrificed in [these] instances where alternative HTC services exist outside the workplace". These findings also seem to resonate in areas outside Africa workplace settings. For example in a focus group research conducted in the United States of America to investigate perspectives towards HIV testing in non-health care settings such as mobile VCT or workplace based testing centres Joseph, Fasula, Morgan, et. al (2011) established concerns about perceived lack of privacy, confidentiality and negative beliefs about the professionalism of staff rendering VCT services as negatively impacting on the level of VCT uptake. These findings are also confirmed in a more recent research done in Kenya wherein Museve, George and Lobongo (2013) are able to identify the quality of service, the location of the VCT centre and its overall appearance as relevant factors to uptake and use of VCT services in a community. In Mabuto, Latka, Kuwane et al. (2014) observations are made the level of education and type of occupation also help to explain incidences of low HTC utilisation levels among traditionally low testing population groups including men, adolescence and the elderly in South Africa. These population groups occupy a larger number of employees found in the workplace, which explain why utilisation figures consequently drop.

The effect of stigma, discrimination and social relationships on VCT uptake in the world of work has also been investigated. Arimoto, Ito, Kudo and Tsukada (2013:2) argue for the desirability of workplace based VCT programs. They recognise “compared to VCT at distant public clinic, offering HTC at a company onsite clinic may also induce uptake by reducing both material and emotional burden of receiving the test” as employees can easily access the services and can receive direct encouragement from the employer to test. The impacts of social relationships on VCT uptake were also explored by Joseph et. al, (2011) in the United States of America, who found although conveniently located VCT facilities in local communities [workplaces] were welcome individuals expressed great anxiety about being seen going to a testing centre, with others travelling to other communities where they are unknown and their privacy secured. In context, a randomised trial participation study conducted in Harare by Corbett, Dauya, Matambo et al., (2006) also demonstrated the importance of convenience and accessibility in influencing uptake of VCT services among employees at work. The study results showed the mean uptake for onsite VCT was 51% while the off-site rate was 19.2%. Nonetheless, it has been cautioned results of this study do not conclusively support it is best to offer VCT services onsite than offsite as the uptake rates may suggest. Scott, Campbell, Skovdal, Madanhire et al., (2013) remarked it is a complex issue to be definitive as to whether onsite or off-site VCT will yield better results than the other will.

In African communities’ culture and tradition underline practices explaining how rights and roles of women in marriage are undermined leading to restrained access and use of VCT, condoms or HIV and AIDS educational programs by women. A study done by Mwale (2014) in Malawi found that because women fear divorce, labelling and cannot negotiate with their husbands for spousal VCT or condom use, their uptake of HIV and AIDS support services is limited. Apart from reaching similar conclusions Mbonu, den Borne and De Vries (2009) observed gender inequality, religious beliefs, partner’s attitude towards VCT and the element of male domination in sexual relationships impacted on women’s negative participation in accessing ART services or use of condoms, more so in poor communities. It can be said the positive element resultant from onsite work-placed based HIV and AIDS support services such as ART, VCT and treatment for sexually transmitted diseases is to liberate vulnerable women from social and cultural constraints associated with gender inequality. This position is also observed in Musheke, Ntalaka, Gari et al. (2013) where the negative impact of gender inequality in married relationships is insinuated as affecting women’s uptake of testing services as they may be forced to seek permission from their husbands to test. Accordingly the dominant masculine role some men occupy in marriage and social relationships disempower women from making self-decisions about own health matters including testing for HIV. In practice, it

emerges that if HIV and AIDS intervention programs are not acculturated to liberalised sense of gender equality and rights for women, the effectiveness of these programs is effectively compromised. As reported in Feeley et al (2007), Heineken Company once ran a program, which qualified cover only to the legally married woman, despite extant acknowledgment of existence of polygamous relationships among the employee beneficiaries. While the idea would not be to promote pursuit of polygamous or extramarital relationships, implementing programs inconstant with the cultural practices of the target group does give little effect. As the traditionally married women get excluded from the program an open window through which the threat of the virus would attack families remain. This reduces the positive impact the program will have on minimizing HIV transmission. This practice also show the limitations of centralised HIV and AIDS policy formulation by large multinational companies, as Head Office policy guidelines are bound to neglect local cultural practices and social orientations to the detriment of programs effectiveness.

Further insight into the behavioural patterns of use and uptake of the VCT is contained in an analysis of the role of the private health providers in HIV testing by Johnson and Cheng (2014). Their study established men use private HIV test providers more than women even after discounting the antenatal counselling visits when women are pregnant. These findings probably indicate availability and ease of access that workplace based VCT programs provide have little impact to improving uptake of HIV testing onsite among men who are more concerned about anonymity, privacy and perception of quality of the service. Other studies have shown the VCT utilisation levels are higher for women compared to men (Anderson and Louw-Potgieter, 2012; Subramian et al., 2008). WHO/UNAIDS/UNICEF (2007:48) had earlier observed “social factors such as individual attitudes and personal perceptions of risk also have a considerable effect on the uptake of VCT” and reiterated that negative reactions following disclosure of test results also act to discourage individuals, especially men from willing to test and know their status.

For employees wanting to know their HIV and AIDS status, the provision and access to treatment in the event they are HIV positive is an important consideration whether or not they will use company sponsored on-site HCT services or make use of external service providers such as private clinics and public hospitals. Govender, Akintola, George, Petersen Bhagwanjee and Reardon (2011) explored the relationship between availability of ART and testing established attitudes favourable towards ART served as motivation for individuals to test. Phakathi, Van Royen, Fritz and Ritcher (2011:177) are in support in their own study where “equally affirming was the strong, motivating and hope-inducing role that ART played in encouraging individuals and communities to test for HIV”. In South Africa, evidence in support of this can be seen from the comparison of HIV test uptake levels between companies in the

mining industry and other industries. Most mining company workplace HIV and AIDS programs provide for access to ART and their commitment to its management is more intense than in other industries such as retail, where basic related education and awareness programs, wellness day events and ad hoc VCT service providers can be hired to give employees access to the services.

CONCLUSION

Findings and research data from scholarly articles on the general scope of low uptake of HIV and AIDS services has been looked at to explore reasons why low incidences of HTC, enrolment into ART programs and non-clinic attendance is becoming a characteristic element of the problem of HIV and AIDS management in the workplace. Evidence show low levels of utilisation of workplace based HIV and AIDS intervention services, and the bigger challenge remain that of finding ways to stimulate uptake levels among employees. Low utilisation of services complicate business ability to control its threat to viability, costs, competitive capacity and diminish business contribution to attainment of public health goals. There is need to implement intensive programs to increase the utilisation of these services before business withdraw their initiatives in this regard.

WAY FORWARD

The above discussion suggest more research need to be carried out to explore opportunities for better HIV and AIDS management strategies to upscale utilisation levels in the workplace. Whereas limited access to HIV and AIDS services is still cited as one of the visible challenges in global efforts to deal with the epidemic, associated low utilisation of those existing in the workplace presents a practical dilemma. The real rests on how business will view its role in providing these services if employees continue to underutilise them. Given the primary role business play in both social and development initiatives in poor communities such as in African economies, losing business participation in addressing HIV and AIDS challenges would be catastrophic. Efforts to stimulate workplace based testing are therefore necessary to retain business interest.

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