HIV/AIDS Care and Support in the Workplace: Identifying Effective Practices

Draft background paper,
Inter-regional tripartite meeting on best practices in workplace policies and programmes on HIV/AIDS

Geneva, 15-17 December 2003

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August 2003
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INTRODUCTION

HIV/AIDS is described by the 2003 Human Development Report as the “greatest shock to development” in recent decades.\(^1\) Since the first cases were recognized in the early 1980s, this disease of epidemic proportions has claimed over 22 million lives and has left 13 million children as orphans. Current estimates show a staggering 42 million people living with the virus. It continues to cripple parts of Africa, and it is expanding rapidly in other regions of the world\(^2\). Without decisive action at the global level, it is estimated that 68 million more people will fall victim to the pandemic in the next twenty years.\(^3\)

The considerable economic and social costs of the epidemic are becoming more painfully apparent causing an unacceptable depth of human tragedy. The scope of the disease is extensive and its implications apply to many facets of life, in particular working life seeing as the epidemic has its primary impact on the working age population. The unabated spread of HIV/AIDS in many regions means that alongside the continuing need for prevention, there is an escalating demand for care and support of HIV/AIDS infected and affected people. Even in areas that are approaching the peak of HIV prevalence, the nature of the disease with its long incubation period between initial infection and the onset of illness, means that the levels of illness and death are still increasing, and therefore, the demand for care and support is also rising.\(^4\)

Public health systems are struggling to cope with the disease and alternative delivery points and partnerships for the provision of care and support to persons living with HIV/AIDS (PLWHA) and to their care givers are increasingly being explored.

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\(^2\) Regions with large populations and at particular risk include China, India and the Russian Federation. The Human Development Report 2003 estimates that there are about 7 million people currently infected with HIV/AIDS in these countries. It estimates that with a moderate response to the disease and considering social characteristics, almost 200 million people could be infected in these countries alone by 2025.

\(^3\) UNAIDS. *Report on the Global HIV/AIDS Epidemic.* Geneva: UNAIDS, July 2002, p. 45. This projection is based on the assumption that prevention, care and treatment programmes will have a modest effect on the growth and impact of the pandemic.

In light of the fact that the vast majority of people living with HIV/AIDS are in the prime of their working lives, with workers accounting for two-thirds\(^5\) of all adults living with HIV/AIDS, the workplace clearly represents a vital entry point for tackling the pandemic. The ILO’s position is that the workplace should be seen as an integral part of a broad social protection and public health approach, as well as a part of socio-economic policy for combating HIV/AIDS. This is necessary not only because the disease has a particularly severe impact on working people, but also because the workplace, being part of the local community, has a role to play in promoting HIV/AIDS prevention, and in providing care and support to mitigate its socio-economic impact.

Based on a literature review, this paper identifies effective workplace practices that have been undertaken to provide care and support for persons infected and affected by HIV/AIDS. The world of work, with which the ILO is concerned, has an important potential to combat the disease for it covers all sectors - governments and their agencies, the private sector (business and labour), as well as non-governmental organizations. Nevertheless, its potential remains largely untapped. Private sector employers, particularly large multinational corporations, are undertaking notable workplace programmes to address HIV/AIDS, including the provision of care and support for PLWHA and their families. The advent of new and simplified treatments for resource poor settings for HIV/AIDS as well as the significant reduction in drug prices, now make treatment, in particular antiretroviral (ARV) therapy, a more feasible and viable target for workplace action\(^6\). At the same time, global commitment by political, economic and social decision makers to respond to the HIV/AIDS epidemic has increased substantially, as reflected by the UN General Assembly Special Session (UNGASS) on AIDS in 2001, and the establishment of a new financial mechanism, the Global Fund to Fight AIDS, Tuberculosis, and Malaria

\(^5\) Represents adults between 15 – 49 years of age, using 2002 populations numbers.

Moreover, annual global resources for HIV/AIDS have increased from just over US$ 300 million in 1999 to almost US$ 3 billion in 2002. These developments give rise to new opportunities for action in order to intensify the fight against the disease.

The challenge is clearly formidable and is made more complex by the circumstances and needs of populations at particular risk to the disease, such as women, children and youth, migrant and mobile workers. At the same time, the fact that the vast majority of the working population affected by the pandemic work in the informal economy, the majority of whom are women, means that a great amount of work remains to be done if there is to be an effective global response to the epidemic.

The untapped potential of the workplace in the area of care and support represents an important opportunity for broadening the fight against HIV/AIDS. There are important lessons that can be learned from workplace practices, including those notable efforts to extend care to the informal economy, vulnerable populations, and to affected communities. The ILO Code of Practice on HIV/AIDS and the World of Work (hereinafter ILO Code of Practice) provides the framework to guide action, while the workplace programmes that have been undertaken to date offer an opportunity to review the lessons that have been learned. Taken together, they can be used to define a strategy for the way forward.

THE RATIONALE FOR CARE AND SUPPORT

Care, support and treatment, including access to antiretroviral (ARV) drugs, were first recognized as an essential element to the response to the global HIV/AIDS epidemic in the historic landmark Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session in June 2001. Care and support is also a key guiding principle of the ILO Code of Practice as well as being one of the four key areas of action to address the HIV/AIDS pandemic in the world of work.

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7 Other notable commitments include: The World Economic Forum’s Global Health Initiative in 2002, the Accelerating Access Initiative launched in 2000, and the UN Global Compact Policy Dialogues which convened a meeting on HIV/AIDS hosted by the ILO in Geneva, Switzerland, 12-13 May 2003.
Fundamentally, the requisite for care and support highlights the fact that health is a human right. Several human rights are threatened in the context of HIV/AIDS and the failure to protect human rights increases the risk of transmission of the disease since it prevents people from accessing needed care and treatment.8

With respect to other health arguments, access to care and support contributes to the prevention of HIV infection and to the transmission of the disease. It also decreases the spread of infectious diseases that are commonly associated with HIV/AIDS, such as tuberculosis (TB) and sexually transmitted diseases (STDs), by early diagnosis and treatment of these conditions. The critical relationship between prevention and care, support and treatment is now widely recognized and the full integration of prevention strategies with care, support and treatment interventions is now a central element of a comprehensive HIV/AIDS care strategy. The incorporation of treatment and care is essential to ensure the success of prevention and early diagnosis through voluntary counselling and testing (VCT) services since the knowledge that care, support and treatment are available provides a strong incentive to an individual to seek testing. In short, prevention, care, support and treatment are no longer seen as unrelated strategies but are instead seen as mutually supportive.9

There are also a number of important social reasons for the provision of care and support. One of the main arguments is that it alleviates stigma and discrimination. A workplace which cares openly and compassionately for PLWHA and their carers reduces the fear and shame associated with the disease. As will be demonstrated later in this paper, stigma and discrimination remain key obstacles in the fight against the disease in the workplace. At the same time, care and support strategies can also address critical equity issues by targeting groups that are hard to reach and at particular risk of HIV/AIDS, such as women, sex workers, migrant and mobile populations, which may have a direct or indirect impact on workplace interventions.


In addition, care and support can also build confidence and hope in people infected with HIV/AIDS, their families and their communities, particularly if it improves the quality of life of people living with HIV and AIDS. Given the significant advancements in treatment, specifically the simplified treatment regimes for ARV therapy and the drastic reduction in drug prices, the provision of care and support become more essential to ensure that these treatments are managed successfully and that the new optimism in treatment is not lost. By prolonging and improving life in a significant way, care, support and treatment can also mobilize communities in the fight against the epidemic.\(^\text{10}\)

The provision of care and support also has the potential of elevating the issue of care, specifically the social and economic contribution of care work (both formal and informal).\(^\text{11}\) The role of caregivers cannot be overlooked in the fight against HIV/AIDS. The epidemic has placed the greatest responsibility for care on women, which highlights the gender dimension of this issue. It has also had a significant impact on older persons who are often left to care for their orphaned grandchildren. People’s income earning potential is being comprised as they have to take time off of work and other income-generating activities, or leave work all together in order to fulfill their care giving responsibilities. Increased absenteeism or the loss of work due to care giving responsibilities impoverishes households, and is a significant cost to workplaces and national economies. At the same time, the burden of care can lead to children, primarily girls, being taken out of school, which hinders human capital formation. In the worst cases, children may be forced into child labour. While the


economic costs are of urgent importance, the vital social contribution of the people providing care cannot be minimized. The vast majority of people suffering from HIV/AIDS rely on their families for care. Without their compassion and assistance, the situation for PLWHA would be far worse. As a result of their vital role, the needs of caregivers require fuller attention. The disease has placed enormous care responsibilities on people and many are working beyond their limits, particularly in poor households which are likely to be underserved by basic public services such as sanitation and piped water. Workplace programmes can serve to alleviate some of the pressure and facilitate a minimum quality of care in the home.

The economic impact of HIV/AIDS is felt at both the micro- and macro-economic levels. Although more research and analysis is required to gain a more in-depth understanding of the economic impact of the epidemic, studies in the last decade have begun to illustrate the significant economic costs of the disease on households and enterprises and the resulting impact on national and regional economies. A recent study by the World Bank argues that the long-term economic costs of HIV/AIDS, as measured by reduced GDP growth rates, are far greater than currently estimated when the impact of the pandemic on human capital formation over generations is factored in. Given the substantial economic impact, the provision of care and support is a necessary intervention in order to mitigate economic costs. From a workplace perspective, by improving the quality of life and by prolonging life itself, care and support keeps people with HIV working longer and alleviates the

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responsibility of care from care givers thereby allowing them to continue productive activity as well. This helps organizations maintain their labour supply and reduce labour costs otherwise incurred from increased absenteeism and early retirement. Skilled and experienced workers are also safeguarded, saving training and recruitment costs. Additional costs are saved in reduced health insurance and pension payments. Moreover, levels of productivity and profits are less adversely affected and enterprises are able to meet their supply demands. At the household level, disposable incomes and savings are protected keeping families out of poverty. Consumer demand for goods and services is also sustained, thereby encouraging investment and enterprise development. At the macroeconomic level, the benefits of care and support safeguard economic growth. The pressure on health and social protection systems is reduced, and national efforts in poverty reduction and food security are not put at risk. Human capital is protected as adults remain in productive activity, children stay in school, and families are not at risk of the worst forms of labour in order to generate income. In a globalized economy, a nation’s most precious resource is its human capital, and as such, no action should be spared in order to protect it. Overall, the economic and social benefits of providing care and support are far-reaching, and all segments of society “win” in adopting a care strategy in the fight against HIV/AIDS.

THE WORKPLACE AS AN ENTRY POINT FOR CARE AND SUPPORT

HIV/AIDS has placed a great strain on public health systems around the world. Poor public health infrastructure in vast parts of the developing world has debilitated the fight against HIV/AIDS. With limited infrastructure and resources (as well as political will) to offer the necessary care and support for people and communities affected by the virus, other sectors of society have stepped in to curtail the devastation of the disease. An illustration of this are the workplace programmes that have been initiated by private and public sector employers. These programmes have highlighted the potential of the workplace as another entry point for combating HIV/AIDS. The strengths of the workplace are many. For example, a workplace is characterized by a cohort of people who share a common work space which can be used as an avenue to educate and raise awareness about the disease in order to promote prevention and care, and the protection of rights. Occupational health services or medical services of some type for employees, which are likely to be in
place in larger workplaces, and could be extended to include HIV/AIDS care and treatment. With respect to treatment, in particular the provision of ARVs, workplace health services can play an important role in ensuring adherence to treatment regimes which is critical to the success of ARV therapy. Moreover, occupational health and safety procedures can also be reviewed to ensure that conditions at work prevent transmission of HIV/AIDS. Similarly, occupational social services or employee assistance programmes may also be available. At the same time, social security and occupational schemes offered in bigger workplaces are important to promoting the care and support of PLWHA and their families. Workplace arrangements are also particularly useful for implementing social security and health insurance schemes that could improve access to care and treatment. The workplace also has the potential of helping communities mobilize in the fight against HIV/AIDS. Workplaces do not function in isolation but are an important part of their communities. As the workplace strategies presented in the next sections will demonstrate, community involvement and outreach is a vital component to a comprehensive care strategy against HIV/AIDS. Within the context of care and support, linkages between the workplace and the broader community will lead to more effective responses. Even small enterprises have a role to play and can make important symbolic contributions within their communities to demonstrate their support for people and their families living with the virus.

People living with HIV/AIDS need to have access to a wide range of care and support options in order to cope with the disease. This entails a comprehensive approach to HIV/AIDS care and support, involving different sectors of society. As the analysis above illustrated, the workplace has the potential of offering another care option for PLWHA and their families. However, until recently, its potential contribution has largely been absent from policy discussions. In this regard, the ILO

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16 Due largely to the work of the ILO in recent years as a cosponsor of UNAIDS, in particular, the ILO established the Global Programme on HIV/AIDS and the World of Work which developed the ILO Code of Practice on HIV/AIDS and the World of Work and its accompanying education and training manual as a framework to guide global efforts to fight the pandemic.
has been working to fill this gap by working with its partners to ensure that HIV/AIDS is recognized as a workplace issue and that the workplace constitutes a vital entry point in the global response to the pandemic. An important aspect of this work is ensuring that the workplace is incorporated in the continuum of care needed by PLWHA and their families, as illustrated in the diagram below:

The HIV/AIDS Continuum of Care

![Diagram of the HIV/AIDS Continuum of Care](image-url)

The concept of care across a continuum recognizes the need for care through all stages of HIV infection, from VCT services, formal health and social services to community based support and home care. In order to ensure that people receive the care they need, it is necessary that the people and organizations providing care collaborate together to ensure a continuum of service. Therefore, linkages and partnerships between different providers of care is necessary in order to ensure that people receive the comprehensive care they need since no single provider can fulfill
all the care and support requirements. With respect to the workplace, it can provide some of these services through workplace programmes (e.g. medical services, psychosocial support, nutritional advice, etc.). However, the comprehensive nature of the care required, is likely go beyond the scope of what the workplace is able (financially) or capable (qualified) to offer. Therefore, linkages and partnerships with other care providers in the continuum will be necessary. At the same time, the providers of care along the continuum, be they hospitals, counseling services, etc., are also workplaces in themselves, and as such, they should ensure that their workers receive the care and support that they need should they develop HIV/AIDS. Additionally, they should ensure that conditions at work, in particular health and safety procedures, prevent the risk of HIV being transmitted in the workplace.

**HIV/AIDS CARE AND SUPPORT IN THE WORKPLACE**

Fundamentally, HIV/AIDS should be treated in the workplace in parity with other serious illnesses. This is the basis for the provision of care and support that is advanced by the ILO Code of Practice. Specifically, it states that HIV/AIDS should be treated “no less favorably” than any other serious illness or condition. This recognizes that workers with HIV/AIDS should not receive less care compared to the care for other chronic or terminal illnesses. At the same time, it accommodates the need for special treatment which could be necessary for treating HIV effectively, such as psychosocial support or practical assistance with respect to healthy living. Indeed, the significant advancements in HIV treatment, in particular ARV therapy, has made it possible to treat HIV/AIDS as a chronic illness, allowing people to remain working and contributing to their societies. While ARV treatment has primarily been a “luxury” of the developed world, positive developments in recent years has meant that it is within reach of developing countries. The WHO published guidelines in 2002 on simplified ARV regimes for resource-poor settings and has initiated pilot projects to scale-up ARV treatment in these regions, including initiatives in Haiti,
Uganda and South Africa, which demonstrate its viability in developing countries.\textsuperscript{18} While these advancements are making it possible for ARV treatment to be a target for care and support in the workplace, it should not be the sole focus of workplace initiatives at the exclusion of the range of interventions necessary to provide effective care and support. In a development context, the treatment of opportunistic diseases such as TB and STDs, which are the primary cause of fatality in HIV/AIDS patients, as well as good nutrition,\textsuperscript{19} are crucial interventions to delay the progress of the virus. These interventions are also more viable and feasible for workplace action.

In the context of the ILO and the world of work, ‘care and support’ for people living with HIV/AIDS includes the following broad categories that should form the basis for interventions:

- Access to treatment and drugs (including ARV therapy, treatment of opportunistic and concurrent infections, pain relief, palliative care);
- Practical support for healthy living, with particular emphasis on nutrition.
- Psychosocial support and counselling, including family planning, medication adherence, end-of-life and bereavement support, legal assistance, and practical economic assistance such as assistance on alternative employment or income generating opportunities, and support for education and training.
- Reasonable accommodation including the adaptation of the workplace, work time and tasks in order to enable people to continue working for as long as possible.
- Access or the provision of social protection which includes the implementation of social security, medical benefits, health insurance schemes and other decentralized insurance and income support schemes.

\textsuperscript{18} See the following Draft Perspectives and Practice in Antiretroviral Treatment available from the WHO: Access to Treatment and Care: Haiti Experience (Draft); Antiretroviral Therapy in Primary Health Care: South African Experience (Draft); Scaling Up Antiretroviral Therapy: Ugandan Experience (Draft), Geneva, May 2003.
Linkages with relevant groups and services within the local community or region used to inform and refer workers and their families.

Furthermore, the provision of care and support in the workplace should be done without discrimination, and it should be undertaken with the strictest respect for privacy and confidentiality. As stated earlier, care and support is only one key element of an HIV/AIDS workplace strategy. The effectiveness of care and support programmes relies on other essential interventions in the workplace, primarily, information, awareness-raising and education initiatives to address stigma and discrimination and prevention programmes, which together lead to an holistic and integrated approach critical to an effective workplace response to tackle the disease.

WORKPLACE PRACTICES IN CARE AND SUPPORT

The following section identifies a variety of workplace practices in care and support that have proven to be effective and that provide important lessons that can help advance work in this area. As some of the examples will illustrate, the development of effective strategies is a learning process for organizations, and good approaches are continually evolving. Indeed, the complex and multifaceted nature of HIV/AIDS demands that efforts to fight the disease be consistently monitored and evaluated to ensure their effectiveness. Similarly, good organizational management and policy development call for constant monitoring and evaluation to ensure that strategies are timely, effective, cost-efficient, and sustainable.

The literature review revealed a number of noteworthy workplace programmes being spearheaded by large multinational corporations whose resource base and institutional capacity enable them to undertake comprehensive action against the impact of the pandemic on their operations. Most of these private sector initiatives are being undertaken in southern and central Africa where HIV/AIDS is most rampant and is having its most detrimental impact. At the same time, there are also exceptional initiatives being undertaken by small enterprises. Although they are far fewer and more limited in scope, given that the magnitude of the challenge is far greater for small workplaces, they are nevertheless an invaluable contribution to filling the huge gap of necessary workplace responses by small- and medium-sized
enterprises (SMEs) in both the formal and informal economies. The collective influence of business coalitions, chambers of commerce, and other similar associations, as well as outreach by large companies to their suppliers and contractors, are also critical steps in increasing the capacity of smaller scale workplaces, where the vast majority of people work, to respond to the disease. In addition, trade unions, employers’ organizations as well as public sector workplaces are also taking advantage of their competencies to play a more active role in the fight against HIV/AIDS. Together, these examples illustrate the importance of collective action and collaboration, where partnerships have become an increasingly vital component of effective workplace strategies, particularly in the area of care and support where the cost and management of interventions can be significant obstacles.

The workplace practices highlighted in this paper were selected based on their conformity with the guiding principle and the six broad categories for care and support set out in the ILO Code of Practice. The initiatives undertaken by large multinational companies have been selected to illustrate comprehensive approaches to care and support, including ARV medication and treatment. In particular, they are intended to illustrate how organizations have been able to fully apply the principle and categories of care and support promoted by the ILO Code of Practice. Workplace practices by a small enterprise, trade union, and a public sector employer are also highlighted. The purpose of these examples is to illustrate how organizations with more limited resources and institutional capacity are still able to promote care and support for their workers. While short of being comprehensive in approach, these initiatives are invaluable examples of how organizations can use their comparative advantage to mobilize support for the care and treatment of persons living with HIV/AIDS and their families. Together, these examples demonstrate how all sectors have an important role to play in combatting the disease.

The first example is of Volkswagen do Brasil which has been successfully providing comprehensive care and support, including ARV treatment, to its workers since 1996. Heineken International in Africa is the second example, which highlights a company’s recent decision to provide ARV therapy as part of its care and treatment provision to workers. This is then followed by a notable effort by Placer Dome Western Areas Joint Venture, South Deep Gold Mine in South Africa, whose care
process involves a comprehensive program to generate alternative employment and income generating activities, as well as a home-based care project to support families affected by HIV/AIDS. The example of DaimlerChrysler South Africa illustrates how a company has revamped its workplace programme by undertaking an exemplary public-private partnership in order to provide better care and support to its employees and their families. RRR Industries in India, is an example of a notable small business initiative, highlighting that significant inroads in care and support can be made on a small scale. The examples of the Trade Union Congress of the Philippines, and the Kenya Port Authority illustrate the important contribution that can be made by trade unions, and public sector workplaces.

**Volkswagen do Brasil**

Volkswagen do Brasil initiated its AIDS Care Programme in 1996, which includes the provision of ARV drug treatment and clinical tests. Out of the organizations researched, it is one of two companies which has the longest standing commitment to providing ARV therapy as part of its care and support workplace programme for HIV/AIDS. The effectiveness of its AIDS Care Programme is reflected by key quantitative and qualitative results from the Company’s monitoring activities. In particular, since 1999 there has been a 90% drop in hospitalizations; a 40% reduction in treatment and care costs; and 90% of people living with HIV and AIDS covered by its scheme remaining active and symptom-free. Qualitatively, the Company notes a perceived improvement in employee satisfaction, benefits from greater clinical control of HIV patients, and an improved quality of life for PLWHA within the workplace and in the community.
Volkswagen do Brasil: Providing Successful ARV Treatment since 1996

Volkswagen do Brasil is a subsidiary of the Volkswagen Group. It employs over 320,000 people globally and is the fourth largest automobile manufacturer in the world. The operations in Brazil employ approximately 30,000 people.

In 1996, the Company initiated the AIDS Care Programme as an extension of its self-managed medical plan that had been in existence for 22 years. The impetus for the Programme was to respond to the increasing level of HIV infection in the Company’s workforce and to curb the associated heavy costs experienced as a result of absenteeism and the loss of skilled employees. The Programme made all existing tests and treatment resources available to people with HIV/AIDS, and expanded prevention measures.

Its AIDS Care Programme is one of several programmes in Volkswagen’s global health care policy, which is implemented by internal and external providers (1,900 in total). Coverage is extended to employees, their dependents, extended family members as well as retired personnel. Approximately 80,000 people are covered by the Programme.

The Programme is centralized at headquarters with specialized technical personnel. Specifically, programme activities are coordinated by a medical coordinator specializing in collective and occupational health, a medical specialist in infectious diseases and occupational health, and administrative professionals with experience in marketing and education. The medical professionals come from the public sector who work on health care policies, particularly in occupational health and STD/AIDS programmes. Consequently, company activities comply with the STD/AIDS prevention and treatment recommendations of Brazilian Government programmes.

A central feature of the AIDS Care Programme is its technical protocol which standardizes care services within the Programme, while at the same time allowing for a degree of flexibility to address individual needs. The care and support elements of the Programme include:

- Access to ARV drug treatment and clinical tests, such as viral load measurement.
- Access to medical personnel specialized in infectious diseases.
- Hospital Reference.
- Nutritionists.
- Psychosocial Support (e.g., social workers, psychologists).
- Home Care Treatment.
- Reintegration into the workplace and society.

Prevention measures figure prominently in the Company’s workplace strategy, including the promotion of condom use and their distribution through workplace vending machines.


In this case example, it is important to note that the Brazilian Government has taken a strong policy stance with respect to HIV/AIDS. Its prevention initiatives are complemented with an extensive treatment and care programme that has guaranteed free and universal access to ARV treatment to all people living with HIV/AIDS since 1996. The Ministry of Labour and the Ministry of Health also signed a decree in 1998 requiring all companies in Brazil to implement HIV/AIDS prevention programmes in the workplace. While government commitment and the development of national frameworks to address the disease facilitate efforts by the private and non-profit sectors to undertake workplace initiatives, there is still a significant challenge in convincing businesses in Brazil to undertake action. Even with the support of Government, Volkswagen do Brasil appears to be a notable exception in its approach.
to HIV/AIDS in the business community. Research by Family Health International has found that the private sector in Brazil does not consider HIV/AIDS to be a priority public health concern and does not see the epidemic as a threat to business operations. Only a few companies have implemented comprehensive HIV/AIDS prevention programmes and are providing treatment for STDs, and a very few provide access to condoms.

Heineken International in Africa

Like other companies in Africa, Heineken operations have been affected by HIV/AIDS. The Company has been implementing an HIV prevention programme in its African operations over the last 10 years in an attempt to address the impact of the pandemic. In 2001, Heineken decided to allow Highly Active Antiretroviral Treatment (HAART) to be part of its existing Health Support Programme for employees. The significant reduction in the prices of ARV drugs and the possibility for the private sector to have access to the drugs at those prices enabled the Company to provide ARV treatment to its employees. Its decision was also based on an in-depth risk assessment which evaluated the impact of providing HAART versus withholding its provision. The risk analysis allowed Heineken to fully formulate a response to HIV/AIDS and to understand the broader policy implications of its approach to health care. The ARV programme is being piloted in five countries (Rwanda, Burundi, The Republic of Congo, Nigeria and Ghana) before being phased in throughout company operations. The 2001 decision and follow-up action signaled a move by the Company into the area of treatment and care.

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21 The risk assessment was undertaken in 3 production locations (Ghana, Burundi and Thailand) by the Futures Group using its AIDS Impact Model.
Heineken International in Africa: Expanding into Care and Treatment

Heineken is the world’s most international brewing group. It runs important operations in Africa where it has 20 breweries in 9 countries, employing some 7,000 people.

The Company’s HIV/AIDS policy is founded on the principles of non-discrimination and confidentiality. Accordingly, employees with HIV/AIDS will be treated in the same manner as employees suffering from any other chronic illness. Specifically, HIV status will not affect job security, terms of employment, or social protection. Key elements of the expanded Health Support Programme for HIV and AIDS patients include:

- Voluntary Counselling and Testing (VCT) available at sites where ARV treatment is becoming available provided by internal and external personnel with the support of trade unions. Counselling is made culturally appropriate by local provision and training.
- ARV Therapy (medication, required tests, and where necessary additional medical care). Adherence to treatment is promoted by interspersing periods of directly observed treatment with times when employees and family members take medication outside of the clinics (e.g., weekends, holidays, etc.). Two regimes of ARV combinations are used to allow substitution between treatments should one fail.
- Mother-to-child transmission prevention which entails short courses of ARVs. Treatment is available in the medical clinics of six of the Company’s central African breweries where antenatal HIV testing is carried out with informed consent.
- Opportunistic Infection Management, including general opportunistic infections (OI), and Tuberculosis (TB). The treatment of OIs is part of the existing Health Support Program for HIV and AIDS which provides support to HIV+ employees and their families through counselling and care.
- Treatment and management of sexually transmitted diseases (STDs) through workplace medical clinics. Rapid detection and treatment of STDs has been available since 1996.
- Post-exposure prophylaxis policy has been available since 1996.
- General protection and preventative measures such as safe blood supplies and occupational health and safety measures.
- Reasonable accommodation (transfer to less demanding position or work environment).
- Access to social benefits and protection.
- Condoms available free of charge or at low, subsidized prices since 1996.
- Community outreach by allowing local communities to benefit from the spin-off of preventative activities organized for employees.

Heineken will only offer ARV therapy if a controlled supply of medication is reasonably guaranteed over an extended period of time without interruption. If the Company cannot guarantee quality treatment in a particular location or with respect to a special group (e.g., children), it will not offer the therapy. The Company is collaborating with PharmAccess International, a foundation that organizes ARV treatment in Africa, including drug acquisition and advice on treatment. Company doctors have received training in the Netherlands, while the training of nurses and laboratory technicians has been undertaken in the region. Treatment is managed by Heineken’s workplace medical clinics. The Company receives support from the German Agency for Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit, GTZ) for its prevention programmes and onsite assistance.

ARV therapy is offered as part of existing local medical programmes unless a worker is eligible under a comparable external programme. Entry to its Health Support Programme is available to employees, one partner and children up to the age of 18 (the Company is currently considering how to ensure continuing access to treatment for chronic conditions once employees’ children cease to qualify for company benefits). Qualification for ARV therapy is solely based on medical grounds. Once qualification criteria is met, the therapy will continue even after redundancy due to company reorganization, unless the individual fails to adhere to the stated terms for therapy or is eligible for a comparable external programme. Local management will endeavour to promote access to alternative external programmes when an employee no longer qualifies for ARV therapy under the existing entry/exclusion rules of Heineken’s medical policy (Heineken International Medical Services (HIMS)).

Those persons receiving ARV treatment are expected to make a reasonable personal financial contribution. The level of the contribution is determined by local management and should be reasonable in relation to disposable income. The objective of the contribution is mainly to promote adherence with the requirements of the therapy.

The costs associated with the development of programmes, materials, training of staff, etc. are in principle charged to HIMS. The local administration of these programmes, including the cost of any medication, will in principle be the responsibility of the local organization, unless otherwise decided.

Current average health care costs in Heineken breweries in Africa is US$ 400 per employee per year (US$ 70 per beneficiary per year). The estimated immediate cost to include HAART is US$ 110 extra per employee which...
might grow to US$ 220 if all HIV+ employees receive treatment. In total, the Company estimates that the maximum recurrent cost is US$ 1,600 per employee, including drug costs, cost of monitoring, and costs associated with building up infrastructure, training of staff and other overhead costs. With an estimated 1000 employees infected with HIV, it means a total estimated cost of US$ 1,600,000. However, the Company estimates that in reality less than 50% of known HIV+ employees need immediate ARV therapy.

The organization and management of health care in the Company is decentralized. A committee will be established in every operating company where this is relevant to advise on the organization of the prevention programme, the Health Support Programme, ARV therapy, and associated issues. Similarly, local management is responsible for implementing the Company’s HIV/AIDS policy. Local management is also encouraged to share its experience and infrastructure with its local business community and other enterprises, and form partnerships, where possible, in order to pursue effective policy with respect to HIV/AIDS.


In undertaking its HIV/AIDS policy, Heineken has relied on a number of partnerships between itself and the private sector, governments, NGOs, universities, and international bodies such as the ILO, UNAIDS and the WHO. It has entered into specific partnerships with PharmAccess International, the World Economic Forum-Global Health Initiative, the Global Business Council, the Business Exchange on AIDS and Development (BEAD) group, as well as research institutes in order to develop its care and treatment programme.

A preliminary review of its efforts to expand treatment and care has identified some important challenges. Social dilemmas with respect to the provision of ARV treatment include the trade-off between adherence and ensuring confidentiality, continuity problems with respect to treatment, and problems arising from restructuring, and the advantages to employees of remaining employed instead of undertaking treatment. The Company has also identified a number of technical issues including the complicated and high-tech nature of ARV treatment and monitoring, inexperience with small children, and frustration over changes in best treatment practices. External challenges identified by the Company include the reluctance shown by other companies to follow suit, conservatism in the medical sector, difficulties collaborating with government (e.g., difficulties to import drugs, stock shortages), and the outside impression that the Company policy may paint of unlimited financial resources.
Work is essential to all societies. It is a means of sustaining life and a vehicle for personal fulfillment, social integration and human dignity. Those excluded from work are excluded from vital social relationships and denied a decent livelihood. In developing countries, the loss of work and income as a result of HIV/AIDS has a particularly severe economic and social impact on impoverished households, where the salary of a worker often supports a large extended family. The inordinate burden of caring for family members with AIDS also erodes household resources as caregivers forego work or other income generating activities or school, and as spending on healthcare and the burden of funeral costs increase. As a result, for already poor households, HIV/AIDS is likely to be the tipping point from poverty into destitution.

In light of the above, a significant contribution by workplace care and support programmes is to include strategies that promote alternative employment or income generating activities for workers with HIV/AIDS and their families, as recommended by the ILO Code of Practice. The Placer Dome Western Areas Joint Venture workplace programme for the South Deep Gold Mine in South Africa provides an illustration of a company’s ‘care process’ where the promotion of alternative employment and income generating opportunities is becoming a central component of its response to the HIV/AIDS pandemic. The Company also undertakes a home-based care project, which also facilitates income generating activities, to aid families caring for ill workers. Together, the two programmes are extending the Company’s approach to HIV/AIDS beyond treatment and towards more comprehensive care and support.

The Placer Dome Western Areas Joint Venture is a 50/50 enterprise between the Placer Dome Inc. of Canada and Western Areas Ltd. to operate the South Deep Gold Mine in South Africa which was initiated in April 1999. As of 2001, the Mine employed over 4,700 people and 1,700 contactors, generating US$ 94 million in revenues. Placer Dome is one of five leading resource companies forming the World Alliance for Community Health, a non-profit organization which works to facilitate improvements in community health in cooperation with the World Health Organization. As part of its corporate strategy, it has a sustainable development
programme stressing 4 strategic principles of sustainability leadership; community health; collaboration with stakeholders, NGOs and community (around mine sites and in labour sending areas); and, strong internal and external communication. Efforts to mitigate the social and economic devastation of HIV/AIDS are integral to programmes aimed at communities.

The joint venture resulted in the retrenchment of 2,560 workers (30%) between July and October 1999, impacting not only the retrenched and their families but also affecting the communities of the large labour sending area.\textsuperscript{22} The retrenchment was challenged by the main union, the National Union of Mineworkers (NUM). The industry standard retrenchment package of two weeks salary for every year of service plus a 3 month training period was also considered as inadequate by management. As a result, the Company developed The Care Project to provide a more effective programme of support for retrenched employees and their families, and set the target of assisting 70% of the retrenched workers and their families to become economically active within two years. In order to engage in a cost-sharing agreement with the Canadian International Development Agency (CIDA)\textsuperscript{23}, South Deep agreed to develop an HIV/AIDS programme and to utilize The Care Project model as a basis for developing an AIDS impact mitigation program.

The Care Project represented the first time a retrenchment programme has attempted to operate at the community level beyond the employer’s locale. For South Deep, it was a daunting challenge as it meant that it had to develop the capacity to provide socio-economic support and assistance to retrenched workers and their families who lived in villages scattered throughout 5 countries in southeastern Africa. The project also represented the first time that women had ever been able to directly access retrenchment benefits. A unique feature of the Project is that it allows retrenched workers, who are unable to participate in the programme (due to age, HIV/AIDS, etc.), to nominate a ‘proxy’ from their immediate or extended family as the lead person to receive training and assistance which will enable them to become

\textsuperscript{22} At the time, industry-wide retrenchment affected over 100,000 workers in the South African mining sector. The industry-wide retrenchment removed over 50 million Rand per month from local economies, with remote rural communities being most severely affected.

\textsuperscript{23} CIDA contributed 10 million Rand to the Project. As part of this agreement, CIDA also requested that the project be expanded to also focus on strengthening the capacity of partner organizations.
economically active and to replace the income that mine employment had provided. The Care Project also provides participants with appropriate allowances to cover expenses associated with participating in the initial counselling sessions and in other activities, since failure to compensate for expenses makes it difficult for retrenches to stop subsistence activities and participate in Care Project activities.

To overcome the considerable operational and logistical challenges of delivering the Project in the vast region where the retrenchees live, key partnerships have been developed with The Employment Bureau of Africa (TEBA) and The Mineworker’s Development Agency (MDA). TEBA provides logistical support to the fieldworkers and project manager through their infrastructure of offices and networks throughout the region. The TEBA Bank also plays a key role in facilitating microfinance. The MDA assists in providing training and support to retrenchees or proxies as they identify and develop new economic opportunities. The partnerships were also developed to help these organizations to improve their own capacity in undertaking development programmes.

The Mine has recruited and trained around 25 retrenchees to be fieldworkers who are based throughout the region and work directly with retrenchees and their families. They are primarily responsible for registering and counselling participants. A Care Project Coordinator is responsible for the day-to-day operations. As the Project progressed, 6 Regional Facilitators (each responsible for a region in the 5-country area) were identified. Each have from 2 to 7 fieldworkers reporting to them. The Manager for Sustainable Development oversees the strategic direction of the Project, and a Steering Committee made up of project partners TEBA and MDA as well as senior Care personnel facilitate coordination among the various stakeholders. The Project is characterized by its tripartite partnership, ranging from national and local governments, union support (MDA), NGOs (TEBA), and support from international institutions such as the World Bank.
The Project faced a number of challenges in the beginning, including the problems posed by HIV/AIDS and related illnesses which made it more difficult to assist retrenchees and their families become economically active\textsuperscript{24}. In response, the Mine collaborated with project partner TEBA to develop a home-based care programme for affected mineworkers and their families. These challenges have meant that the Company has not been able to meet its 70% economically active goal within the two year time frame. However, by evolving its approach, the goal appears to be in reach. As of December 2002, 92% of retrenched mineworkers have been located and registered; 57% (1,250) of those registered are economically active; and, 65% (1,566) of retrenches and their families have been given unique financial life skills training, benefiting many women. Its care process is becoming an industry standard in South Africa and its home-based care project was recognized by the World Bank.

In combination with South Deep’s HIV/AIDS Policy which was developed and signed by both labour unions in both 2000 and 2002, its ‘care process’ and its home-based care project represent a comprehensive and holistic workplace approach to addressing the impact of HIV/AIDS, and sets the company apart from others.

\textsuperscript{24} Other challenges included: union opposition; industry skepticism, partnerships took time to develop; remoteness and isolation of villages meant finding and registering retrenches was much more difficult than expected; working across national borders; development of fieldworker training programs needed which meant a considerable investment in time and money; access to microfinance at realistic rates proved to be extremely difficult; managing the implementation of a new process in such a vast area; currency fluctuations; lower than expected education levels of retrenchees and families meant that additional programs and support was needed; the need for counselling (e.g., in some instances the retrenched had not told his wife that he had been retrenched); the entire program had to be provided much closer to people’s home than management had originally expected.
South Deep is developing a Transition with Dignity Program which is founded on The Care Project and the Home-Based Care Programme with TEBA. The Programme’s aim is to enable employees to transition out of the workforce with dignity by mitigating the social and economic impacts of transition. The Company has identified a workforce transition path comprised of 4 groups of workers:

1. Healthy Productive
2. Less Healthy (Initial HIV, etc.)
3. Unhealthy (Beginning AIDS)
4. Medically Incapacitated

The focus of the Transition with Dignity Programme is to keep workers in Group 1, and for those that do become HIV+, to slow the move to Group 4 and to improve the quality of life for them and their families as the disease progresses. The critical objectives of the Programme are to prevent HIV infections through education and other programmes; to identify alternative work for HIV+ workers in recognition that the length and quality of life of workers substantially increases when they can be moved from the physically demanding mining environment to other work with similar earning potential; and, dignified withdrawal from the workforce as HIV turns into AIDS. The following is made possible through the Company’s HIV/AIDS treatment and care provisions, its care process for alternative income generation, and its home-based care activities.

**HIV/AIDS Treatment and Care Provisions**

South Deep’s HIV/AIDS Policy is based on non-discrimination and confidentiality. It provides treatment and care both at the workplace and in the communities where workers relocate after ill-health retirement. All employees have access to mine health facilities and HIV/AIDS treatment. Dependents are eligible for HIV/AIDS treatment if the employee contributes on behalf of his/her dependents to the company medical scheme. There is currently no explicit HIV/AIDS policy for contractors. Key elements include:

- Informed Consent Voluntary Counselling and Testing (ICVCT) services free of charge, which was launched with union support in August 2002.
- Syndromic treatment of STIs available free of charge to employees through the company clinic.
- Wellness Programmes that deal with chronic diseases. Services include health and lifestyle education; nutritional and vitamin supplements; treatment of opportunistic diseases such as TB. Access to wellness services were secured in August 2002.
- Prevention activities, including the distribution of male and female condoms provided free by the state health department and distributed through workplace dispensers and peer educators.
- Safeguarding of employee benefits and social security coverage.
- Encouraging the development of support groups for employees living with HIV and AIDS.

Future plans by the Company include the provision of ARVs to prevent mother-to-child transmission. South Deep’s HIV/AIDS Programme is implemented and monitored by an HIV/AIDS committee. The group is made up of representatives from health, sustainable development, labour and the project coordinator, which meet on a monthly basis. The budget for the 2002 HIV/AIDS Programme was set at US$ 240,000 which corresponds to US$ 51 per employee per year. Budget allocation was as follows: home-based care (48%), prevention (29%), community outreach (16%), administration, assessment and monitoring (7%).

**Care Process for Alternative Income Generation**

The Care Project, developed initially for retrenched workers, will be extended to include those workers who are medically repatriated due to illness, such as HIV/AIDS, or unable to work due to injury. It will be called the ‘care process’. Its primary elements are to (1) counsel retrenchees and ill health workers and/or their proxies on project benefits, skills training options, local economic and enterprise development opportunities, and after-care counselling and coaching. This task is undertaken by field workers who meet one-on-one with workers and their families; (2) provide skills and entrepreneurial training; (3) strengthen institutional capacity of training and service providers (TEBA and MDA); (4) develop microfinance and micro enterprise through the creation of a facility to provide start-up capital and working capital loans and other financial assistance to micro enterprises; and, (5) support families and communities affected by HIV/AIDS by providing counselling, assistance and other support services.

The ‘Care Process’ is comprised of multiple steps leading to alternative economic activity for retrenched and ill health workers and/or their families. Alternative employment options can be either in the informal economy (e.g., chicken farming) or in the formal economy (e.g., skilled trade required for mining).
Currently, Placer Dome Western Areas Joint Venture owns thousands of hectares of potentially productive farmlands. The Company believes that if the agricultural potential of these lands could be developed, they could provide the foundation from which suitable work could be developed for HIV+ mineworkers and their families. These lands could provide agricultural products for South Deep and other local markets.

**Home-Based Care**

In the planning stages of The Care Project, the project designers recognized the critical importance of addressing the HIV/AIDS epidemic. In many instances, retrenchees and other key stakeholders in the project had AIDS or other related illnesses which made it significantly more challenging to assist retrenched mineworkers and their families to become economically active. As a result, South Deep entered into a partnership with TEBA to develop a home-based care programme which would enable mineworkers to return home to a functioning care system. A
fee for service model was developed which would facilitate broad buy-in support from the mining industry. With support from the World Bank Mining Group a proposal was submitted to the AIDS Campaign Team (ACT) Mining, which gave rise to the ACT Mining Home Based Care Project that was piloted as a cost effective, fee for service programme to support medically repatriated mineworkers and their families. Currently, 8 mining companies, including South Deep, have entered into a service level agreement with TEBA for the provision of home-based care (there are plans to develop a strategy to roll out the Programme to other industries and public sector stakeholders). The agreement provides for TEBA to manage the home-based care programme, paid for by each mining company, based on a marginal fee per month for each miner employed from the region where the home-based care programme is based. The service provides palliative care for the dying with links to primary care, and provides monthly medical kits. It also offers assistance for families in bereavement to access welfare support for both the incapacitated terminally ill person and the orphans that are left behind. Efforts are also made to integrate the Programme with other community development activities, such as care of children, counselling for families, income generating activities, and nutritional programmes including food gardens. TEBA also seeks to extend the Programme’s services to other ill community members. At the same time, South Deep also works with municipal authorities to ensure that ill-health retirees and their families have reasonable access to required services such as water, sanitation, clinics and hospitals.


The Company’s vision for the future is to develop a ‘Care Positive’ initiative with a targeted focus to mitigate the social and economic impact of HIV/AIDS on rural communities. Care Positive would integrate the Home Based Care Project with the Care Process, which would be launched as a fee for service based programme in order to ensure its financial sustainability. While the service would start with the mining industry, the infrastructure and management systems would be designed to enable participation by other industries, governments and donor community stakeholders. Placer Dome believes that ‘Care Positive’ represents a cost-effective and scalable programme and is willing to lead and co-finance the project. However, the proposed project is beyond the scope of a single mining company, and therefore, the Company is looking for assistance to develop the appropriate financial and technical cooperation.
DaimlerChrysler South Africa (DCSA)

In December 2000, DaimlerChrysler South Africa (DCSA) entered into a comprehensive public-private partnership with the German Agency for Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit, GTZ) to develop a project which would improve the Company’s management of HIV/AIDS. A formal HIV/AIDS programme had been in place in DCSA since 1991. However, rising infection rates and employee deaths attributable to the disease, and the associated increasing financial burden on the Company, prompted DCSA to undertake a thorough review of its HIV/AIDS policy and programmes and to overhaul its strategy in order to ensure a more effective systematic response to the epidemic’s impact on company operations. A three year project (2001 to 2003) was developed by DCSA and GTZ with three specific objectives:

- To increase the effectiveness of DCSA Health Services related to HIV/AIDS prevention and care.
- To ensure adequate and cost-effective benefit schemes to meet employees’ needs in the HIV prevalent environment, while minimizing the cost of HIV/AIDS impact on DCSA business operations.
- To increase and improve information, education and communication about HIV/AIDS and new services offered by DCSA among employees in order to decrease stigma and encourage preventative and care-seeking behaviours.

Joining in a public-private partnership with GTZ provided DCSA with project management, technical expertise and financial support from a partner with a proven record of operating successful development projects. The project was also launched in partnership with the trade union. The union was involved in both the design and operation of the project which provided it with the mandate and necessary input to engage the workforce. The president of National Union of Metalworkers of South Africa and the chairman of DCSA are co-sponsors of the project. NGOs specialized in HIV/AIDS programs were also involved in the Project’s development.
The project was implemented in parallel with conducting in-depth assessments\textsuperscript{25} of the company situation and the impact of the epidemic. This enabled the project to meet its objectives more rapidly than if implementation would have followed the assessments. The studies demonstrated key challenges faced by the Company. In particular they revealed that the majority of employees did not have sufficient and appropriate knowledge of the disease. For example, 20\% of employees in one plant believed that HIV/AIDS can be cured by traditional medicines; 18\% in the same plant believed that the disease can be cured by having sex with a virgin; 49\% have never used a condom; and, 84\% noted that the fear of rejection prevented people from discussing HIV/AIDS. Moreover, the assessments also showed that employees did not have adequate knowledge about the treatment opportunities offered by the Corporate Health Plan (funded by DaimlerChrysler Medical Fund (DCMed) and managed through Aid for AIDS (AFA), a disease management programme).

To address these and other challenges, the project has set significant targets, which also serve as project-specific process and outcome indicators that will determine the project’s effectiveness. In keeping with the project’s three objectives, the targets are as follows:

**Improved DCSA Health Services**: (1) 40\% of employees to obtain VCT within 3 years, including 80\% of all patients seeking treatment for STIs or TB; (2) increase TB cure rate in all locations to 80\% within 2 years; (3) reduce the number of new and recurrent STI treatments by 50\%.

**Human Resources and Planning (Adequate and Cost-effective Employee Benefits)**: (1) ensure insured benefit increases are equivalent in quality but keep costs in the bottom quartile in the industry; (2) ensure appropriate restructuring of payment methods of death benefit allocations; (3) maintain medical aid premium increases below 20\% per year; (4) maintain operational productivity at 2000 levels for the next 3 years.

\textsuperscript{25} In May 2001, the University of South Africa conducted a Knowledge, Attitudes Perception/Behaviour (KAPB) assessment. In October 2001, DCSA conducted a semi-linked (to job bands) cross-sectional anonymous seroprevalence survey in all three of its locations with the Medical Research Council. In April 2002, in conjunction with the University of Natal in Durban, Boston University and the WHO, DSCA conducted an economic impact analysis on HIV/AIDS.
Education and Awareness: (1) ensure that 90% of employees have access to HIV/AIDS information, 40% have access to intranet resources, and 40% will utilize national Health Department hotline within 3 years; (2) reach 80% of employees with peer education and enroll 50% of HIV+ in the Aid for AIDS (AFA) disease management programme within 3 years; (3) improve knowledge, attitudes, behaviour and perceptions across high need areas by 50% within 5 years.

The total cost of the project, excluding treatment, was estimated at US$ 600,000, with DCSA financing 80% and GTZ 20%. The Company exceeded its budget significantly in 2002, and will likely do so in 2003. Higher than anticipated expenses for project related scientific research, the information and education campaign, and costs for advocacy and external communication, led to some of the additional spending.

DaimlerChrysler South Africa: Treatment, Care and Support through a Public-Private Partnership

DaimlerChrysler is one of the world’s largest automotive, transportation and services companies. It has manufacturing operations in 37 countries and distribution operations in over 200 countries. Its operations in South Africa include 3 plants which manufacture, market, import and export motor vehicles and automotive parts. In 2001, DCSA employed 4,500 people and had 3,000 suppliers and contractors. The Company also has an indirect impact on some 2,900 other workers who are members of other DaimlerChrysler affiliates or employed as part of the dealer network. Its estimated revenues in 2001 were US$ 1.4 billion, with a net profit of US$ 79 million.

DCSA’s HIV/AIDS workforce policy was first codified in 1996. The policy is updated on an annual basis and is signed and approved by the union and management. The policy is based on the principles of non-discrimination and confidentiality. DSCA has been overhauling its strategy on HIV/AIDS in partnership with GTZ to ensure a more comprehensive and effective approach to treatment, care and support for workers with HIV/AIDS. The HIV/AIDS Project with GTZ is based on the principles of Corporate Social Responsibility (CSR), and is an extension of DaimlerChrysler’s signing of the UN Global Compact on CSR.

With respect to treatment and care, every employee is required to belong to the Corporate Health Plan. The financial backbone of the Company’s plan is its medical fund, DCMed, to which DCSA contributes 50 to 55% towards the cost of the insurance premiums for each participant. All of the health plan’s options provide coverage for HIV treatment, including HAART. Up to US$ 2,000 in coverage is provided for HAART per registered participant per year. The Company has set up a US$ 1.5 million fund to pay for individuals who may exceed this allowance, and will approve such expenditure on a case by case basis. Treatment is managed by Aid for AIDS (AFA), a disease management programme, which was launched by the Company in 1999. DCSA’s health, retirement and other insurances do not discriminate against HIV/AIDS status. Depending on the retirement plan selected, ill-health retirees can gain access to a fraction of regular wages and potentially a lump sum payment after two years. All benefits cover employees and their direct families. Currently, contractors and on-site suppliers are not required to adhere to DCSA’s HIV/AIDS policy, however, any contractor who works on the DCSA’s site has access to DCSA prevention, wellness and on-site treatment projects. They are, however, excluded from accessing the AFA disease management programme.

The DCSA HIV/AIDS programme provides the following treatment, care and support services:

- Sustainable access to ARV medication and treatment since 1996, including HAART.
- ARV Therapy for mother-to-child transmission prevention.
- ARV Therapy provided as prophylaxis for employees with occupational exposure as well as victims of rape.

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26 Due to the growing costs for HIV/AIDS treatment, DCSA envisages increasing its share to 60%.
Voluntary Counselling and Testing, which was launched in 2001. The service is available to employees and dependents free of charge both through company clinics and external providers. Training for the Company’s nurse practitioner counsellors was provided by the national Health Department.

- Treatment for people with TB in line with the Ministry of Health’s National TB Control Policy. In particular, Directly Observed Treatment/Short Course Chemotherapy (DOTS) will be undertaken.

- Adherence to occupational health and safety standards.
- On-site Employee Wellness Services and Employee Assistance Programme.
- Reasonable Accommodation.
- Condom availability and distribution. Free government male condoms are available at workplace health facilities, through peer counselors and company vending machines. Branded male and female condoms are available at reduced rates.
- Access to multilingual ‘info-islands’ or computer touch screen information kiosks, an interactive Wellness Information intranet site, a national employee helpline, and the AFA counselling telephone line.

In 2003, DCSA will begin extending its activities into the community. Its Community Strategy will help train 80 General Practitioners on clinical guidelines for HIV/AIDS and related illnesses as well as help develop training manuals in partnership with the South African HIV Clinicians Society. DCSA will also enter into a partnership to develop training standards for home-based care in order to train 80 home-based care volunteers in four communities. The Company will also partner with provincial departments of education to train HIV/AIDS peer educators at primary and secondary schools at all DCSA sites.

An HIV/ Project an with repr and the GTZ. As the Project’s focus evolves towards community outreach and advocacy, the steering structures are likely to become more encompassing to include external constituents. It is felt that the Project’s tripartite planning process could serve as a prototype for the development of HIV/AIDS workplace policies and programmes for other industries. Furthermore, DCSA and GTZ are contractually obligated to regularly review the Project’s performance. Upon its completion, DCSA will conduct an HIV seroprevalence survey and a KAPB assessment. DCSA is also undertaking efforts to ensure that it can continue to achieve the Project’s objectives once the agreement with GTZ ends.

The partnership between DCSA and GTZ has received significant public and media attention, and GTZ has replicated the partnership with the support of DCSA with three other multinational corporations active in South Africa, including Volkswagen. In general, DCSA’s partnership approach with key stakeholders (governments, NGOs, unions, community based organizations, etc.) has been the cornerstone for the HIV/AIDS Project’s success.


While DCSA has made substantial inroads in increasing uptake of care and support services by its employees, much work remains to be done. Employees willingness to get involved in the HIV/AIDS Project has increased over time, but participation remains a difficult issue as stigma and discrimination are deeply entrenched in South African society. Although DCSA has succeeded in having 40% of its employees submit to VCT since its launch in 2001, the remaining intensity of social stigma and discrimination is shown by the fact that by October 2002 not a single employee has publicly admitted to be HIV+, in spite of an estimated number of
400 HIV+ employees and 137 employees being officially enrolled in the Aid for AIDS treatment programme. The unsupportive societal environment is also likely to be behind the low family uptake of treatment and care services, with only 30 family members being enrolled in the AFA programme. The low number suggests that spouses employed by DCSA and enrolled in AFA do not make the same treatment and care available to their supposedly HIV+ partners and their children. In response, the Company plans to engage ‘Health Visitors’ or nurse practitioners who will visit dependents at employees’ homes to offer health promotion services, preventative health care, information about employee benefits, VCT, and registration with AFA. At the same time, the union is encouraging DCSA to involve families and communities more systematically because it argues that within the Company there remains little more that can be done to change perceptions and behaviour, and an emerging fatigue with respect to the issue is occurring. It asserts that employees’ attitudes and behaviours will only evolve, if the changes are supported by their families and communities. DCSA’s Community Strategy hopes to address these concerns.

The relevance of stigma on the effectiveness of workplace programmes has also been recently demonstrated in interim results of an intervention study by the Horizons Program (Population Council) in collaboration with South Africa’s giant Eskom power company. The study suggests that HIV/AIDS-related stigma has a significant impact on the workplace environment and on the utilization of workplace HIV/AIDS programmes. Key findings include that Eskom workers fear stigma more than discrimination in the workplace. While Eskom’s non-discriminatory HIV/AIDS policies may help workers feel secure in their jobs, fear of social isolation and ridicule from colleagues and community members discourages them not only from disclosing their HIV status but also from making full use of all the services available to them, particularly VCT. The findings are crystallized by the following statement by a peer counsellor in the Company: “It’s the stigma attached to HIV infection that causes the denial that leads so many to refuse to deal with HIV – because admitting you’re infected means that you’ve already died, socially.” The study has also found that

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women fear stigma more than men, since women are more likely to be blamed for HIV infection. Researchers have also found that stigma by association affects many groups. For example, HIV/AIDS programme staff indicated that they experience stigma because they offer AIDS-related services. A final round of data collection for the study is planned for 2004. After the data has been analyzed, Eskom plans to use the findings to strengthen its HIV/AIDS activities.28

The experience from both companies with respect to the impact on stigma on workplace practices suggests that appropriate measures for stigma and stigma-reduction strategies need to be considered when developing care, support and treatment interventions if workplace programmes are to be fully utilized and cost-effective. This undertaking is not only a question of identifying measures that will reduce stigma in order to increase the uptake of workplace programmes, but, it is also a matter of identifying workplace care, support and treatment interventions which will reduce stigma and discrimination.

**Action by Small- and Medium- Siz**

Most of the focus and information regarding workplace responses to HIV/AIDS has tended to be on large national and multinational corporations. As the examples above illustrate, these large companies are making an important contribution to the fight against HIV/AIDS, and are highlighting the potential that the workplace represents. Nevertheless, in light of the fact that in much of the world, particularly in developing countries, small and medium-sized enterprises (SMEs) make up the majority of business operations and sources of work, it is of crucial importance that more attention is given to strengthening their capacity to respond to the epidemic. At the same time, most SMEs are found in the informal economy which makes it critical to reach out to this segment of society as well. In a continent like Africa, where only 5% of the workers are employed in the formal sector, the

importance of reaching SMEs and the informal economy cannot be emphasized enough.²⁹

The same business and wider social reasons for responding to HIV/AIDS identified in this paper, apply in the same way to SMEs. In many respects, they become even more important in situations where SMEs have very few workers, and the loss of one person can be catastrophic in comparison to large corporations. While SMEs are lacking the resources and the institutional capacity to undertake comprehensive programmes, they can often demonstrate significant creativity and innovation through small scale and less costly endeavours that can be more easily adapted and replicated. Given that SMEs are the typical place of work for most of the world’s people, it represents a very important entry point for fostering a more accepting and compassionate society conducive to fighting the disease. Small scale and even symbolic action on the part of SMEs will go a long way to removing fear and stigma, thereby enabling communities to mobilize against the epidemic. In this regard, SMEs can play an important role in awareness-raising and prevention efforts, such as providing in-kind support for designing and printing education materials and promoting condom use. They can also extend their support in the area of care by ensuring that workers are well-informed of health care options available in their communities. Partnerships with larger enterprises, NGOs, governmental organizations and business associations, are also a key way that SMEs are able to generate the capacity to respond.

²⁹ 5% estimate provided at the Global Policy Dialogue on HIV/AIDS, hosted by the ILO in Geneva, Switzerland, 12-13 May 2003.
RRR Industries: A Small Company’s Response

RRR Industries is a manufacturing technology group, providing IT services to SMEs and the informal sector. It is located in Mumbai, India and employs 15 people. Its response to HIV/AIDS began in 1996. Today, its activities extend beyond its employees to the wider community.

The Company has developed a partnership with Rotary International (RI), through the HIV/AIDS Task Force for Rotary International District (RID) 3140. The RID 3140 was founded in 1996 by the Company’s CEO, who has been an advocate of social issues and a member of Rotary International for many years. The Taskforce was formed in support of the 1996 Rotary International and UNAIDS statement on AIDS “Working with New Generations for a Safer World”. It is part of the Rotary-UNAIDS Cooperation Programme on HIV/AIDS, RID 3140. RRR Industries functions as an operational secretariat for the Programme’s HIV/AIDS awareness and prevention initiative.

The Company’s HIV/AIDS policy specifies action in the area of care and support. Of notable mention is that it extends its workplace programmes to its customers. Policy provisions in care and support include:

- To foster a culture of caring towards individuals infected with HIV and AIDS.
- To provide possible pre and post counseling services to employees and their family members and customers seeking help on issues related to HIV/AIDS.
- To direct all employees, their families and customers to appropriate Health Care Center and follow “universal precautions” to prevent spread of the disease.

The Company has symbolically placed the Red Ribbon symbol of HIV/AIDS on all its office stationary and electronic materials. It introduced a health care package for its employees and their families between 1988-1990. Since 1996, it has undertaken regular in-house awareness programmes on HIV/AIDS for its employees and their families. These programmes are extended to its customers, suppliers, and other organizations providing services to the company such as, municipal offices, electricity companies, banks, etc. As part of its workplace awareness initiatives, it has trained its employees as Trainers of Frequently Asked Questions (FAQs) on HIV/AIDS which provide HIV/AIDS education to their families as well as to customers. The trainers are also available to provide project support at the community level.

In partnership with RI, the Company has also been part of a public health drive targeted towards transport workers and industrial workers from the informal sector, which included a one day event to install a condom vending machine in one of the largest industrial areas in the city. In spite of initial resistance, response has been positive. Based on the public support generated, RRR Industries is joining again with RI to install 200 more condom vending machines at various target locations in Mumbai, such as public toilets, railway stations, public markets, and educational institutions. With the support of the Rotary network, the Family Planning Association of India (FPAI) and the private sector, there are plans to install 1,000 condom dispensers in other metro areas in India during the Rotary year 2002-2003. RRR Industries will jointly coordinate a support package for each purchase of the machine, including printing of logos, stickers, FAQs in English and Hindi, and supplies of condoms at subsidized government rates. By undertaking this initiative, RRR Industries and Rotary International hope to achieve the triple goal of population control, healthy and happy family life, and prevention of HIV/AIDS.

As an innovative part of the initiative, the installation of condom vending machines has also been turned into an income generating scheme for the ‘care takers’ of the machines. Condom vending machine care takers receive 30% from the sale of condoms for upkeep of the dispensers, thereby making them partners of a social service. The remaining share goes to FPAI to procure the condoms. RRR Industries is also developing partnerships with PLWHA groups to develop other possible employment opportunities and business credit programmes for individuals living with HIV/AIDS.


Small- and medium-sized enterprises are increasingly becoming more important to the supply chains and operations of large corporations. The changes in global systems of trade and production towards specialization, contracting and subcontracting have made large corporations more dependent on an effective network of supplier and service enterprises, the majority of which are SMEs. In recognition of
the importance of their supplier network to business operations and profitability, some larger corporations have extended their workplace HIV/AIDS programmes to their suppliers and contractors. As noted above, DaimlerChrysler South Africa extends access to its prevention, wellness and on-site treatment projects to its suppliers and contractors. In the Spring 2003, The Coca-Cola Company announced that all 40 Coca-Cola Bottlers in Africa, employing some 60,000 people in 54 countries have enrolled in the Coca-Cola Africa Foundation healthcare initiative to extend healthcare benefits to its independent bottlers. The programme enables Africa’s Coca-Cola bottlers to offer comprehensive HIV/AIDS awareness, prevention and treatment, including ARV Therapy, to all of their employees, their spouses and children. The Foundation will provide up to 50% of the cost of HIV/AIDS healthcare coverage, while the bottlers and employees will contribute 40% and 10%, respectively. Implementation is decentralized, with each bottling company being responsible for rolling out the programme at the local level. At the same time, some organizations have gone beyond their own employees, requiring contractors doing work for the enterprise to have active HIV/AIDS workplace programmes. In July 2003, the UN Office in Kenya announced that it will require contractors to provide an eight-point health and welfare package, including the provision of ARV medication, to all staff members who work at least half the week at the UN campus in Kenya. The programme represents the first of its kind for the United Nations in a developing country. In other instances, business coalitions or associations, comprised of large and small enterprises, have used its collective strength to help SMEs provide care and treatment services. For example, the South Africa Chamber of Business, representing some 40,000 large and small companies, has used its collective influence to help SMEs gain access to ARV drugs at competitive prices.

30 http://www2.coca-cola.com/citizenship/africa_network_partners.html
Responses from Other Key Sectors

No sector is left untouched by HIV/AIDS, and as a result, action is required on all fronts – business, labour, government and the non-profit sector. As the examples in this paper illustrate, trade unions have been an important partner in the development of workplace HIV/AIDS programmes. Some unions have used collective bargaining to address HIV/AIDS workplace issues, while others have developed policies and undertaken independent initiatives to safeguard the rights of their workers. In some instances, these efforts have extended into the area of care and support as the example by the Trade Union Congress of the Philippines illustrates. Trade unions are uniquely placed to fight HIV/AIDS as the workplace represents a significant entry point for action against the epidemic.

Trade Union Congress of the Philippines (TUCP): Workers Providing Care for Workers

The Trade Union Congress of the Philippines (TUCP) has created 7 clinics where its members and their families can visit a doctor free of charge. The clinics contribute to the prevention of sexually transmitted diseases, including HIV. The personnel of the clinics also make regular visits to companies where their members work. They provide basic medical care, distribute condoms, as well as provide advice on health issues to workers and management. They also try to use their company visits to hold seminars on STDs and family planning. TUCP has also developed training programmes for its members so that they can inform their co-workers of the dangers of STDs. It has also set up a telephone hotline that people can call for advice on health-related issues. As part of its policy on HIV/AIDS, it endeavours to establish funds and/or endowments to assist/support workers with HIV/AIDS and STDs.


Fundamentally, responsibility for leading and coordinating a national response to HIV/AIDS rests with governments. At the same time, however, governments are themselves employers. In many countries, it is the largest employer. Moreover, many of its employees are in the frontline of managing the impact of HIV/AIDS, such as health and social workers, local government administrators, and public servants involved in human resource development and training. In this regard, governments and public authorities need to develop strategies to address the impact of the disease on the public sector and its services. At the same time, in its capacity as an employer, public authorities should fulfill their responsibilities to develop workplace HIV/AIDS policies and programmes and serve as model employers.

Kenya Port Authority (KPA): A Public Sector Response

The Kenya Port Authority employs 6,000 people in Mombasa, Kenya. Businesses that serve the port account for thousands of additional workers. On any given day, more than 20,000 people visit the port.

As HIV/AIDS has spread among its workers, the response from KPA has improved. Currently, there are nearly 700 employees with HIV, the majority of whom were diagnosed when they sought medical care at the staff clinic.

The KPA revitalized its HIV/AIDS prevention program with technical assistance from Family Health International in the year 2000, after its initial programme lost its leadership and direction. The cornerstone of the new Programme is its network of 120 peer educators and 6 counsellors, which are drawn from the ranks of shop stewards, union representatives and various levels of administrative and management staff. As part of their responsibilities, the peer educators promote awareness of STI symptoms and the need for prompt care. Since on-site treatment is unavailable, they refer individuals for treatment to appropriate health facilities. Outreach activities are closely linked to intensive condom distribution, also led by the peer educators. The KPA has recognized the value of VCT in preventing HIV/AIDS. Although it does not offer VCT services of its own, trained KPA nurses refer clients to VCT centers in Mombasa. It is also establishing a post-test club.

In spite of these efforts, the KPA has no formal HIV/AIDS policy. Management has recognized this shortfall and is working with the Federation of Kenyan Employers (FKE) to adapt the ILO Code of Practice as part of its HIV/AIDS policy. The KPA is also developing plans to bear the entire cost of its HIV/AIDS workplace programme.

With respect to the timing of HIV/AIDS policies and prevention programmes, there is no specific rule about which should come first. Both are necessary, and will evolve over time as conditions change. In organizations where policies can take a long time to be developed and approved, it is best to move forward with implementation of the prevention programme before the policy is in place. Where prevention programmes already exist, it is not necessary to put them on hold until an HIV/AIDS policy is formulated.

MOVING FORWARD: KEY ISSUES

The workplace HIV/AIDS care and support practices identified in the previous section demonstrate the important contribution being made in the world of work to address the impact of the epidemic. The workplace approaches to the provision of care and support have been affected by organizational size, type, financial and human resources and institutional capacity, as well as by the reality of local conditions and way of life, and national legislative frameworks. In all instances, the workplaces highlighted in this paper have worked within these parameters to develop effective responses to address the care needs of their workers affected by HIV/AIDS. More importantly, they demonstrate their capacity to go beyond the workplace by investing in their communities to strengthen the response against the pandemic.

The lessons learned from these and the many other diverse workplace initiatives undertaken to date are key to helping define future strategies. In order to move forward, we need to learn from the past and to capitalize on its lessons. Given the depth of human tragedy brought on by the disease, there is no time to spare on making the same mistakes and sidestepping key issues. Accordingly, the analysis that follows attempts to highlight key issues and lessons learned from the workplace practices in care and support profiled in this paper. Additional examples are also provided to support some of the key issues raised.

Setting Priorities

The experiences from the large multinational corporations highlighted in this paper demonstrate the importance of quality information for initiating workplace responses and for identifying areas of action. Analyses most commonly undertaken by enterprises include risk assessments of the prevalence and demographics of the disease, the awareness and knowledge among workers about the epidemic, and the economic and financial impact on work operations. These analyses are used to convince management of the need for action, as well as for prioritizing action areas and identifying population groups that may be at particular risk (e.g., women, mobile workers, etc). To ensure the effectiveness of workplace responses, these studies
should not be limited to the starting phases of workplace action, but should continue as part of regular monitoring and evaluation efforts.

Large enterprises are able to benefit from these studies because they provide a much needed assessment of complex work operations and interactions, as well as a representation of a large and diverse workforce, which are not easily measured particularly if activities are undertaken in different geographic locations and/or include a large supply chain. For smaller organizations, the costs of the studies may outweigh the benefits, specifically if it is a very small workforce with one main line of activity. Nevertheless, this does not preclude the need for quality information in order to gain an understanding of the disease and viable options for action. Information provided and made available by other sectors can be solicited such as from national governments, local authorities, NGOs, as well as the private sector.

Access to care, support and treatment is prioritized in the workplace because it is seen as being integral to the prevention of HIV/AIDS and the spread of other opportunistic diseases associated with the epidemic. Its provision encourages people to seek early diagnosis through voluntary counselling and testing since it gives them the reassurance that they (and their families) will be cared for should they test positive for HIV. For similar reasons, it also encourages other care-seeking behaviour crucial to curtailing the transmission of the disease. In the economic interest of the workplace, it is key to undertake action that promotes early intervention in order to avert the significant costs of inaction or waiting too long when only limited and costlier responses are left as options.

Many larger workplaces, like Heineken International, have decided to expand their care and treatment programmes to include ARV treatment following the significant decline in drug prices. The significant reduction in prices for ARV drugs and simplified treatment regimes is making ARV treatment a more viable target for workplaces and other sectoral responses against the epidemic. ARV therapy is a proven treatment that prolongs lives and provides a great degree of hope for societies. This notwithstanding, however, it should not be the sole response in the fight against HIV/AIDS, and there should be caution not to become too complacent in undertaking prevention and other treatment and care measures which are an integral part to a
comprehensive approach against the pandemic. The workplaces profiled in this paper demonstrate the understanding that care and prevention go hand in hand, and they continue to make significant investments in other prevention and care strategies in addition to their decision to provide good quality ARV treatment. They realize that care and support is a comprehensive package of measures that not only involves the care of medical and health needs, but also psychosocial support, social protection and employment considerations.

**Managing Care and Support Strategies**

The workplace initiatives described in this paper brought to light the necessity of an organizational structure or mechanism with the role to undertake the workplace strategy, such as a committee, taskforce or coordinating body and/or person. Crucial to the success of the programme was the support from the highest levels of management and its active involvement (i.e., participation in the organizational structure, as well as serving as champions of the workplace strategy). Another critical element was the multi-stakeholder approach to the workplace strategy which was manifested in the representation of the organizational structure to include management, trade unions, staff (including health and human resource personnel), and in some instances external partners who were providing technical expertise and financial assistance (e.g., GTZ participation in the HIV/AIDS taskforce formed by DaimlerChrysler South Africa). These organizational structures are often supported by a strong network of peer educators.

From a healthcare perspective, the workplace programmes relied on internal and external healthcare providers for the provision of treatment and care. This required the formation of linkages with community health services. In some instances, it led to community outreach initiatives to strengthen the capacity of health services, such as the training of general practitioners in rural communities by Placer Dome Western Areas Joint Venture, South Deep Gold Mine. Indeed, there is a severe shortage of trained medical personnel in many of the high prevalence countries, not only in HIV/AIDS, but throughout the health sector. HIV/AIDS is stretching the health infrastructure of these countries to impossible limits, and therefore, efforts to fill this shortfall and to generate capacity are important investments.
Patient management is critical for effectively treating HIV/AIDS, particularly for ARV therapy where adherence to treatment is critical to its success. The simplified ARV treatment regimes developed by the WHO, has made patient management considerably less complex and less reliant on specialized medical care. These simplified ARV regimes recommended by the WHO are the same as those being used in developed countries and should not be considered as sub-standard care. This is an important development for the workplace because it makes HIV a more manageable disease, and thereby makes it more possible for workplaces to generate the capacity to provide treatment on-site and to have greater control over managing adherence to treatment. The WHO is currently exploring strategies to delegate routine aspects of patient management to other health care workers as well as suitable tasks to community and family members as part of developing a public health approach to HIV/AIDS treatment. Workplaces with a health infrastructure may represent an additional alternative where workplace facilities can be used to expand and manage treatment.

The above notwithstanding, good patient/clinical management is a challenge for many workplaces. A recent report showed that poor clinical management and poor adherence to treatment, is compromising the cost-effectiveness of care and treatment programmes in the workplace. Inappropriate treatment and lack of compliance fails to keep workers healthy and productive. Without support and proper follow-up, workers are falling ill and recovering not once, but several times which represents a double dipping into costs in terms of treatment costs and losses in productivity. The same study also stresses the importance of driving the uptake of HIV/AIDS programmes, particularly voluntary counselling and testing, in order for treatment strategies to be cost-effective. The more people come forward to determine their status, the more workplaces will stand to save. This highlights the fact mentioned earlier in the paper that HIV/AIDS policies and programmes must address


several issues as part of a comprehensive approach in tackling the disease, most notably the mutually supportive relationship between prevention and care.

With respect to the development of workplace programmes, organizations have found that it is important to address cultural sensitivities and to work within the local context. The Home-Based Programme developed in partnership between the South Deep Gold Mine and the Employment Bureau of Africa (TEBA) found that the involvement of local leadership and traditional healers improved the local acceptance of the initiative as well as its community and family impact. By way of another example, Tata Tea Limited of India helps provide training in HIV/AIDS care to ‘bare-foot tribal doctors’ in recognition of the important role that traditional healers play. At the same time, it is critical for the workplace to identify local resources so that appropriate linkages can be formed in order to ensure that persons infected and affected by HIV/AIDS receive the continuum of care that they need.

**Mobilizing Resources**

Organizations have adopted a range of financing mechanisms in order to pay for treatment and care. Those organizations that can afford the costs and have quality health services are able to provide direct in-house services for their workers and their dependents. In implementing their programmes, they are likely to need to form linkages and partnerships with other organizations, such as local governments, NGOs, donor agencies, for those services that they cannot provide themselves (e.g., home-based care as in the case of South Deep, and VCT which is best provided outside the workplace). These types of partnerships can be described as contractual arrangements. Organizations also adopt contracted-out financing options, such as health insurance and HIV disease management programmes (such as the case of DaimlerChrysler South Africa, Heineken International, Placer Dome, South Deep Gold Mine). As in the examples in this paper, these contracted-out services are paid through employer and employee contributions. In some instances, employees are only required to pay a marginal amount (e.g., 10%) or a reasonable fee compared to disposable income, as in the case of the South Deep Gold Mine. The argument for copayment is that it provides an incentive for workers to adhere to treatment and care programmes.
The paper highlighted an interesting service level contract for the provision of home-based care in South Africa between 8 mining companies (including the South Deep Gold Mine) and The Employment Bureau of Africa (TEBA). The ACT Mining Home Based Care Project is a fee for service programme which is financed by each mining company based on a marginal fee per month\(^\text{36}\) for each miner employed from the region where the home-based service is provided. The agreement provides for TEBA to manage the programme. Participants in the programme range from mining companies employing over 32,000 employees to those employing under 100. This is a good example of organizations working together to mobilize a feasible approach for providing a much needed service to help families and communities deal with the impact of HIV/AIDS. As already noted, the South Deep Gold Mine, which conceptualized the project, is soliciting financial and technical assistance to develop a similar fee for service based programme that would incorporate the home-based care project with its care process for alternative income generation. It would be designed to enable the participation by other stakeholders.

Another approach to financing HIV/AIDS treatment is to set an upper limit for persons receiving coverage under a workplace health plan, as in the case of Daimler Chrysler South Africa. To coincide with this requirement, the Company has also set up a fund to pay for individuals who may exceed this limit. Other companies, like the Compagnie Ivoirienne d’Electricité (CIE), have set up ‘solidarity’ funds which are supported by employee contributions in order to cover the cost of treatment and care. In the case of CIE, contributions by employees vary according to their level of employment in the company (for example, US$ 1.30/month for technicians; US$ 6.70/month for directors).\(^\text{37}\) The Debswana Diamond Mine Company, in Botswana, Africa, also recently recommended a similar workplace saving scheme, with the creation of a trust fund to manage the provision of ARV drugs and its clinical management in which employees contribute 10% of drug and monitoring costs.\(^\text{38}\)

\(^{36}\) 3.75 Rand based on a 2001 Home-Based Care Partnership Agreement with TEBA Limited, making Placer Dome’s contribution per annum 172,035.00 Rand for 3,828 employees.


The concept of a ‘solidarity’ contribution or fund has also been used to help finance health care for poor and disadvantaged groups who have traditionally been excluded from health insurance. Financing of a health scheme is ensured by a ‘solidarity’ contribution collected under a contributory health care scheme and by a state subsidy that varies with the economic status of beneficiaries, who are largely self-employed workers or workers working in the informal economy. Indeed, financing health care for the self-employed and workers in the informal economy is a great challenge. One approach that is being promoted by the ILO’s Global Programme on Strategies and Tools against Social Exclusion and Poverty (STEP) is the development of prevention and care programmes in the context of mutual health funds which are being established by small enterprises and informal economy operators in a number of countries. Mutual health funds, or health micro insurance schemes, are being created by a wide range of civil associations and organizations, such as informal trade associations, informal economy cooperatives, women’s and youth associations, to cover workers and households that do not have access to statutory systems of social protection. In addition to functioning as a financing mechanism, it also plays an important social role that may be equally important to the fight against HIV/AIDS. This social role generates community capacity to take action related to prevention and care, and it also facilitates linkages between individuals and households affected by HIV/AIDS and support structures that provide a variety of social services. At the same time, they can increase the capacity of national HIV/AIDS programmes to penetrate deeper into communities to reach families and people in need.

Collaboration with public sector services is also another option available to organizations for mobilizing resources, particularly in countries like Brazil and Botswana which have extensive public sector treatment programmes. As in the case of Volkswagen do Brasil, organizations are able to align their treatment and care efforts with government programmes and facilities, as well as purchase care services from the public sector, such as access to VCT, and diagnostic services.

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In addition, trade unions have also used collective bargaining to mobilize workplace action in the area of care and support. For example, the recent amendments to the AIDS agreement between the National Union of Mineworkers and the Chamber of Mines of South Africa incorporated the provision to end single-sex hostelling systems and to make family accommodation available, as well as referred to the prevention of mother-to-child transmission prevention, including ARV therapy. A collective bargaining process can take place in parallel alongside the development of a workplace HIV/AIDS policy, or it can be modified once the workplace policy is finalized.

Furthermore, there is also the need to integrate insurance companies and pension plans to achieve a wider understanding of their roles and the costs incurred as a result of the disease. This is particularly useful for workplaces restructuring employee benefit schemes as part of their response to HIV/AIDS. In some cases, the existence of an HIV/AIDS workplace programme can be used to negotiate lower insurance rates. This is the policy of American International Assurance (AIA), Thailand, through its Evaluation and Accreditation Programme. The primary aim of the Programme is to promote HIV/AIDS prevention and non-discrimination in the workplace of AIA policy holders using financial incentives. The Company provides discounts of up to 10% on group life insurance premiums to AIA policy holders implementing HIV/AIDS workplace policies and education programmes.\(^{41}\)

A central lesson stemming from the workplace care and support strategies profiled in this paper is that no single organization provided its programme in isolation. Rather, the workplace strategies integrated a network of resources and services involving local, national and international stakeholders. Accordingly, the success of the programme depended on effective linkages and partnerships between the various societal actors that make up the continuum of care. Indeed, the comprehensive approach that is needed to effectively combat HIV/AIDS is beyond the capacity of any one organization or sector. As such, an effective response requires

a multi-pronged and a multi-sectoral approach which elevates the importance of effective partnerships between diverse stakeholders. In this regard, the roles and responsibilities of each stakeholder should be recognized and used to set the parameters of the partnership.

As in the case of DaimlerChrysler South Africa, partnerships between the private and public sector have proven successful in developing workplace programmes. Public-Private Partnerships have received increased attention as they are seen as a way to expand and scale up the response to HIV/AIDS. The central purpose of public-private partnerships in the context of HIV/AIDS is to strengthen and extend sustainable prevention, care and treatment efforts by ensuring that communities also benefit from HIV/AIDS workplace programmes undertaken by local private enterprises for their employees. The Global Fund to Fight AIDS, TB and Malaria is a new financial mechanism designed to increase public-private partnerships. It is actively seeking the full involvement of the private sector and specifically promotes co-investment schemes as part of Country Coordinating Mechanisms. One possible area of collaboration in this regard could be the use of business facilities to expand treatment, where national governments and donor agencies could contract companies with existing healthcare infrastructures to extend HIV treatment to communities in which local health structures are weak. The ILO is currently exploring technical cooperation opportunities to expand access to HIV/AIDS through occupational health services available in larger workplaces.

At the same time, innovative means of funding care could also be explored through debt swaps. The Highly Indebted Poor Countries (HIPC) debt initiative devised by the World Bank and the International Monetary Fund, is designed to

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43 For an overview of Public-Private Partnerships and the use of co-investment see the final report of the Global Compact Policy Dialogue on HIV/AIDS hosted by the ILO in Geneva, Switzerland, 12-13 May 2003, pp. 32-35.

44 Country level partnerships that develop and submit grant proposals to the Global Fund, monitor their implementation, and coordinate with other donors and domestic programs.

provide debt relief to eligible countries if they meet certain conditions. Currently, the HIPC spend more money on servicing their debts than on social spending, including that for HIV/AIDS. As part of meeting the conditions, countries are required to draft poverty reduction strategies in which social spending is given a priority. Countries are encouraged to add HIV/AIDS programmes to their strategies.

**Equity Considerations**

Workplace programmes in care and support face challenging equity issues. A key consideration is determining who receives coverage. The enterprises profiled in this paper extend coverage to employees and their dependents (one spouse and children). In one case, there was an upper age limit of 18 years for the coverage of children. There are also those workplace programmes that are limited to employees only, while others set a maximum number of dependents to be chosen by the employee. Setting coverage eligibility is a challenging issue as the local definitions of families differ. At the same time, however, the extent of coverage should not undermine the sustainability of the programme. In societies that define a family more broadly, community outreach efforts could resolve concerns that key family members are excluded from accessing care and support. The ILO Code of Practice recommends that all necessary steps should be taken to ensure that workers and their families receive coverage.

Another important issue concerns the length of time that care, support and treatment will be provided to workers and their families following the termination of employment due to ill health. Some organizations provide care and support for as long as an employee requires it, regardless of future employment status, such as the multinational corporations profiled in this paper. In other cases, corporate practice is to hand over responsibility to the state when an individual ceases to be an employee. This is particularly problematic if the state does not provide the same level of care. Placer Dome, South Deep Gold Mine provides a good example of a company extending support to families after an employee retires due to ill health, to include alternative employment or income generating opportunities. Gold Fields Limited, another South African mining company, endeavours to recruit a family member as a
replacement when an employee has been ill health retired.\textsuperscript{46} Moreover, the question of what happens to families upon the death of the employee is another important issue. Placer Dome continues to support families for a period beyond death through its home-based care programme which helps families in bereavement access welfare support and other community services. It also continues to support family members who have been identified as ‘proxies’ for alternative income generation activities.

On a broader scale, workplace programmes offered in communities with particularly poor health infrastructure also must deal with the difficult issue that their efforts may be creating disparities in care and treatment within those communities. Here again, community outreach efforts can partially address this concern. Fundamentally, however, employers’ decisions to provide care and treatment need to be supported by national policies and programmes in order to secure an equitable level of care in societies. If government and workplace action do not coincide, increasing disparities may lead to social unrest over time.

\textbf{High Risk Groups}

HIV/AIDS affects the most impoverished, marginalized and disadvantaged populations. Women, children and youth, migrant and mobile workers, sex workers, and people working in the informal economy are at particular risk. The reasons for their vulnerability to HIV/AIDS are well documented in other ILO publications and will not be undertaken in this paper.\textsuperscript{47} The important point to emphasize is that workplace practices in care and support have been successful in developing interventions which target these groups as part of their response to the impact of the epidemic. For example, Placer Dome, South Deep Gold Mine extended its retrenchment program for alternative income generation to women, by enabling mine workers (retrenchees) to nominate a family member (proxy) as the lead person to

\textsuperscript{46} World Economic Forum - Global Health Initiative: Private Sector Intervention Case Example: Gold Fields Limited (http://www.weforum.org/globalhealth/cases).

receive training and support. This represented the first time that women had ever been able to directly access retrenchment benefits. In implementing the programme, gender considerations were also taken into account. For example, husbands and wives were separated for some of the initial counselling sessions in order to ensure a discussion of issues that are difficult to raise when they are together. In the DaimlerChrysler South Africa case, men were approached about gender issues related to HIV/AIDS in its education and information activities, and a special campaign along the lines ‘how to be a responsible man’ was planned.

Other examples which address the gender dimension of HIV/AIDS, include the formation of a ‘Ladies Core Group’ as part of Tata Iron & Steel Company’s (India) workplace HIV/AIDS programme.48 The group’s focus is on education and awareness-raising targeted at women who are unable to express their problems due to social inhibitions. Mining companies in South Africa in recognizing the wider causes of the spread of HIV/AIDS in terms of the sexual behaviour of their large migrant worker population, especially with respect to commercial sex workers, have entered into multisectoral partnerships to address this issue. These projects have directly benefited women who represent the majority of sex workers as well benefiting women with limited economic resources who enter into sexual relations with miners for money or material support. The ‘Lesedi Project’, located around the Harmony Mine community in South Africa, established mobile STD health clinics and peer education services for women at a high risk of infection living in the communities surrounding the mine.49 Anglo Coal also initiated a joint project in 1996 called the ‘Kriel Project’ to seek to change sexual behaviour through community meetings, condom distribution and HIV/AIDS education for commercial sex workers and their clients. The Company is initiating the expansion of the Kriel Project under the new name ‘Mpumalanga Powerbelt AIDS Project’ which will cover 16 rural and semi-rural areas over a 10 year period.50

community-based prevention project, involving stakeholders from mining companies, local and provincial governments and the communities being served, to train commercial sex workers as peer educators. These peer educators, who receive a stipend of US$ 25 per month from the government, distribute male and female condoms as well as hold regular education sessions.\textsuperscript{51}

Other notable examples include initiatives undertaken by small enterprises, such as Teddy Exports (India), which employs less than 300 employees, and has a commercial relationship with The Body Shop International. Through its HIV/AIDS trust fund, ‘Teddy Trust’, it has undertaken a ‘Women in Prostitution Project’ which provides HIV/AIDS awareness, medical assistance and counselling provision for commercial sex workers in southern Madurai, using peer educators. The all female project team promotes condom use through education and innovative designs for condom carrying by the commercial sex workers.\textsuperscript{52}

The issue of care giving also has a significant gender dimension, with women predominantly assuming the inordinate burden of care brought on by HIV/AIDS. While some workplace programmes have addressed this issue through their support of home-based care programmes, the literature review did not reveal any specific examples of how workplaces tried to accommodate employees who served as primary care-givers of family members infected by HIV/AIDS. In particular, reasonable accommodation through flexible work arrangements or compassionate leave for caring responsibilities. This suggests that it is an area in need of further consideration.

A most cruel consequence of the HIV/AIDS epidemic is that it has stripped millions of children of their parents, leaving them as orphans under the care of other family members or under institutional care, with far too many being left to look after themselves. Children and youth represent the human capital of tomorrow that will
drive economic progress, however, all this is forfeited if their basic rights to shelter, food, health and education is deprived. Old Mutual Financial Services is an example of a South African company which has incorporated this issue into its HIV/AIDS care and support programme. As part of the programme, it supports 5 independently run AIDS orphan programmes across the country. Employees are also encouraged to participate in the ‘Staff Adopt an Orphan Programme’ where employees make monthly contributions from their salaries towards financially supporting one or more orphans. The Old Mutual Foundation then matches their contributions on a 1 to 1 ratio. As of March 2003, approximately 189 employees were supporting 313 orphans. In recognizing that youth are at particular risk to becoming infected with HIV, ChevronTexaco, Nigeria, helped fund an HIV/AIDS and STI Education Programme for public school classrooms by the Federal Ministries of Health and Education in Nigeria.

Migrant and mobile populations are also another group at special risk. HIV/AIDS responses by enterprises for migrant and mobile populations include Teddy Export’s ‘Healthy Highway Project’ which supports two ‘trucker booths’ on two of India’s main highways. The Project provides information on HIV/AIDS and prevention to over 80,000 truck drivers, including condom distribution. RRR Industries profiled in this paper has also been involved in a public health drive to distribute condoms to transport workers in India. Moreover, the interventions targeted at commercial sex workers undertaken by the mining companies in South Africa described above, are also in response to the risk of infection faced by their large migrant workforce.

Reaching workers in the informal economy is a far greater challenge and one of urgent need since the majority of workers are found there. Large enterprises which have extended their care and support programmes for HIV/AIDS to their suppliers and contractors are making an important contribution in this regard. The supply chain of large enterprises is often comprised of small enterprises, with a portion likely to be operating in the informal economy. The collective action of business associations to

facilitate access to treatment and care by small enterprises are also noteworthy interventions. The response for the informal economy requires innovative interventions and partnerships, such as the development of mutual health funds described earlier in this paper, and other microfinance strategies\textsuperscript{55}. Trade unions may also be able to play a key role given their considerable outreach capacity, including to informal sectors.

**Reaching Out**

The enterprises highlighted in this paper recognized the value of extending their programmes to their surrounding communities; not only for business interests but also for humanitarian reasons. The devastating impact of HIV/AIDS and the depth of its human suffering have given employers a greater sense of social responsibility and many have looked beyond their bottom lines when investing in the needs of their communities.

Reaching out to communities is vital to the effectiveness of workplace programmes in care and support. The community is where people’s attitudes and behaviours are formed, reinforced and changed. It is also where the majority of care activities are undertaken. By reaching out into their communities, workplaces can more effectively help in tearing down the societal barriers that fuel the epidemic, and in turn, compromise their workplace practices. Enterprise investment also generates capacity and mobilizes communities to respond.

As the workplace practices profiled in this paper illustrate, there are a wide range of initiatives that enterprises can undertake in order to reach out into their communities. Initiatives range from providing health services, education and information to supporting projects tailored to high risk groups such as women, children and youth, and mobile workers. Workplaces have realized that they derive economic benefits from their investments in community outreach. They also make significant public relation gains with respect to improved corporate image, which may

in turn translate into economic profit. This notwithstanding, however, the most important benefit of community outreach initiatives is that it contributes to developing a more equitable society.

CONCLUSION

HIV/AIDS is widening global disparities and condemning increasing numbers to poverty. Over 90% of the people affected with HIV/AIDS live in developing countries with limited capacity to respond to its devastating impact. In the developed world, HIV/AIDS is a treatable and manageable disease while in much of the developing world it continues to be a leading killer. Significant international and national efforts are underway to strengthen national responses against the epidemic. Initiatives to scale up and accelerate treatment and care are at the forefront of these efforts.

The continuum of care required to effectively meet the needs of people living with HIV/AIDS, their families and their communities, is made up of a diverse set of societal actors. Each has an important role to play and a vital contribution to make. This paper argues that the workplace should be seen as part of that continuum of care. The fact that two out of three people living with HIV/AIDS go to work everyday clearly makes the workplace a vital entry point for tackling the disease. The workplace practices profiled in this paper show how different private and public sector enterprises are making crucial contributions in the area of care and support, and how they are able to go beyond the workplace to reach into their communities. Although workplace programmes cannot substitute for major public programmes, they can and should be part of a national response. Efforts should be made to tap the potential of the world of work and to include it as part of a broad public health and social protection approach as well as part of socio-economic policy for combating the disease.

The care needs of people with HIV/AIDS and their families continue to rise, and there are significant deficits in care. Workplace initiatives can make an important contribution to filling some of these gaps. However, the challenge is great, and it necessitates the collaboration between all social partners. Advantage should be taken
of the new funding opportunities to develop effective partnerships which will extend and scale-up treatment, care and support. The workplace practices profiled in this paper provide good examples of possible action and partnerships to expand care and support for people infected and affected by HIV/AIDS and their communities. The ILO has an important contribution in sharing these experiences and exploring with its partners potential areas for action.
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