Perceived HIV/AIDS impact among higher education institutions in the Eastern Cape

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Abstract

A descriptive questionnaire based study was undertaken among higher education institutions in the Eastern Cape Province. The objectives of the study were to establish costs and trends in costs associated with HIV/AIDS morbidity and mortality, and to assess perceived HIV/AIDS impact on job performance and coping with performance problems. To this end, a systematic random sample of 137 head of departments from 14 higher education institutions was interviewed using a structured questionnaire. The results of the study showed that HIV/AIDS increases indirect costs, lowers job performance and increases staff turnover. It can be concluded that HIV/AIDS is having a serious impact on the fiscal situation of tertiary institutions in much the same ways as it does on other institutions. It is, therefore, imperative for higher education institutions to respond to HIV/AIDS for their own benefit and that of their broader stakeholders. Early action will reap tremendous savings in both economic and human terms.

1 INTRODUCTION

HIV/AIDS remains the primary threat to South Africa’s economic, social and political development. The epidemic is maturing and prevalence rates still put South Africa squarely in the category of high prevalence countries (Chetty and Michel 2005). The country has the fastest growing HIV/AIDS epidemic in the world, with more people infected than in any other country (UNAIDS 2004). The Nelson Mandela Human Sciences Research Council (HSRC) study of HIV/AIDS (2002) revealed that South Africa has the largest number of people living with HIV/AIDS in the world: 14.4 per cent of all people living with HIV/AIDS live in South Africa. The study estimated that of the 5.6 million South Africans living with HIV/AIDS, the highest prevalence is among those aged 15 to 49 years with major differences for males and females. Among South African women aged 25 to
39, the estimated HIV prevalence in 2002 was 17.7 per cent, much higher than 12.8 per cent among males. The epidemic has been increasing steadily as follows: 22.4 per cent in 1999, 24.5 per cent in 2000, 24.8 per cent in 2001 and 26.5 per cent in 2002 (Department of Health 2003a). The antenatal survey which was conducted in 2002 estimated that between one in five South Africans aged 15 to 49 is HIV positive, of the 10 per cent of 15 to 24 year olds who are infected, 77 per cent are young women. By the year 2005, there will be six million South Africans infected with HIV and there will be almost one million children under the age of 15 whose mothers will have died of AIDS (Department of Health 2003b). Dorrington, Bradshaw, Johnson and Budlender (2004) estimated that just over five million people of a total 46 million South Africans were HIV positive in mid-2004, giving a total population prevalence rate of 11 per cent. The highest prevalence rate was among those aged 15 to 49 years with major differences for males and females. The incidence rate of the total South African population was 1.3 per cent and the total number of orphans was 1 126 000. New AIDS sick during 2004 was 525 000. Total deaths during 2004 was 701 000; of these non-AIDS deaths were 389 000 and AIDS deaths were 311 000, and accumulated AIDS deaths mid-year were 1 212 000. The percentage of deaths due to HIV/AIDS was as follows: 70 per cent for adults aged 15 to 49 years, 45 per cent for adults aged 15 years and above and 42 per cent for children under 15 years of age.

These statistics show that AIDS deaths occur predominantly among workers in their most productive years. Therefore, AIDS deaths lead directly to a reduction in the number of available workers. As younger, less experienced workers replace experienced workers, worker productivity is reduced, which in turn results in a decline in international competitiveness. As the HIV/AIDS epidemic advances, increases in deaths will lead to increased absenteeism or compassionate leave, if this is available as employees attend funerals for family members, friends and colleagues. Department of Labour (2003) estimated that a typical employee of a South African company loses about 250 productive days over the course of the illness. The Global Business Council on HIV/AIDS (2002) maintains that with increasing absenteeism companies will experience loss of skills and declining morale which is more likely to lower productivity. In addition, UNAIDS (2004) and Rehle and Shisana (2004) indicate that among others, HIV/AIDS threatens productivity due to increased absenteeism, higher recruitment, training and employment benefits and loss of skills and reverses years of investment in training and education. It claims some of the best leaders, managers and a great number of workers at all levels in the production system. For example, in terms of life expectancy, most infected workers will become ill and die within seven to 10 years of becoming infected. The Department of Labour (2003), the Nelson Mandela/HSRC (2002) and DPSA (2002) state that the HIV/AIDS epidemic not only threaten the lives of individual employees and employers, but has significant impact on each and every workplace, the effective functioning of the labour market and the national economy as a whole. The epidemic reduces the projected number
of people, reduces life expectancy, increases infant mortality, greatly increases the
need for health care and increases the need for poverty assistance, exacerbates
inequalities, leads to large number of orphans, changes the demographic structure
of the population, increases the number of the aged people who need care (who
have lost adult children), affects income and expenditure patterns, reduces grants,
reduces the ability of households to pay for services, rents and rates.

The impact of HIV/AIDS is also significant among higher education
institutions. Chetty and Michel (2005) purport that HIV/AIDS has an effect on
all the categories of people that make up the university community, that is,
students, academic staff, clerical staff, administrative staff and support staff. These
effects manifest themselves in a host of different ways. Illness, death, trauma, and
reduced capacity to work and study affect both staff and students. Institutions lose
students and staff through mortalities. Illness and absenteeism affect productivity.
The pool of skills and knowledge that sustains universities is depleted and the loss
of staff and students may ultimately call into question the viability of the
institution.

The magnitude of the HIV/AIDS epidemic, calls for more studies than ever
before, geared toward controlling and limiting the further spread of the disease
(SADC 2002; World Bank 2002). One way of doing so is through conducting
impact surveys to inform policy, programme development, advocacy efforts,
curricula, strategic plans, financing models, human resource plans and skill
succession plans. Against this background, this study explored the impact of HIV/
AIDS among staff in higher education institutions in the Eastern Cape. This target
group was chosen because responses to HIV/AIDS in higher education institutions
have tended to concentrate on prevention and impact management in students
served, rather than on employees. Effective responses to HIV/AIDS among
employees are also important to respond to other HIV/AIDS-related socio-
economic impacts and broader development agendas. It is hoped that this study
will enable institutions to respond to HIV/AIDS in a strategic manner, to identify
the scale of expected impacts, pinpoint factors that increase the susceptibility of
employees and vulnerability of core functions and allow the development of a
well-informed, coherent, prioritised approach to HIV/AIDS based on feasibility,
affordability and cost-effectiveness.

The objectives of the study were to establish costs and trends in costs
associated with HIV/AIDS morbidity and mortality among the employees of
higher education institutions and to assess impact of HIV/AIDS on job
performance and coping with performance problems.
2 METHOD

2.1 Design and setting

A descriptive survey was conducted using a semi-structured questionnaire to collect data from Heads/Deans of Departments/Schools/Faculties in the 14 ETDP SETA member institutions of the Eastern Cape Province, South Africa.

The Eastern Cape Province is situated along the south-east coast of South Africa and covers an area of 170,000 km², representing about 14 per cent of the country’s land mass. It has a population size of approximately seven million, representing 16 per cent (third largest) of the South African population. The non-urban population amounts to nearly 4,100,000, and dense concentrations of rural and peri-urban settlements occur in other districts and areas. The Eastern Cape is one of the provinces with the highest level of poverty, underdeveloped infrastructure and unemployment (Eastern Cape Department of Social Development 2004).

2.2 Sample and procedure

Fourteen institutions that are ETDP SETA members participated in the study. The institutions included two technikons, namely Border and Eastern Cape Technikons; four universities, namely University of Port Elizabeth, Vista University, Rhodes University and University of Transkei and eight Further Education and Training Colleges, namely Ikhala, Ingwe, King Sabata Dalindyebo, Port Elizabeth, Lovedale, Buffalo City, King Hintsa and East Cape Midlands. In each of the 14 participating institutions, a list of Heads/Deans of Departments/Schools/Faculties was compiled based on annual reports, internal telephone communication books and human resource lists. The list contained the name of the HOD/Dean, telephone number, fax number, office number and e-mail address. The total number of Heads/Deans in the 14 institutions amounted to 530. Systematic random sampling was used to select 10 Heads/Deans in each institution based on each institution’s sampling frame. Therefore, the sample size included 140 Heads/Deans representing 26.4 per cent of the target population of 530 Heads/Deans across the 14 institutions. The 140 Heads/Deans were subsequently approached by trained researchers to participate in the study via e-mail, personal consultation, telephone contacts and fax invitation. The researchers advised each HOD/Dean on their status as volunteers, their right to refuse to answer any question, the legal liabilities of their participation, confidentiality, and the limitations of anonymity due to the nature of the study. From a total sample of 140 Heads/Deans, 137 Heads/Deans who constituted 97.6 per cent of the sample agreed to participate in the study. Only 2.4 per cent did not participate in the study, as they were not available at the time when the study was conducted. Subsequently, each researcher secured an appointment with the concerned HOD/Dean, to administer the
questionnaire. In some cases questionnaires were hand delivered for completion by the HOD/Dean and in other cases the researchers interviewed the respondents. Completion of the questionnaire lasted for about 1 hour.

Ethical approval to conduct the study was given by the Faculty Research Committee.

2.3 Measures

Prior to administering the questionnaire, a pilot study with 5 HODs/Deans was undertaken at Border Technikon. Thereafter, the wording of the original questionnaire was reviewed and modified accordingly. Ambiguity of meaning was eliminated; clarity, comprehensibility and simplicity of items were ensured. The questionnaire was adjusted in order to accommodate the cultural sensitivity of the participants. Five measures were used for the study as reflected below:

- Assessment of employee benefits which included the following questions: What are expected impacts of HIV/AIDS on future claim levels and costs for Medical insurance? Number of sick leave days taken? Number of compassionate leave? Death and disability cover? Funeral benefits? Is there any evidence of increased/exhausted claims on benefits as yet (last 5 years)? Are there effective systems to monitor impacts on employee benefits? Have all options for restructuring benefits to make them sustainable and meet employee needs been considered?

- Indirect costs which included determining the extent to which higher education institutions were experiencing the loss of experience, hiring new personnel, redeployment, training and loss of man-hours.

- Job performance which included determining the extent to which institutions were experiencing less staff concentration, work overload, loss of commitment, failure to meet deadlines, less output, loss of team work, poor customer service, failure to meet organisational obligations, poor customer confidence and victimisation.

- Staff turnover which included determining reasons why staff members left their jobs such as for greener pastures, HIV-related, voluntary, abscondment, dismissal, deaths other than due to AIDS, and others.

- Absenteeism-coping strategies such as reassign, redeploy, counseling, multi-skilling, coaching, hire labour and replace.

- Sick leave coping strategies such as reassign, replace, redeploy, tolerance, multi-skilling, coaching, counseling, hire labour and do nothing.

2.4 Data analysis

Researchers submitted all the questionnaires that they had collected from participants to the principal investigator. Each questionnaire was numbered to ensure that data capturers were able to go back to it should there be some queries.
The principal investigator created the variables for quantitative data on SPSS version 11.0. Responses to quantitative questions were then entered on SPSS. The data were then cleaned and analysed as reflected in the results section. Responses to qualitative questions were analysed according to guidelines for analysing qualitative data as outlined by Krueger (1994). The researchers paid attention to words and phrases in participants’ own vocabularies that capture the meaning of what they do or say; identified different themes and looked for underlying similarities between them; named and categorised themes (open coding); and made connections between a category and its sub-categories (axial coding). Approximately 20 per cent of the data were given to an external researcher to rate the initial codings and a .61 interrater reliability was achieved. The recurrent themes, which emerged in relation to each qualitative question, have been presented in the section on results.

3 RESULTS

The findings include estimated indirect costs incurred due to HIV/AIDS in the past year, job performance, staff turnover, absenteeism-coping strategies, and sick leave-coping strategies as perceived by HODs/Deans.

3.1 Estimated indirect costs

The question on indirect costs incurred due to HIV/AIDS was measured on a 10-point scale, with 0 representing no costs at all, 1–3 representing small indirect costs, 4–7 representing moderate costs, 8–10 representing huge costs. A relatively high percentage of HODs reported that there was a small to moderate: loss of experience, hiring of new personnel, redeployment, training and loss of man-hours due to HIV/AIDS (see Table 1).

| Table 1: Estimated indirect costs incurred due to HIV/AIDS in the past year |
|-----------------------------|---------------|-------------|-------------|-------------|-----------------|
| **Items**                  | None  | Small  | Moderate | Huge  | Don’t know |
| Loss of experience         | 14.7  | 45.3   | 18.7     | 8.0   | 13.3         |
| Hiring new personnel       | 14.5  | 43.4   | 21.1     | 8.0   | 13.2         |
| Redeployment               | 17.2  | 51.6   | 10.9     | 4.9   | 15.6         |
| Training                   | 15.1  | 37     | 26.0     | 8.2   | 13.7         |
| Loss of man hours          | 15.1  | 38.4   | 24.7     | 8.2   | 13.7         |
3.2 Job performance

The HODs reported that HIV/AIDS resulted in varying degrees to less concentration, work overload, loss of commitment, failure to meet deadlines, less output, loss of team work, poor customer service, failure to meet organisational obligations, poor customer confidence and victimisation (see Table 2).

Table 2: Perceived impact of HIV/AIDS on staff job performance in percentage

<table>
<thead>
<tr>
<th>Items</th>
<th>Little</th>
<th>Much</th>
<th>Very much</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less concentration</td>
<td>69.8</td>
<td>12.7</td>
<td>7.9</td>
<td>9.6</td>
</tr>
<tr>
<td>Work Overload</td>
<td>57.4</td>
<td>24.6</td>
<td>8.2</td>
<td>9.8</td>
</tr>
<tr>
<td>Loss of commitment</td>
<td>46.9</td>
<td>18.6</td>
<td>6.8</td>
<td>27.7</td>
</tr>
<tr>
<td>Failure to meet deadlines</td>
<td>59</td>
<td>14.8</td>
<td>16.4</td>
<td>9.8</td>
</tr>
<tr>
<td>Less output</td>
<td>48.4</td>
<td>19.4</td>
<td>22.6</td>
<td>9.6</td>
</tr>
<tr>
<td>Loss of team work</td>
<td>55.7</td>
<td>11.5</td>
<td>22.6</td>
<td>9.8</td>
</tr>
<tr>
<td>Poor customer service</td>
<td>55</td>
<td>20</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Failure to meet organisational obligations</td>
<td>53.3</td>
<td>28.3</td>
<td>8.3</td>
<td>10.1</td>
</tr>
<tr>
<td>Poor customer confidence</td>
<td>66.1</td>
<td>15.3</td>
<td>8.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Victimisation</td>
<td>68.5</td>
<td>13.0</td>
<td>7.4</td>
<td>11.1</td>
</tr>
</tbody>
</table>

3.3 Staff turnover

This includes reasons for leaving the department, reasons for absenteeism and sick leave.

Table 3: Staff members who left department in 2002 for various reasons in percentage

<table>
<thead>
<tr>
<th>Items</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3 and more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greener pastures</td>
<td>52.9</td>
<td>36.8</td>
<td></td>
<td>9.5</td>
</tr>
<tr>
<td>HIV related</td>
<td>89.0</td>
<td>5.9</td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>Voluntary</td>
<td>75.0</td>
<td>16.9</td>
<td></td>
<td>8.1</td>
</tr>
<tr>
<td>Abscondment</td>
<td>90.4</td>
<td>3.7</td>
<td></td>
<td>5.8</td>
</tr>
<tr>
<td>Dismissal</td>
<td>89.0</td>
<td>5.1</td>
<td></td>
<td>5.9</td>
</tr>
<tr>
<td>Deaths other than due to AIDS</td>
<td>89.7</td>
<td>5.9</td>
<td></td>
<td>4.4</td>
</tr>
<tr>
<td>Others</td>
<td>83.8</td>
<td>10.3</td>
<td></td>
<td>5.8</td>
</tr>
<tr>
<td>Retrenchment</td>
<td>90.4</td>
<td>3.7</td>
<td></td>
<td>5.9</td>
</tr>
</tbody>
</table>
Table 3 shows that a sizeable percentage of staff members (46.3 per cent) left their work for greener pastures, HIV-related reasons, voluntarily, absconded, dismissal, death other than due to AIDS, retrenchment and others.

### 3.4 Absenteeism

The HODs reported that they used various absenteeism-coping strategies such as reassigning tasks, redeployment, counselling, multi-skilling, coaching, hiring labour, replacement (see Table 4)

**Table 4: Absenteeism coping strategies in percentage**

<table>
<thead>
<tr>
<th>Items</th>
<th>Little</th>
<th>Much</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reassign</td>
<td>56.9</td>
<td>31.9</td>
<td>11.2</td>
</tr>
<tr>
<td>Redeploy</td>
<td>75.9</td>
<td>17.2</td>
<td>6.9</td>
</tr>
<tr>
<td>Counselling</td>
<td>61.2</td>
<td>28.4</td>
<td>10.4</td>
</tr>
<tr>
<td>Multiskilling</td>
<td>58.2</td>
<td>27.3</td>
<td>14.5</td>
</tr>
<tr>
<td>Coaching</td>
<td>63.6</td>
<td>25.5</td>
<td>10.9</td>
</tr>
<tr>
<td>Hire labour</td>
<td>71.2</td>
<td>20.3</td>
<td>8.5</td>
</tr>
<tr>
<td>Replace</td>
<td>71.7</td>
<td>23.3</td>
<td>5.0</td>
</tr>
</tbody>
</table>

### 3.5 Sick leave

In the case of sick leave, the majority of the HODs reassigned tasks, tolerated the situation, provided staff with a variety of skills and a relatively lower percentage replaced staff, redeployed, coached, counselled, hired labour to address the situation (see Table 5).

**Table 5: Sick leave coping strategies in percent**

<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reassign</td>
<td>69.4</td>
<td>30.6</td>
</tr>
<tr>
<td>Replace</td>
<td>21.1</td>
<td>78.9</td>
</tr>
<tr>
<td>Redeploy</td>
<td>28.8</td>
<td>71.2</td>
</tr>
<tr>
<td>Tolerance</td>
<td>77.9</td>
<td>22.1</td>
</tr>
<tr>
<td>Multiskilling</td>
<td>50.7</td>
<td>49.3</td>
</tr>
<tr>
<td>Coaching</td>
<td>30.8</td>
<td>69.2</td>
</tr>
<tr>
<td>Counselling</td>
<td>39.7</td>
<td>60.3</td>
</tr>
<tr>
<td>Hire labour</td>
<td>30.3</td>
<td>69.7</td>
</tr>
<tr>
<td>Do nothing</td>
<td>26.8</td>
<td>73.2</td>
</tr>
</tbody>
</table>
4 DISCUSSION

4.1 Estimated HIV/AIDS on indirect costs

In the current study a relatively high percentage of the participants acknowledged that their institutions incurred indirect costs due to HIV/AIDS in the form of loss of experience, hiring of new personnel, redeployment, training and loss of man-hours. Similar findings were found in previous studies. In a study on the impact of HIV/AIDS on the public service in Uganda, Baguma (2000) found that loss of skill and experience resulted in hiring new personnel, redeployment, training and loss of man-hours, thereby increasing HIV/AIDS-related expenditures from 7.1 per cent of the total costs in 1995 to 15 per cent in 1999. Absenteeism and turnover had increased. These costs included loss of skills and experience, costs resulting from hiring new personnel, redeployment, training and loss of man-hours. Like in the current study as reflected in Tables 4 and 5, departments had coped with these costs by reassignment, redeployment, counselling, multi-skilling, coaching, hiring and replacement. Based on a five-company study in Botswana, the average cost to recruit and train a replacement for an employee lost to AIDS is R8 405 (Greener 1997). Morris, Burge and Cheevers (2000) found that the cost per worker for each of the last two years was R8 463.73. These costs were primarily divided between replacement worker costs (28 per cent), lost productivity (28 per cent), training (5 per cent), hospitalisation (1 per cent) and clinic and physician visits (10 per cent) as well as lost wages (28 per cent). These costs represent only a fraction of the total costs of HIV/AIDS to a company. They omit, among others, the costs of funeral leave and expenses, use of company health clinics, reduced on-the-job productivity and the time managers and supervisors devote to HIV positive employees. In the United States (US) labour costs for some firms range from US$3 500 to US$46 000 per year for each employee with HIV. In South Africa, the Goldfields Mining Company found that HIV/AIDS indirectly costs the company US$4 for every ounce of gold produced. A Thai Government study calculated that the direct and indirect cost of HIV/AIDS to the nation was US$1.2 billion in 2000 (DoL 2003). A survey by the Kenyan Federation of Employers revealed that HIV/AIDS is costing companies an average of US$25 per employee annually, and that costs would increase to an average of US$56 per employee by 2005, if the rate of infection continued unchecked (DoL 2003). A survey by the Kenyan Federation of Employers showed that HIV/AIDS is costing companies an average of US$25 per employee annually, and that costs would increase to an average of US$56 per employee by 2005, if the rate of infection continued unchecked (DoL 2003). An analysis of costs per HIV infected worker showed R2 350 for lost productivity, R2 328.64 for replacement workers, R400 training costs, R102 for hospitalisation and follow up R846 for clinic visits and R2 437.09 for lost wages. It could, therefore, be concluded that HIV/AIDS increases indirect costs to the organisation. The major responsibility of each organisation is to ensure that these costs are properly forecasted, budgeted for and managed.
4.2 **Perceived HIV/AIDS impact on job performance**

Participants in the study reported that HIV/AIDS resulted, in varying degrees: less concentration, work overload, loss of commitment, failure to meet deadlines, less output, loss of team work, poor customer service, failure to meet organisational obligations, poor customer confidence and victimisation. These affect employee productivity negatively. The results in this regard support those of previous studies that overall productivity of the workforce declines due to HIV/AIDS (AIDS Directorate 2001). For example, USAID (2002) found that AIDS reduced the productivity of African businesses by both increasing the cost of production and decreasing the productivity of African workers. Rising production costs for business not only affect current profit margins, but also future profits by reducing the investment capacity for increasing productivity, expansion, research and development, and workforce training and support. Studies in Zambia (Smith and Whiteside 1995), Kenya (Roberts, Rau and Ernery 1996; Roberts and Rau 1995), Botswana (Greener 1997), Zimbabwe (Bollinger and Stover 1999; Moore 1999), Malawi (Jones 1996) and South Africa (Morris and Cheevers 2000; Morris, Burge and Cheevers 2000) have found that reduction in productivity is among the largest HIV-related costs faced by companies. Productivity will decline given changes in the age profile and the related losses of labour, skills and experience in the economically active population (15–65 years) (Arndt and Lewis 2001). The loss of productivity clearly reduces Africa’s competitive advantage (USAID 2002). Declining levels of productivity due to increased absenteeism and organisational disruption leads to declining profits, unless production costs are declining at even faster rate. Declining and fluctuating productivity makes it difficult for a company to meet supply demands from consumers, thus influencing its overall growth and development. DoL (2003) maintains that a decline in productivity discourages foreign investment and adversely affects consumer and business confidence. Therefore, it is critical that the higher education sector becomes aware of the HIV/AIDS problem and takes immediate steps to mitigate its impact. Such steps should include workplace peer education programmes, condom distribution, voluntary counselling and testing, STI treatment and treatment for HIV-related opportunistic infections.

4.3 **Perceived HIV/AIDS impact on staff turnover**

The results showed that workers left their workplaces for various reasons, namely greener pastures, HIV-related reasons, voluntarily, absconded, dismissal, death other than due to AIDS, retrenchment and ill-retirements. Studies have shown that staff turnover, especially due to HIV-related reasons, affects business negatively. For example, employees who leave a company due to AIDS take an average of 27.7 additional paid sick days in each of the years before termination, for a total of 55.5 days. This estimate comes from a study conducted among a cohort of male sugar mill workers in South Africa (Morris et al. 2000). In this study, it was found
that HIV-infected workers took ill health retirement status from 1991 to 1998. Of the 23 men taking ill-health retirement, each had a mean loss of 11.75 days due to ill health, 21.2 outpatient visits and 5.4 days lost due to hospitalisation for each of the last two years prior to leaving the workforce. If one estimates a one half day of work lost due to a clinic visit then this resulted in a total of 27.7 days lost due to illness per year for each of these last two years of employment. Increased staff turnover and loss of skilled workers raise recruitment and training costs. Companies incur recruitment costs, position is held vacant until new employee is hired, additional resources must be brought in, cost of overtime wages increases to compensate for vacant positions, to cope with staff fluctuations and losses (Morris et al. 2000). Companies incur costs of pre-employment training (induction, etc.), costs of in-service training to bring new employee up to level of old one and salary is paid to employee during training. In addition, scarcity of skilled labour not only increases training costs but also results in demand for higher wages. Wages for skilled employees increase as labour markets respond to loss of workers. Performance is low while new employee comes up to speed and other employees spend time providing on-the-job-training. There is an overall reduction in the experience, skill, institutional memory and performance of the workforce. Work unit productivity is disrupted due to increased staff turnover (Morris et al. 2000). With high levels of staff turnover, transmission of skills and knowledge becomes difficult. These less visible organisational factors, built up over long periods of time, are critical for a more efficient, effective and ultimately productive workforce. Rosen, Simon, Thea and Vincent (2000) maintain that if a company’s workforce is not stable, such that there are high rates of employee turnover, co-workers’ morale, discipline, and concentration are disrupted and are demoralised by the loss of a colleague. Even in the absence of HIV, the company’s liability for future costs may be smaller than that for a company with a stable workforce.

5 CONCLUSION

Overall, the purpose of this study was to assess the HODs/Deans perceptions of the indirect costs of HIV/AIDS, its impact on job performance, staff turnover and the strategies used to cope with absenteeism and sick leave among higher education institutions in the Eastern Cape. In general, the findings confirm trends in existing data, that is, HIV/AIDS is having a serious impact on the fiscal situation of higher education institutions in much the same ways as it does on other institutions. The disease increases operating costs, reduces productivity (especially through high absenteeism), diverts resources and threatens sources of income (HEARD 2000; Klinghorn, Steinberg and Whiteside 2001; Abt Associates 2000; DoL 2003) in the labour market and higher education institutions are not an exception (Katjavivi and Otaala 2003; DPSA 2002). It is, therefore, imperative for higher education institutions to respond to HIV/AIDS for their own benefit and that of their broader stakeholders. In the face of one the greatest socio-economic challenges and the
worst epidemic for 600 years, the tertiary education and training sector, which is the primary mechanism for the development of the future human resources, must respond decisively. Early action will reap tremendous savings in both economic and human terms.

Decision makers must be prepared to pursue policies that can mitigate the social and economic impacts. The financial benefits of pushing further into the future the types of costs analysed above are only a subset of the overall gains to a company of investing in keeping its workforce as healthy as possible for as long as possible. By implementing HIV/AIDS management strategies, skilled and experienced employees will be retained longer. This would then reduce the time managers and supervisors would have spent coping with employee deaths and high turnover rates. It would also reduce the impact on morale, motivation and concentration on the rest of its workforce of having colleagues fall sick and die. If a company invests in activities that prevent new infections, then for each infection averted, it saves the full amount of the money which would have been lost when an employee becomes infected. These savings represent the return on its investment. A holistic approach to the management of HIV/AIDS that covers future projections, quantified direct and indirect costs involved, customised managed care products, effective intervention and awareness programmes, human resource planning, effective communication strategy and counselling and support is the only solution to curb this malady. Health-care provision, such as treatment of sexually transmitted diseases, can help reduce infection rates. Provision of antiretroviral therapy, though costly, can help prolong the lives of employees, and hence provide long-term benefits to the company.

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