



STANFORD

GRADUATE SCHOOL OF BUSINESS

CASE #: IB-31
VERSION: (A) 02/15/02

HIV/AIDS IN SOUTH AFRICA 2001: BACKGROUND NOTE

'Africa will never be the same,' says Clem Sunter, an executive director of Anglo American, South Africa's gold and diamond mining colossus. 'We don't know yet what the social and economic consequences will be, but AIDS will define the shape and structure of society in Africa. It is the biggest thing, bar none.'

—*Fortune*, November 13, 2000

Since its first documented outbreak in Los Angeles in 1981, HIV/AIDS has wreaked havoc in many nations. The disease, almost unheard of a generation ago, has infected 58 million individuals worldwide as of 2001. Every day, fifteen thousand more individuals become infected. Half of those infected are young people between the ages of fifteen and twenty-four.¹

The disease has taken its harshest toll on developing countries—95 percent of the individuals living with HIV/AIDS in 2001 resided in developing countries, and sub-Saharan Africa has been hardest hit of all: of the 36 million people worldwide currently living with HIV/AIDS, 25 million reside in sub-Saharan Africa. This is in startling contrast to the numbers of HIV-positive individuals in other regions: 1.4 million in Latin America, 920,000 in North America, 400,000 in northern Africa and the Middle East, and 1.2 million throughout both eastern and western Europe.² The statistics paint a chilling picture of the current and potential economic and social devastation posed by HIV/AIDS: it is the leading cause of death in South Africa, accounting for more than 20 percent of deaths.

BACKGROUND OF THE EPIDEMIC

The Human Immunodeficiency Virus (HIV) that causes AIDS was not identified until 1983. HIV-related disease viciously attacked susceptible people, weakening their immune systems and

¹ UNAIDS Report, AIDS Epidemic Update, December 2000,
http://www.unaids.org/wac/2000/wad00/files/WAD_epidemic_report.htm.

² Ibid.

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making them more vulnerable to infection. An individual infected with HIV was diagnosed with AIDS when he or she became ill as a result of a low t-cell count and/or one of many HIV-related opportunistic infections. HIV's incubation period was typically between six and ten years, during which time the virus remained hidden from the individual until the person fell ill from related illnesses or infections.

HIV/AIDS In Southern Africa: Social Context

In southern Africa, HIV was transmitted primarily through heterosexual intercourse and from mother to newborn child. Although education throughout Africa appeared to have alerted people to the dangers of unprotected, non-monogamous sex, the population was slow to adopt behavioral changes that would check the spread of the disease. Several factors in sub-Saharan Africa contributed to both the rapid proliferation of HIV and to difficulties curbing the spread of the disease, including a variety of cultural beliefs, sexual norms, and health care factors. Africans had high rates of untreated sexually transmitted diseases, which could increase a person's likelihood of contracting HIV twenty-fold. Most men in the region were uncircumcised, which also increased the probability of contraction. Various entrenched sexual beliefs increased the spread of the disease. For example, some men believed that they could cure HIV/AIDS by having sex with one hundred virgins; others believed that sex with a condom would reduce their virility and fertility. In South Africa, where mining companies served as primary employers, migrant labor and hostel living accelerated the spread of the disease.

In the United States and other relatively wealthy Western countries, antiretroviral therapy was highly effective in extending and improving the quality of life for HIV-positive individuals. The success of this breakthrough therapy generated a heated debate as to whether the treatment model could be exported to the African context or whether other, more basic health problems should be attended to first. Some human rights activists argued that, particularly for poor communities, basic infrastructure such as access to clean water, sanitation, and food had to be in place before effective treatment interventions could be introduced. South African activist and business consultant Sharon White noted, "For me, what is a major problem in South Africa today is that if you ask people in informal settlements to focus on HIV and AIDS, they say, 'Well, why must I focus on something that's going to kill me in seven, eight years if my need today is to bring food into my household?'"³ Individuals on this "infrastructure-first" side of the debate argued that, without access to proper water or nutrition, poor South Africans would have difficulty adhering to a sophisticated regimen of drugs that could make them severely ill. Moreover, many of them viewed antiretroviral therapy as a cosmetic solution that treated the outward symptoms of the disease while failing to address the root causes—severe poverty and dehumanization—that lead to shortsightedness and sexual risk-taking. In a national climate like South Africa's, in which social welfare resources were scarce, many advocates felt resources were better directed towards efforts that addressed the severe poverty and dehumanization of the population. Those on the treatment side of the debate had a different rationale: they argued that while living standards could be improved over the longer-term, there was no reason to deny treatment—and, as such, impose a death sentence—on the 25 million South Africans infected with HIV in 2001.

IMPACT OF THE EPIDEMIC IN SOUTH AFRICA

³ Interview with Sharon White, HIV/AIDS activist, August 29, 2001.

South Africa's population was estimated to be nearly 44 million in 2001. Approximately 75 percent were black, 14 percent white, 9 percent "coloured" (the South African term for individuals of mixed race), and 3 percent Indian.⁴ South Africa's gross national product was approximately \$120 billion in 2001, with real GDP growth calculated at 3 percent. The economy relied largely on South Africa's plentiful mineral and energy resources. Diamond and gold lead exports, and even much of the manufacturing was based on mining.

The South African economy was not a strong one—unemployment was at 30 percent and economic growth remained slow. The country had to contend with some of the most extreme income disparities in the world. Its per capita income of \$3,170 placed it among the middle-income countries, however 53 percent of its population lived in "third world" conditions that included limited or no access to electricity and running water, high rates of child malnutrition, and extremely low education levels. Only 13 percent of the population lived in conditions most akin to those in developed countries.⁵ Many of the problems of inequality could be traced back to the apartheid era: "daunting economic problems remain from the apartheid era, especially the problems of poverty and lack of economic empowerment among the disadvantaged groups."⁶ Unemployment remained particularly high among the black population, and was tied to lower levels of education and higher levels of poverty. The economic status of black South Africans was markedly lower than that of whites, coloureds, and Indians.

In a country struggling to resolve issues of severe income disparity, stagnant growth, and high poverty levels, the social and economic challenges posed by the HIV epidemic were staggering. Half of all people who seroconverted from HIV negative to HIV positive worldwide were infected before the age of twenty-five. Most would die of AIDS or AIDS-related illness before thirty-five. In 2001, disease ravaged the most economically active members of society, a situation that South Africa's already-fragile economy could not afford.

Societal Impact

The implications of an exploding HIV/AIDS epidemic for South African society were sweeping and terrifying: it was projected that many of the social advances achieved during the 1980s and 1990s would be erased. For example, the U.S. Census Bureau predicted that by 2010 the average life expectancy in South Africa would fall from the non-AIDS baseline rate of 68.2 years to a meager 48 years. Social and economic problems were expected to accompany the dramatic increase in deaths. A massive orphan population was emerging and entire families would fall into poverty as economically productive parents and relatives succumbed to the disease. In *AIDS: The Challenge for South Africa*, Alan Whiteside and Clem Sunter described the impact of the disease:

Nearly one million South African children under the age of 15 will have lost their mothers to AIDS by 2005. This is estimated to increase to around two million by 2010, according to the Department of Health... [T]hese figures, if anything, may underestimate the problem.

⁴ Central Intelligence Agency, *The World Factbook 2001* (<http://www.cia.gov/cia/publications/factbook/geos/sf.html>).

⁵ World Bank Group South Africa country profile: <http://www.worldbank.org/afr/za2.htm>.

⁶ Central Intelligence Agency, *The World Factbook 2001* (<http://www.cia.gov/cia/publications/factbook/geos/sf.html>).

Studies have been conducted on the plight of orphans and their caretakers in various African countries. Among the findings are that: families [with] foster children in Kenya usually live below the poverty line; and orphan households in Tanzania have more children, are larger, and have less favourable dependency ratios. Children who lose a parent to AIDS suffer loss and grief like any other orphan. However, their loss is exacerbated by prejudice and social exclusion, which can lead to the loss of education and health...⁷

As poverty increased and family units deteriorated, the already-shocking rate of crime in South Africa was predicted to increase. According to Whiteside and Sunter, “A bleak future is predicted by Martin Schoenteich of the Institute for Security Studies in Pretoria. He warns that ‘AIDS and age will be significant contributors to an increase in the rate of crime in South Africa over the next ten to twenty years... Growing up without parents, and badly supervised by relatives and welfare organizations, this growing pool of orphans will be at greater than average risk to engage in criminal activity.’”⁸ If the forecast proved true, then the impact of AIDS would include severe negative economic consequences, generating downturns in economic development and expansion and in inflows such as tourism dollars and foreign direct investment.

Macroeconomic Impact

It was extremely difficult to estimate accurately HIV’s total macroeconomic toll on the South African economy; models attempting to examine and quantify the problem were fraught with difficulties. However, it was possible to examine areas in which the macroeconomic repercussions of the epidemic were most likely to be felt. According to the 2000 UNAIDS report “The Business Response to HIV/AIDS: Impact and Lessons Learned,” the epidemic “ha[d] a considerable impact on business operations through its influence on markets, savings, investment, services, and education.”⁹

The business impact on firms could vary widely depending in large part on the demographic profile of the customer base and the susceptibility of that population to the disease. Losses to firms were expected to be greatest in already-saturated markets, where the decline or slowing in population growth (and hence potential customers) would have a severe impact. In rapidly growing markets in which demand for goods was still unsaturated, it was expected that the dollars spent by those consumers who had contracted AIDS would be replaced rapidly by revenues from new consumers.¹⁰ Additionally, businesses that relied largely on the South African market for their consumer base were likely to be hit hardest, while those companies that exported products to areas with far lower infection rates, such as the United States or Europe, were buffered from much of this risk.

Another HIV-related concern for South African businesses was the potential loss of investment dollars. The problems created by the reduction in domestic investment were likely to be further

⁷ Alan Whiteside and Clem Sunter, *AIDS: The Challenge for South Africa* (Capetown, South Africa: Human and Rousseau (Pty) Ltd. and Tafelberg Publishers Ltd., 2000).

⁸ Ibid.

⁹ Kieran Daly, “The Business Response to HIV/AIDS: Impact and Lessons Learned,” produced by The Joint United Nations Program on HIV/AIDS, the Prince of Wales Business Leaders Forum, and The Global Business Council on HIV/AIDS (Geneva and London, 2000).

¹⁰ Whiteside and Sunter, *AIDS: The Challenge for South Africa*.

exacerbated by the loss of foreign direct investment (FDI). In 2001, no systematic studies isolating the effect of disease prevalence on levels of FDI had been completed; however, as international attention focused on the epidemic and as the disease spread, there was a strong possibility that foreign investors would be driven away by fear. This concern motivated some South African firms to mount vigorous HIV/AIDS campaigns. Companies hoped to signal to investors that they were actively fighting and managing the disease, thus curbing panic and potential investment flight.

In addition to reduced investments and consumer base erosion, the South African HIV/AIDS crisis created a host of labor-related issues. As the pool of available productive and skilled labor declined, the costs to business of essential production and service inputs such as transport and utilities increased.¹¹ The epidemic weakened educational services, reducing the numbers of experienced teachers and children who could afford to attend school, thereby handicapping businesses that relied on a strong educational sector for skilled workers, managers, and executives. According to *Fortune*, “The homegrown managerial talent Africa so desperately needs is being decimated. The prevalence of HIV/AIDS among skilled and highly skilled workers is predicted to peak at 23 percent and 13 percent, respectively, in five years.”¹²

Despite the epidemic’s twenty-year history, preliminary estimates of the long-term costs of the disease to national economies such as South Africa’s were just beginning to emerge, and they varied widely. Early estimates from the World Bank suggested that in countries with adult prevalence rates over 10 percent, HIV/AIDS could result in up to a one-third reduction in national income growth. South Africa had over twice that rate of HIV prevalence. Other studies produced less startling projections: a 2000 ING Barings study predicted that in South Africa the epidemic would generate annual GDP levels that were 3 to 4 percent lower than the no-AIDS baseline rate over the next fifteen years.¹³

DIRECT COMPANY-LEVEL COSTS

The impact of the HIV epidemic on South African businesses clearly had been—and, for the near future, would remain—significant, one that businesses ignored at their own peril. In addition to the challenges posed by the macro-level trends—reductions in market size, higher cost inputs, lower savings and investments rates, and more—businesses also faced direct costs that negatively affected operations. Relatively few studies quantifying these effects for South African firms had been made publicly available, in part because many firms appeared reluctant to release this data. However, studies conducted in other countries helped to provide a picture of the potential costs to South African firms.

While HIV/AIDS could create a number of areas for profit loss, the direct costs of the epidemic could be grouped into two broad areas: (a) declining worker productivity, and (b) increased expenditures on health care and benefits. They became apparent in a number of ways, including:

Absenteeism

¹¹ Daly, “The Business Response to HIV/AIDS: Impact and Lessons Learned.”

¹² Brian O’Reilly, “Death of a Continent,” *Fortune*, November 13, 2000.

¹³ ING Barings South African Research, “Economic Impact of AIDS in South Africa: A Dark Cloud on the Horizon” (Johannesburg, South Africa, 2000).

The epidemic increased absenteeism as workers fell ill, missed work to care for ill family members, and attended funerals. The resulting absences were costly in a number of ways, including disruption of the production cycle, higher costs associated with the use of temporary staff, lost production hours, and underutilization of equipment.¹⁴ Absenteeism was one of the biggest drivers of increased direct costs and declining productivity: in a study conducted across a number of countries, it was found that absenteeism accounted for 58 percent of increased labor costs due to HIV/AIDS (**Exhibit 1**).

Reduced on-the-job productivity

Even if able to attend work, HIV-positive and AIDS sick workers could be unfit to carry out arduous tasks. Workplace accidents due to fatigue could increase.

Increased training and recruitment costs

As HIV-positive workers retired prematurely or passed away, companies lost a portion of investments made in recruiting and training workers. With this increased staff turnover, companies needed to invest additional money in training and recruiting to replace lost workers and employ still more labor to cope with the rapid fluctuations in staff. According to *The Economist*, “Mondi, a papermaker [within the Anglo American Group], trains staff to perform several different jobs, so that if one person falls ill, the paper mill need not stop rolling. Some multinationals are taking a different tack, hiring as many as three workers for each skilled position, to ensure that replacements are on hand when trained workers die.”¹⁵

Costs associated with loss of skilled labor

Companies could be forced to pay higher wages to fully productive workers due to an increasing scarcity of skilled labor. Beyond this direct cost, the loss of skilled labor would result in a more intangible loss of intellectual capital or “social” knowledge and experience within the particular environment or sector. Though the cost of this kind of loss was difficult to quantify, companies could find this knowledge difficult, if not impossible, to replace.

Health management

In companies in which health care was provided, costs could escalate rapidly through increased spending on preventive programs and through expenditures for sick workers. For example, one 1999 study of a Kenyan commercial agro-estate showed that, as a direct result of HIV/AIDS-related costs, the firm’s medical expenditures rose to more than 400 percent above the projected costs, which had not included AIDS estimates.¹⁶ In the face of such drastically increased costs, companies might choose to scale back worker benefits and contain costs. They also might choose to make substantial investments in preventive programs that helped workers reduce their risk of infection and, thus, reduce costs over the longer-term.

Higher benefit payments for life insurance, pensions, and funeral benefits

Companies that chose to provide these benefits likely foresaw costs increasing drastically due to workers’ early retirements or premature deaths and might choose to curtail these benefits as infection rates rose. Whiteside and Sunter projected two bleak scenarios: “either payroll costs will rise...or benefits will be cut to contain costs.”

¹⁴ Daly, “The Business Response to HIV/AIDS.”

¹⁵ “Business and AIDS: The Worst Way to Lose Talent,” *The Economist*, February 8, 2001.

¹⁶ G. Rugalema, “HIV/AIDS and the Commercial Agricultural Sector of Kenya” (The Hague: The Institute of Social Studies, 1990).

Not all businesses were affected equally by HIV/AIDS-related costs. Not surprisingly, evidence indicated that various factors influenced the labor-related cost of HIV/AIDS to a company, including, but not limited to, the skill level of the employees, the firm's sectors of operation, and benefit levels. Businesses that faced the most serious cost increases could be those in labor-intensive industries, including transportation, and those that relied heavily on migrant labor, such as mining, where infection rates tended to be especially high. *Fortune* estimated, for example, that by 2005, 29 percent of South African mine workers would be HIV-positive, an increase of 6 percent over the skilled worker population.¹⁷

GOVERNMENT RESPONSES TO THE AIDS EPIDEMIC

I think a lot of people are saying the South African government's response to the AIDS epidemic has been inadequate.... [but] you have to see it in the context of what they inherited—in addition to an overwhelming epidemic.

—Dr. Brian Brink, Senior Vice President-Medical, Anglo-American Corporation¹⁸

Indeed, the new South African government faced tremendous challenges as it struggled to navigate not only the problems facing many developing economies but also the difficulties posed by its unique history of apartheid. In this context, the HIV/AIDS epidemic loomed as yet another threat, one that many in South Africa and around the world believed the government was slow to confront.

The South African government had been sharply criticized by some for its reactions to the country's exploding epidemic. South African President Thabo Mbeki's failure to acknowledge the existence of a link between HIV and AIDS had been the subject of much scorn and ridicule internationally. Likewise, Mbeki's government was roundly criticized for its failure to provide antiretrovirals or AZT to its populace and was questioned for its low levels of investment in HIV/AIDS education, prevention, and treatment.

What the government had done, however, was help place AIDS drug prices within reach of many South African companies, municipalities, and even individuals. In 1997, South Africa passed the Medicines and Related Substances Control Act, a law permitting the use and dissemination of cheaper, generic versions of patented AIDS drugs. In response, the world's leading pharmaceutical companies launched a lawsuit against the South African government, charging that the law was an infringement on patent protection. But in April 2001, the drug companies, faced with a storm of negative publicity and mounting international public pressure, agreed to drop their case against the government. Hailed as a landmark victory in the fight to provide cheaper access to critical AIDS drugs, the case helped smooth the way for businesses interested in taking a more aggressive stance against the epidemic to consider antiretroviral programs for their workers. In time, this may prove to have been a smart, if insufficient, approach for an already-overextended government struggling to meet the basic needs of its people.

FIRM RESPONSES TO THE AIDS EPIDEMIC

¹⁷ Brian O'Reilly, "Death of a Continent," *Fortune*, November 13, 2000.

¹⁸ Authors' interview, August 27, 2001.

For most South African companies, the typical response to the crisis seemed to be a nonresponse. Many firms appeared paralyzed, either unable or unwilling to confront the potential threat the disease posed to their fundamental economies and strategy. “People are burying their heads,” said Gillian Nur Samuels, who led a study for Metropolitan Life, an independent South African insurance company. “Most companies feel it won’t impact them. They are trying to ignore it.”¹⁹

At the same time, a handful of companies were taking bold and varied steps to protect their businesses and their workers. Some “hardnosed” firms, for example, were moving to diversify out of South Africa and, presumably, beyond the reach of the disease. Other firms were focusing on protecting their workforce and markets through a host of prevention and treatment programs.

The JD Group

HIV/Aids should be included among the other business and financial risks investors should take into consideration. ‘There are currency risks, inflationary risks, country risks— and now there is also this risk.’

—Jan Bezuidenhout, Executive Director, JD Group²⁰

One well-known South African company that opted to diversify in order to manage the impact of the impending crisis was the JD Group (JDG), a seller of furniture and household appliances. JDG had a number of store chains throughout South Africa, including Bradlows, Russells, Electric Express, Score, and Joshua Doore; each store catered to a different market segment and socioeconomic population.²¹

In 1998, JDG undertook an extensive study of its customer base, composed of approximately one million accountholders. The report examined the business impact of the HIV/AIDS epidemic and contained a forecast of HIV prevalence among customers by market segment and store group. The prevalence rate of its current customer base was estimated to be approximately 15 percent and expected to rise to 27 percent by 2015.²²

The study predicted a grim future for the firm if it continued along its current course. According to the study’s projections, the firm’s customer base in South Africa would grow, though at a slow rate, until 2010. After that, the demographic impact would “kick in” leading to an 18 percent decline in the firm’s overall customer base by 2015 in virtually all provinces in South Africa.²³ Increased credit risk also was anticipated, as consumers defaulted either due to their own illnesses or the illnesses of family members.²⁴ Considerable increases in employee benefits were predicted as workers fell ill or died.²⁵

JDG’s response to this scenario was firm, although not without controversy. The company expanded into the eastern European market, where HIV infection rates were much lower, although other investment risks existed; acquired Abra, a company based in Poland; and opened

¹⁹ O’Reilly, “Death of a Continent.”

²⁰ *Moneyweb*, August 30, 2001 (<http://allafrica.com/stories/200108310076.html>).

²¹ HSBC Consumer Team Conference on “AIDS and Financial Markets” held on August 24, 2001 in Capetown, South Africa.

²² Whiteside and Sunter, *AIDS: The Challenge for South Africa*.

²³ Ibid.

²⁴ Ibid.

²⁵ HSBC Consumer Team Conference on “AIDS and Financial Markets.”

twenty-two stores in Eastern Europe.²⁶ The number was expected to grow to two hundred by 2006 with the introduction of two new store brands.²⁷ Back home in South Africa, JDG discontinued Score, which served populations at higher risk of HIV/AIDS exposure, and repositioned another store so that it targeted a lower-risk, higher income group.²⁸

While strategically sound, the plan raised questions about the loyalty and commitment of JDG to South Africa. The firm has been ridiculed by its competitors, none of whom have studied the impact of AIDS on their businesses. Bezuidenhout was adamant that JDG was committed to South Africa.²⁹ However, he also maintained that the company had a responsibility to its shareholders to remain profitable and that diversification away from the risks associated with the African AIDS epidemic would help it remain so.

Eskom

Eskom, one of the world's largest electric utilities companies, took a very different approach to the crisis, and focused aggressively on education and prevention at the workplace, community, and national levels. The state-owned South African firm's long-running HIV/AIDS education, prevention, and monitoring programs have undergone a number of transformations.

Starting in 1988, Eskom began a program of HIV/AIDS "education, surveillance, and counseling" for its 35,000 employees.³⁰ By the early 1990s, however, this program began to come under scrutiny due in part to its lack of cohesiveness and comprehensiveness. In 1995, the company began to comprehend the full extent of the epidemic, and decided to undergo a reevaluation of its program. It commissioned an analysis of the impact of HIV/AIDS on the company. The projections were a wake-up call to management—a 26 percent HIV prevalence rate among the workforce was predicted for 2005.

HIV/AIDS was declared a "strategic priority," and a series of new, multifaceted initiatives were instituted to confront the disease, among them: revised prevention and education plans at the workplace, community, and national levels; increased monitoring of business impact; and newly-formed partnerships with a variety of community and governmental actors.

Eskom's education initiatives functioned on many different "tiers" ranging from workplace programs to activities in the international sphere. Workforce education programs, which in 2001 had reached over 75 percent of employees, were extended to all workers through peer-led education. The utility strove to reach out to communities through radio and television talk shows, press articles, and funding for HIV/AIDS awareness events, among other initiatives. At the same time, the firm worked to influence and inform the international dialogue on the disease, initiating another study to examine HIV/AIDS workplace experiences and strategies in several southern African countries. Eskom also assisted in the development of the South African Business Council on HIV/AIDS, which worked to unite businesses to combat the epidemic.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

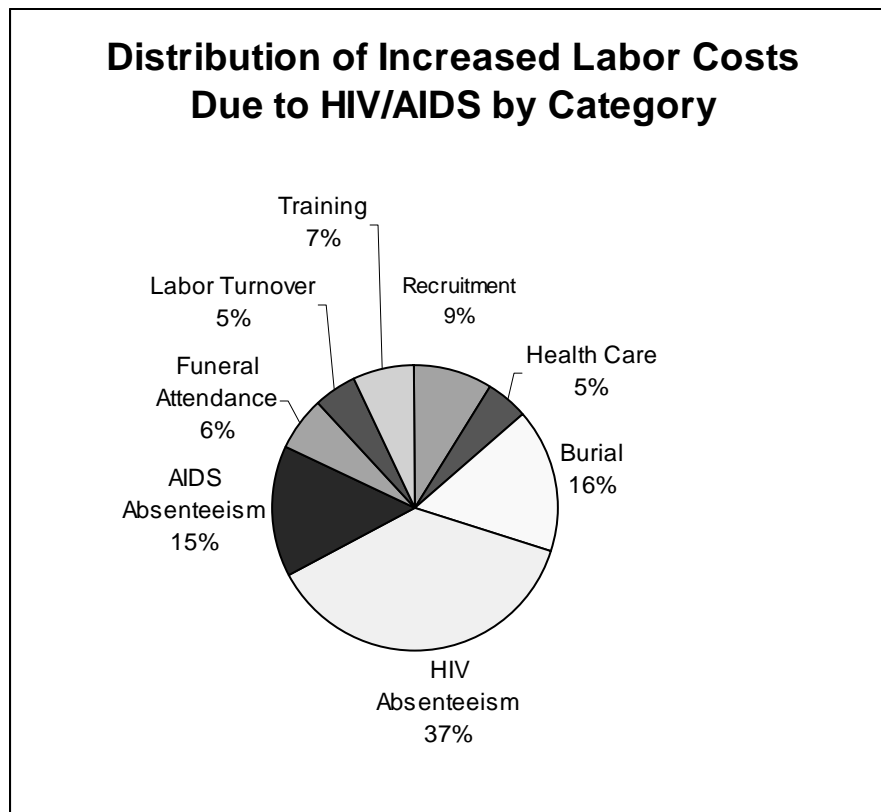
²⁹ Whiteside and Sunter, *AIDS: The Challenge for South Africa*.

³⁰ The Eskom section is based on information provided in Daly, "The Business Response to HIV/AIDS."

Eskom closely monitored the impact of its workforce initiatives, as well as the overall costs to the firm of the disease itself. Eskom was able to track both the appropriate level of HIV-related investment needed and the success of its initiatives. In 1999, the firm commissioned an updated study that highlighted the economic and financial cost of the disease. Other studies examined worker knowledge and attitudes and contained an anonymous and voluntary HIV/AIDS surveillance component. These studies showed a high level of knowledge among workers (80 percent) and an HIV prevalence rate lower than projected by the 1995 studies.

Recognizing that an uninformed local community could undermine the behavioral changes Eskom sought to enforce through its workplace programs, the company leveraged its efforts through partnerships with NGOs, local government, UNAIDS, other businesses, and by funding community and government initiatives. For example, the utility firm teamed up with two mining industry companies in order to initiate the Kriel Project, an education and prevention program for commercial sex workers. The firm also sought to provide financial support to organizations doing work in the HIV/AIDS arena, including committing approximately US\$4.5 million between 1999 and 2001 for vaccine research.

While Eskom and JDG were taking strikingly different approaches to the epidemic, both efforts were noteworthy because, unlike most South African firms, they were working proactively to fight the effects of HIV/AIDS. By contrast, many South African companies, overwhelmed by the sheer enormity of the problem, chose the perilous “do-nothing” option and risked seeing the productivity of their workforce—and their profit margins—eaten away by the disease. Whether motivated by social responsibility or bottom-line concerns, whether trying to prevent loss of stakeholder investment or loss of worker life, South African firms faced a call for clear and decisive action. What remained to be seen was whether South African enterprises had the ability—and the will—to respond in time to check the economic and social impact of the epidemic.

Exhibit 1

Source: Matthew Roberts and Bill Rau, *African Workplace Profiles: Private Sector AIDS Policy*, 1996, Family Health International, Arlington VA, USA.