

HIV/AIDS

Guide for the Mining Sector



INTERNATIONAL
FINANCE
CORPORATION
World Bank Group



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Acknowledgements

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Under the leadership of the IFC Task Manager, Dr. John Middleton, a project team comprised of representatives from the private, public and not-for-profit sectors worked for more than two years to develop the **Guide**. Richard Smith, from Golder Associates, was the Project Team Leader responsible for overseeing the preparation, testing and delivery of the **Guide**. The enormous task of researching, compiling and writing up the **Guide** was handled by Rose Smart.

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Foreword by Peter Woicke



The International Finance Corporation, the private sector arm of the World Bank Group, promotes private sector investment in developing countries to reduce poverty and improve people's lives. Economic growth is sustainable only when environmentally and socially sound, and IFC is at the forefront of supporting investments that combine both economic growth and positive social and environmental impact. HIV/AIDS reduces prospects for development and poses a major challenge for the private sector. In developing countries, which account for 95 percent of all HIV infections, the epidemic is as much a business issue as it is a health and humanitarian concern.

As part of our commitment to sustainable development, we launched the IFC Against AIDS programme in 2000. The programme helps clients understand the multiple impacts of the disease and provides guidance for corporate HIV/AIDS action plans. IFC's approach pays special attention to a company's specific needs and resources, as well as existing corporate experiences and good practices. This way, the programme enables clients to fight the effects of the disease on their operations and their communities.

Southern Africa is particularly affected by HIV/AIDS. The disease has already had a major impact on the economies in the region and especially on the mining sector, which is a key business driver.

Based on its experience in southern Africa, IFC commissioned the **HIV/AIDS Guide for the Mining Sector**. Supported by a technical assistance grant from the Canadian International Development Agency, the **Guide** provides practical advice and management guidance that will help companies implement intervention strategies. It is a valuable tool in the fight against HIV/AIDS and will become an integral part of the IFC Against AIDS programme.

Thanks to their access to resources and the importance of their public voice, businesses can play an important role in combating HIV/AIDS, especially in times of scarce public resources. The **Guide** helps them fulfill their corporate social responsibilities and at the same time improve their profitability.

Peter Woicke
Executive Vice President
The International Finance Corporation



Foreword by Clem Sunter



The publication of this HIV/AIDS **Guide** for the mining sector in Southern Africa is most welcome. Not only is it comprehensive in its coverage of all the issues, it is set out in such a way that it is easy to read and, more importantly, to implement in the work situation. The author, Rose Smart, is to be congratulated. Indeed, this **Guide** can be used by any company in any industry as the elements that form an effective strategy to combat the epidemic are common to all industries.

Broadly, for a company to rise to the challenge and make a comprehensive response in the war against HIV/AIDS, the framework should be as follows:

1. A clear policy should be agreed at Board level and it should be seen as a prime part of the CEO's responsibility to turn the policy into action. HIV/AIDS is such a strategic issue that it cannot be delegated to the Human Resources Department to handle as just another personnel matter. Ideally, where the company can afford it, a dedicated HIV/AIDS Co-ordinator should be appointed to oversee the programmes that convert the policy into activities on the ground. He or she should report directly to the CEO and provide the Board with regular updates on progress. The prime objective of any policy must be to create an enabling, non-discriminatory environment in which HIV/AIDS is viewed as just another medical condition – albeit a very important one – that is handled professionally, compassionately and properly.
2. This ushers in the second point which is the necessity for monitoring the programmes which are implemented in terms of the HIV/AIDS strategy. Key performance indicators on prevention, care and treatment need to be drawn up and agreed. Part of the remuneration package of the managers responsible for achieving results in this area should depend on whether the indicators show a satisfactory trend or not. In other words, HIV/AIDS should be regarded in exactly the same light as safety. After all, it is a huge part of the 'H' in any SHE (Safety, Health and the Environment) programme.
3. In addition, corporate HIV/AIDS programmes have to be evaluated at regular intervals because knowledge of what is and what is not effective is still at an early stage. This will necessitate feedback loops on whether prevention programmes are actually achieving behavioural change and whether care and treatment initiatives are really improving the quality of life of those infected with the virus and their families.

4. More specifically, the centrepiece of any workplace programme should be voluntary counselling and testing. This in turn will only happen on a wide scale if a proper wellness programme is already in place, which includes treatment of opportunistic diseases such as TB and pneumonia as well as antiretroviral therapy (when a patient's CD4 count falls below a certain threshold figure). It goes without saying that people will only come forward in large numbers to be tested if there is something in it for them in the event that they test positive. Another critical element of any prevention programme is to encourage employees to have regular check-ups for sexually transmitted infections in general as these vastly increase the chances of catching HIV and they can all be successfully treated.
5. For a company to fulfil all three legs of the triple bottom line (profits, people and the planet) in regard to HIV/AIDS, outreach programmes in the neighbouring communities of the company's operations must be added to workplace programmes. On a nation-wide scale, support should also be given to NGOs who are involved in such activities such as education for behavioural change, preventing mother to child transmission, looking after AIDS orphans and generally providing care and support for those infected and their families. Many opportunities already exist for partnerships between the public and private sectors and these partnerships should include the trade unions, NGOs and faith-based institutions as well. The war will only be won if past differences are set aside and all parties co-operate to defeat a common enemy.

So read this **Guide** and then act on it. Instead of 'ready, aim, have another workshop, aim ...', you need to fire! Begin by implementing some of the easily doable steps recommended within its pages. Get the momentum going and see where it leads. The war against HIV/AIDS within your company and its surrounding areas can be won, but it requires the Board and the CEO's commitment at the top and workplace/ community participation at grassroots level to do so.



Clem Sunter
Chairman
Anglo American Chairman's Fund



The International Finance Corporation and IFC Against AIDS

The International Finance Corporation (IFC), the private sector investment arm of the World Bank Group, promotes the economic development of its member countries. IFC is committed to providing industry with practical guidance and support in addressing key issues associated with sustainable development.



Introducing “IFC Against AIDS”

Although the AIDS crisis has wide consequences for development, it also challenges businesses that operate in these regions: in many parts of the world, HIV/AIDS is as much a business issue as it is a health and humanitarian concern, because workforces and consumers alike are being destroyed by the virus, while future generations are stunted by its effects.

Like the rest of the development community, IFC acknowledges HIV/AIDS as an obstacle to poverty alleviation and sustainable private sector development. Businesses feel the impact of HIV/AIDS most clearly through their workforce, with direct consequences for a company’s bottom line. These include increased medical expenditures and health insurance costs, funeral and death benefits, as well as higher recruitment and training needs due to lost personnel. In addition, firms experience other financial impacts as a result of higher absenteeism and staff turnover, reduced productivity, declining morale and a shrinking consumer base. While the companies’ revenues shrink, their costs of doing business rise due to disruptions in the supply chain also affected by AIDS.

IFC is seeking to leverage its exposure and reputation in the business community in the developing world to focus attention on the issue of HIV/AIDS and impact on businesses. Our efforts are encompassed within a corporate programme which was initiated in 2000: “IFC Against AIDS”, through which IFC has sought to raise awareness about the risks that HIV/AIDS represents to businesses. The programme provides IFC clients with the tools necessary to begin addressing the effects of the disease on their operations and communities.

Companies that have been recipients of IFC Against AIDS guidance include, among others, an electricity company in Jamaica, a cellular telephony company operating in 14 African countries, a microfinance bank and a soda ash processing company in Kenya, a safari operator in Southern Africa, a fisheries company in Namibia, and an engineering, construction and mining company in Angola. In addition, IFC Against AIDS launched in February 2004, in co-operation with the Africa Project Development Facility (APDF); a training programme targeted at small and medium-sized enterprises (SMEs) to enable them to tackle the challenge that HIV/AIDS poses to their businesses in Africa.

Acknowledging the economic impact of HIV/AIDS in Africa on mining companies, as well as the strategic importance of the mining sector for development, the Environmental and Social Development Department of IFC and the IFC Against AIDS programme commissioned the elaboration, testing, publication and dissemination of this **Guide** in order to provide a resource to help more specifically the mining sector to implement HIV/AIDS intervention strategies. This **Guide** is one in a series of tools that is being provided by IFC to promote action among IFC clients and the wider private sector to engage in the fight against HIV/AIDS. Given the possible uses of this **Guide** in other sectors (for example in other extractive industries such as oil and gas, as well as transportation and construction), we trust that this **Guide** will become a useful resource to build the capacity of the private sector to effectively manage HIV/AIDS in the workplace and in affected communities.

For more information on the **IFC Against AIDS** programme contact ifcagainstaids@ifc.org or visit their website at www.ifc.org/ifcagainstaids.



Section One

HIV/AIDS Guide for the Mining Sector: What, Why and How?

Section One contains:

An introduction to the Guide;

- What is the HIV/AIDS **Guide** for the mining sector?
- Why was the **Guide** developed?
- For whom was the **Guide** developed?
- Why the focus on contractors?
- How should you use the **Guide**?
- How was the **Guide** developed?

An overview of the Guide;

- Contents of the **Guide**
- Format of the sub-sections or interventions

The mining sector and the HIV/AIDS epidemic;

- The HIV/AIDS epidemic in Southern Africa
- The HIV/AIDS epidemic and the workplace
- HIV/AIDS and the mining sector in Southern Africa

A framework for a “blue-chip” response to HIV/AIDS;

A roadmap towards a “blue-chip” response to HIV/AIDS;

A quick reference for contractors; and

A template for customising the Guide for contractors and other sectors.

If we are to reach the Millennium Development Goal of halting the spread of AIDS by the year 2015, there is literally no time to lose. We have to work really very, very hard. It means helping every country understand that speaking up about AIDS is a point of honour, not a point of shame. It means explaining to everyone that stigmatising high risk groups, and imagining that everyone else is safe from infection, is both morally and factually wrong. No one should imagine that we can protect ourselves by building barriers between ‘us’ and ‘them’. In the ruthless world of AIDS, there is no us and them.

*Kofi Annan, UN Secretary General
on a visit to the Ukraine*

Section One

Introducing the HIV/AIDS Guide for the Mining Sector



What is the HIV/AIDS Guide for the mining sector?

The HIV/AIDS **Guide** for the mining sector, referred to throughout as the **Guide**, is a compendium of resources – information, tools and case studies – that can be used individually or collectively by stakeholders and organisations working within mining communities in Southern Africa, to initiate or strengthen their responses to the HIV/AIDS epidemic.

Why was the Guide developed?

Mining communities constitute one of the most important and influential sectors in Southern Africa. They are also communities that are being severely impacted by the HIV/AIDS epidemic.

The **Guide** is intended to support the development of HIV/AIDS competencies in stakeholders and organisations operating in mining communities across Southern Africa.

For whom was the Guide developed?

The Southern African mining sector comprises a range of actors, including small scale miners, mining companies, suppliers, contractors and associated industries, national ministries, NGOs, labour unions and research institutions.

The **primary users** of the **Guide** will be emerging mining companies, trade unions, organisations providing goods or services to the large mining companies (e.g. contractors, consulting firms and service providers) and stakeholders from other related sectors (e.g. construction and transport). For ease of reference these diverse users are referred to throughout the **Guide** as **contractors**.

Also falling into this category are the large mining companies that partner and support their contractors in the development of their HIV/AIDS programmes, and who will use the **Guide** as a resource in doing this.

The **secondary users** of the **Guide** will be large mining companies with well-established HIV/AIDS programmes, who may choose to use the **Guide** to strengthen, audit or validate their own HIV/AIDS programmes. And finally, the **Guide** is likely to have application for other partners of these companies, such as the Chambers of Mines, training and research institutions, government ministries, NGOs, and perhaps even some small medium and micro enterprises (SMMEs).



Why the focus on contractors?

There are multiple organisations – some small, some larger – that interface with mining companies, such as contractors, suppliers, service providers or partners. For example, in many mining companies at any point in time, there could be as many, or more, contractors on site as permanent employees of the company.

Understanding that contractors and employees interact with one another, and that the spread of HIV occurs within sexual and social networks, mining companies have identified that the lack of opportunity to involve contractors in their workplace HIV/AIDS programme, or to ensure that contracting companies have their own synergistic programmes undermines the effectiveness of their own HIV/AIDS programmes.

The **Guide** was therefore developed to assist in addressing this problem; whether it is used by the mining companies as a resource in their interactions with their contractors, or by the contractors themselves.

How should you use the Guide?

There are no rules about how the primary and secondary users should utilise the **Guide**; rather it is intended that every user will discover their own, individual uses for it. So, the **Guide** may be used when:

- Embarking on an HIV/AIDS response;
- Tackling a particular intervention for the first time;
- Reviewing an existing HIV/AIDS response, with a view to modifying and strengthening the response; or
- Reviewing a particular intervention for similar reasons.

The **Guide** can also be used when assisting others, such as contractors, suppliers, unions and partners to establish or strengthen their HIV/AIDS responses.

Because the users and the contexts within which the **Guide** will be applied will vary considerably, adaptation of the tools and score cards will make them more relevant and useful, and users are encouraged to make whatever modifications are necessary to suit their situations and needs. A template for customising the **Guide** can be found at the end of Section One.

How was the Guide developed?

The **Guide** was developed following an assessment of current responses to HIV/AIDS by the mining sector (conducted by Golder Associates Ltd. in association with CARE Canada, in 2002), and involved periodic consultation and dialogue with the IFC and specifically the IFC Against AIDS programme, and mining and social development specialists from the Corporation.

The contents of the **Guide** was then defined based on the assessment results and a review of the emerging best practices in the workplace. Many of the tools and case studies in Sections Two, Three and Four of the **Guide** are drawn from these sources.

The draft **Guide** was field tested in two phases; firstly with a range of mining sector HIV/AIDS experts and secondly with potential users. In 2004, the **Guide** was piloted in selected companies and settings – in South Africa, Botswana and Zambia – following which it was finalised and officially launched.

Section One

Overview of the Guide



Contents of the Guide

The **Guide** consists of **five** sections.

Section One – which introduces the **Guide**, provides key background information on the mining sector and the HIV/AIDS epidemic, describes the contents of, and framework and roadmap for an optimal organisational response to the HIV/AIDS epidemic, and finally provides a template to customise the **Guide**.

Section Two – which covers the strategies for **managing** the HIV/AIDS epidemic within a mining sector organisation.

Section Three – which deals with **workplace or internal** HIV/AIDS programmes.

Section Four – which describes a number of **outreach or external** HIV/AIDS activities.

Section Five – which contains information and tools for monitoring, evaluating, and recording and reporting on an organisational HIV/AIDS response.

A number of appendices follow Section Five, providing:

- Comparative country data for the SADC region;
- Information on the mining sector in Southern Africa;
- The IFC against AIDS corporate roadmap on HIV/AIDS;
- Lists of resources, references and contacts; and
- A glossary of terms.

Format of the sub-sections or interventions

In Sections Two, Three and Four there are a number of sub-sections, each of which refers to a particular HIV/AIDS intervention, e.g. behavioural surveys, workplace HIV/AIDS policies, peer education, wellness programmes, partnerships etc.



Each sub-section consists of four parts. For easy reference, different icons introduce each part:



Part 1: Briefing Note

The **briefing note** contains key background information about the intervention – such as what it is, why it is important for an organisation to include this as part of its HIV/AIDS response, what the components are of the intervention, and any issues for contractors.



Red flags or special challenges, where these exist, are indicated with this icon, serving to draw attention to issues and potential problems that have commonly been experienced by organisations in implementing the intervention.



Part 2: Tool

The **tools** can be used in implementing the intervention. They take many forms; checklists, processes, menus, rules, templates, sets of questions and so on. Typically they are drawn from the literature and have been tested in various circumstances (though not necessarily in the mining sector). They can be used as they appear in the **Guide**, or adapted as required for different contexts.



Part 3: Score Card

The **score card** is a ranking system against which to measure an organisation's status in relation to a particular intervention. In line with the National Occupational Safety Association (NOSA) HIV/AIDS Management System (AMS 16001: 2003)¹, a minimal response equates to a 1 red ribbon rating, a good response earns 3 red ribbons and a “blue-chip” or best response qualifies for 5 red ribbons.

The **red ribbon** is a symbol used all over the world to show awareness and understanding regarding HIV/AIDS and to demonstrate solidarity with those who are infected and affected.

Rating	Future Actions
	Minimal Response
	Good Response
	“Blue-chip” Response

The actions included in each of the score cards are not comprehensive, but are **indicative examples** of different level responses. They are also, in the main, cumulative, i.e. an organisation should have implemented the actions against 1 red ribbon, as well as those against 3 red ribbons, in order to score 3 red ribbons, and all the actions listed, to qualify for 5 red ribbons.

The score cards are thus intended to enable users to identify and quantify (by allocating a rating to each of their interventions) their areas of strength and weakness and to record the next steps (future actions) to strengthen their responses. If you wish to allocate numerical scores to activities, you may rate each listed activity as follows:

- 1 = poor or below average
- 2 = average
- 3 = good

This allows for the calculation of the total of all activities as a score for each intervention (HIV/AIDS risk and impact assessment, peer education, HIV/AIDS partnerships etc.), a total for each of the 3 pillars of your HIV/AIDS response (management strategies, workplace programme and outreach programme), and a composite score for your entire HIV/AIDS response. Over time the score cards can be used as monitoring tools to track and measure progress.

Costs

Following each score card, where data does exist, the costs of interventions are indicated, to guide decision-making regarding prioritising and financing interventions.



Part 4: Case Study

The **case studies** describe one or more real life example of each intervention. These are drawn either from the literature or from the experiences of the informants during the field testing. The case studies are not necessarily best practices, but all contain valuable lessons from the field.



Additional Information

Finally, where good sources for **additional information** about the intervention exist, these are listed at the end of each of the sub-sections.

Examples or quotes appear throughout the text, to illustrate key points.

Remember, each of the Sections (Two to Four) and the interventions within these can be used individually or in combination.



Footnotes



¹ The NOSA AMS is an internationally recognised standard specification against which HIV/AIDS management systems can be assessed and certified. To access the AMS and the accompanying guideline document, go to www.nosa.co.za



Section One

The Mining Sector and the HIV/AIDS Epidemic

Section One

Section Two

Section Three

Section Four

Section Five

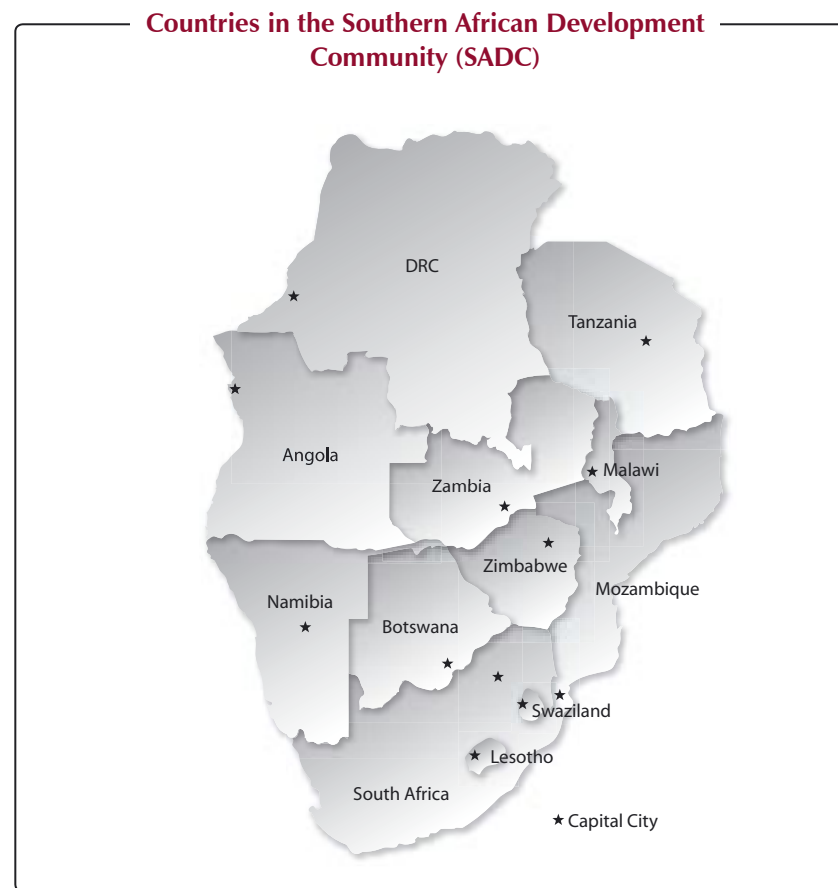
Appendices

Contributors

The HIV/AIDS Epidemic in Southern Africa

As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. Wherever the epidemic has spread unchecked, it is robbing countries of the resources and capacities on which human security and development depend. In some regions, HIV/AIDS, in combination with other crises, is driving ever-larger parts of nations towards destitution.

**UNAIDS; AIDS epidemic update:
December 2002**



UNAIDS estimated that, at the end of 2003, 25 million adults and children were living with HIV/AIDS in sub-Saharan Africa¹, representing an adult prevalence rate of 7.5%. Of the infected adults, more than half are women.

A summary of key HIV/AIDS data for the SADC countries follows. Additional demographic, development and economic data about these countries can be found in Appendix One.

HIV/AIDS data for the 12 SADC countries²

Country	Adults and children living with HIV/AIDS (End 2003) Estimate	Adults (15-49 years) HIV prevalence rate	Orphans (0-17) due to AIDS Estimated Number
Angola	240 000	3.9%	110 000
Botswana	350 000	37.3%	120 000
DRC	1 100 000	4.2%	770 000
Lesotho	320 000	28.9%	100 000
Malawi	900 000	14.2%	500 000
Mozambique	1 300 000	12.2%	470 000
Namibia	210 000	21.3%	57 000
South Africa	5 300 000	21.5%	1 100 000
Swaziland	220 000	38.8%	65 000
Tanzania	1 600 000	8.8%	980 000
Zambia	920 000	16.5%	630 000
Zimbabwe	1 800 000	24.6%	980 000



Southern Africa is home to about 30% of the global total of people living with HIV/AIDS (PLWHAs), yet this region has less than 2% of the world's population. Countries in Southern Africa have the highest HIV prevalence rates in the world, with at least one in five adults infected in a number of the SADC countries. Amongst the factors that have contributed to this are:



- Poverty associated with significant income inequalities and widespread unemployment – circumstances that have been linked to high-risk sexual behaviour and the spread of HIV;
- The low status of women, which increases their vulnerability to HIV infection;
- High prevalence of other STIs, which increases the probability of HIV transmission;
- Multiple sexual relationships;
- Low levels of condom use;
- Low levels of male circumcision;
- Cultural practices, such as early sexual debuts, dry sex and widow inheritance; and
- High mobility, settlement patterns, population dislocation in times of drought, conflict or war and worker migration.

In all of the SADC countries these factors take different forms, and the HIV/AIDS epidemic too is different, not just between countries, but within countries. For example, Botswana, Namibia and South Africa are the least poor of the SADC countries, yet they all have very high levels of HIV prevalence, which may be related to some extent to the huge income disparities in these countries. Countries supplying large numbers of migrant workers to the mines in South Africa – Lesotho and Swaziland – have very rates of HIV infection, but Mozambique, which also falls into this category, has a wide range of epidemics, from high to relatively low.

Countries emerging from conflict and war appear to have relatively low levels of HIV infection, though some of the data should be treated with caution as surveillance systems in these countries tend to be less robust than those in other countries.

As an example, the following extract from the UNAIDS AIDS epidemic update (December 2003) describes the situation in Angola³. Angola gives cause for concern despite the comparatively low HIV levels detected to date. After almost four decades of war, huge population movements are underway. Millions of people have been able to leave the cities and towns they had been trapped in, internal and cross-border trading movements are resuming, and an estimated 450 000 refugees are returning (many from neighbouring countries with high HIV prevalence rates). Such conditions could prime a sudden eruption of the epidemic.

In the final analysis, one similarity does emerge across all countries, namely the very high rates of orphans as a percentage of all children – over 10% in every country, bar the DRC which is close, at 9.4%. As more and more parents succumb to AIDS, this problem will continue to grow, representing arguably the greatest challenge to the future of the Region; a challenge which countries are only very recently acknowledging and attempting to address.

... companies have lost top managers, workers have lost colleagues and huge amounts of time, energy and emotion have been spent pre-occupied with issues of illness and loss. Whole families have collapsed, while companies struggling against a background of chronic poverty have taken on deeper burdens of dependency.

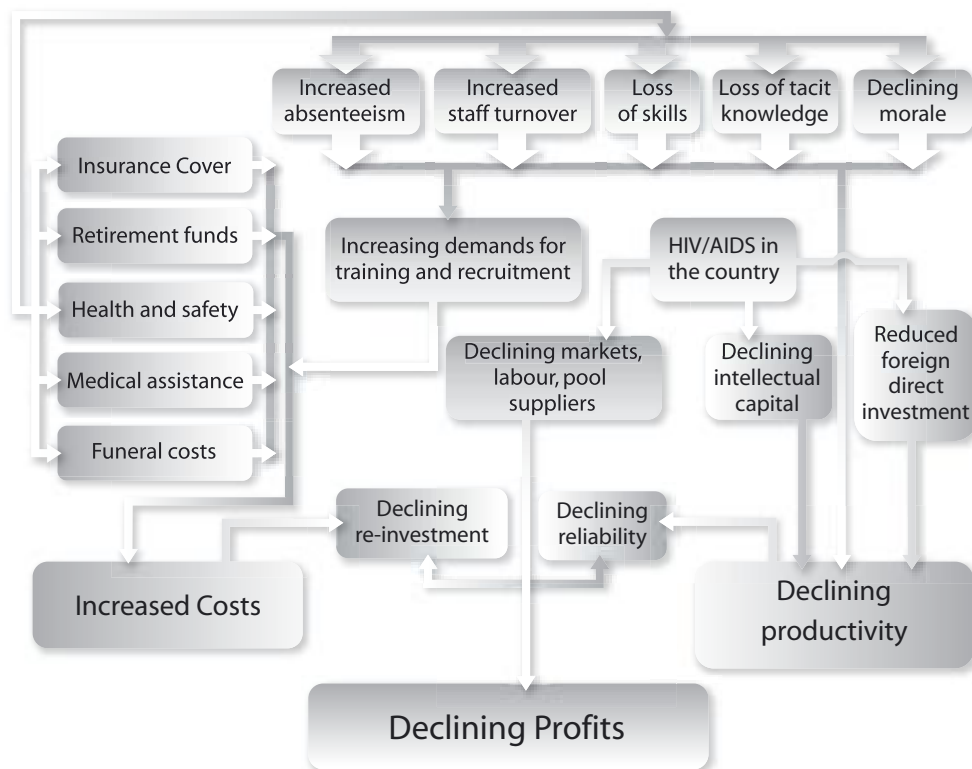
Loewenson, R (1998)

The HIV/AIDS Epidemic and the Workplace

The HIV/AIDS epidemic impacts on all spheres of life. One of the most significant features is its concentration in the working age population (aged 15-49) such that those with critical social and economic roles are disproportionately affected.

HIV/AIDS hits the world of work in numerous ways, as illustrated in the diagram below.

The impact of HIV/AIDS on enterprises⁴



If you are an executive in a corporation with operations in South Africa, or one of its neighbours, chances are that anywhere from 10% to 40% of your employees there are HIV positive.

Harvard Business Review
February 2003

In badly affected countries, it cuts the supply of labour and reduces income for many workers. Increased absenteeism raises labour costs for employers, and valuable skills and experience are lost. Often, a mismatch between human resources and labour requirements is the outcome.

Stigma and discrimination negatively affects production and workplace morale⁵. Associated with lower productivity and profitability, tax contributions also decline, while the need for public services increases. National economies are weakened further in a period when they are struggling to become more competitive in order to weather the challenges of globalisation.



A number of important observations were made in an article entitled “AIDS is your business”, by Sydney Rosen et al, which was included in the Harvard Business Review (February 2003)

- Many corporations benefit from the low cost of labour in developing countries;
- HIV/AIDS, however, is eroding that advantage by adding, both directly and indirectly, to wage bills;
- The disease not only drives up health care and benefit costs, it also reduces productivity for years, unlike other illnesses;
- Rising absenteeism and higher employee turnover due to HIV/AIDS mean that companies have to employ and train more people than usual; and
- HIV/AIDS has forced executives to spend more time coping with lower morale in their organisations as well as in addressing the difficult legal, social and political issues that stem from the epidemic.

In short, the epidemic is affecting the size, growth rate, and age and skill composition of both current and future labour forces. At the same time, HIV/AIDS is raising the cost of labour in all Southern African countries and diminishing the competitiveness of African business in the global marketplace.

Finally, the gender dimensions of the epidemic in general, and specifically in terms of the world of work must be acknowledged.

- Gender inequality – linked to patterns of social, economic and cultural inequality – makes women more vulnerable to infection. The situation is worsened further by the physiological differences between men and women.
- As the epidemic spreads, women are faced with the double burden of having to work and cope with the additional responsibilities of providing care and support for family and community members who fall ill.
- Most women are still confronted with limited access to secure livelihoods and socio-economic opportunities. This increases their dependence on male partners and their vulnerability in situations where there are risks of HIV infection.
- Men, too, are subject to social and cultural pressures that increase their susceptibility to infection and their likelihood of spreading it. Multiple partners and sexual infidelity are condoned for men in many societies.
- Certain occupations tend to encourage risk-taking behaviour, especially those that involve men spending long periods away from their families. This in turn increases the risk of infection for their partners when they return home.



HIV/AIDS and the Mining Sector in Southern Africa

1. Historical milestones

In countries across Southern Africa the mining sector was the first sector to respond to the HIV/AIDS epidemic.

- 1985-6:** First screening conducted in the South African gold mining industry to detect HIV among mineworkers.
- 1986:** First group of mineworkers tested positive from Malawi.
- 1988:** TEBA's healthcare services developed education and awareness campaigns on STIs and HIV/AIDS, including videos shown to all new employees.
- 1989:** Knowledge, attitudes and practices study showed a high level of knowledge by mineworkers about STIs including HIV/AIDS.
- 1989:** A study on truck drivers showed that 50% of the drivers were infected with HIV, while prevalence among mineworkers was negligible.
- 1990:** Mining companies increasingly started introducing HIV/AIDS programmes.
- 1990 - 2000:** A randomly-selected cohort of employees from one company was followed up annually for their HIV status. Prevalence of the disease in the sample increased from 1% to 26% over the life of the study.
- 1993:** The SA Chamber of Mines established a standing committee on HIV/AIDS.
- 1995:** The SA Chamber of Mines commissioned a survey on HIV/AIDS in Southern Africa.
- 1997:** The Southern African Development Community (SADC) Code on HIV/AIDS and employment was adopted.
- 1998:** The International Labour Organisation (ILO) Code on HIV/AIDS in the workplace was developed (and adopted in 2001).
- 1998:** South Africa's White Paper on Mining and Minerals outlined the need to develop an HIV/AIDS policy, the plight of migrant labour, housing and living conditions and the respective responsibilities of government and employers in addressing these issues. It also emphasised the need to protect human and labour rights in relation to education, counselling, testing and treatment.



2000: A SADC HIV/AIDS Strategic Framework and Programme of Action was established, which outlines plans and strategies for dealing with the epidemic for all SADC sectors. Within this strategic framework, a section relating to mining is enunciated, which includes:

- Establishing the extent of HIV/AIDS in the SADC mining sector;
- Minimising the spread of HIV/AIDS in the mining sector; and
- Providing adequate care for the infected and affected in the mining sector.

2001: In Zambia, the Ministry of Energy and Water Development recognised the loss of human resources, lower productivity due to illness and funeral attendance, and the costs of recruiting and retraining new staff as high HIV/AIDS mortality rates took its toll. The 2001 work plan included the training of designated HIV/AIDS focal persons and health committees, the distribution of male and female condoms, establishing counselling centres, and providing support through peer education.

2001: A tripartite HIV/AIDS committee for the mining industry – between government, labour and mining companies in South Africa – was established.

2001: KCM conducted the largest HIV prevalence survey in a single company.

2001: Debswana introduced subsidised (90%) ART.

2001 and 2002: Mining companies signed specific agreements with TEBA to provide home-based care in 4 Southern African countries, for terminally-ill mineworkers who agree to return home to the rural areas.

2002: The MMSD report on mining, minerals and sustainable development in Southern Africa was published, with a strong emphasis on HIV/AIDS.

August 2002: August 2002: Anglo American announced its ART programme for employees.

2003: The first South African summit on HIV/AIDS in the mining industry was held, attended by government, labour and mining companies. Resolutions included that:

- Every workplace will have workplace HIV/AIDS policies and programmes in place by the end of 2004;
- Prevalence survey results will be shared within a national databank framework; and
- Measures will be implemented to improve the standard of housing for mineworkers.



2. The impact of the epidemic on the mining sector

The mining sector is a major sector in most national economies in the SADC region, not only in terms of the number of people employed but also the foreign exchange generated by mineral exports. In South Africa, experts believe that the industry hardest hit by HIV/AIDS will be mining. Studies of the sector show HIV infection rates from one-quarter to almost one-half of the country's miners. Zambia has a similar problem, where copper accounts for 85% of the country's export earnings, and 18% of the copper miners (a skilled workforce) are estimated to be HIV positive. In Botswana, where diamonds account for 80% of export earnings and half of the government's total revenue, a third of the industry's employees are estimated to be HIV positive.

Labour is an essential input in mining and the sector's use of labour leads to unique risk situations in respect of HIV transmission because:

- In many mining situations mechanisation is difficult and the industry is very labour intensive;
- Mineworkers tend to be young males – an age category most affected by HIV/AIDS. They engage in physically taxing and dangerous work for 8-12 hours a day, with infrequent breaks, limited access to food and water, and in sweltering and dusty conditions. They also live with the constant prospect of mutilating or fatal accidents;
- The use of migrant labour is common with the attendant disruption of social support mechanisms and family structures, unpleasant living conditions and limited opportunities for leisure. This, in turn, creates situations conducive to the establishment of new and/or casual sexual relationships.
- The migrant system that has serviced the mines of Southern Africa has also generated exaggerated forms of masculine identity that now abet the spread of HIV. For mineworkers, the lack of control over their life circumstances results in a risk-taking mentality which advocates high levels of sexual activity (often associated with alcohol use) as a way of dealing with dangerous and stressful lives.
- Apart from large numbers of semi-skilled workers, mines also require highly skilled and experienced professionals such as geologists and engineers. The illness or loss of these highly skilled professionals has the potential to disrupt operations significantly.
- Well developed infrastructure and long-distance transportation (both of which are necessary for mining) have facilitated factors such as mobility and thus the spread of the epidemic.

Health is another important factor, as the nature of mining requires peak physical fitness yet it is also associated with the risk of severe occupational illnesses such as pneumoconiosis, asbestosis, silicosis and tuberculosis (TB).

- Silicosis is a substantial risk factor for TB, as is HIV infection; research describes a multiplicative, rather than an additive effect of these three conditions.
- STIs are an important co-factor for HIV transmission and rates of other STIs have, in many instances, been found to be higher amongst mineworkers than in the general population. Although mines may provide STI treatment services for their workers, few provide treatment for their sexual partners and rapid re-infection is common.
- Mineworkers who become disabled as a result of advanced HIV disease are medically retired and frequently return home to remote rural areas where resources and care are limited. With their return, the flow of income to their household ceases, resulting in increased impoverishment.

For more detailed information, the MMSD⁶ report provides a comprehensive analysis of the impact of HIV/AIDS on mining communities.



3. Future responses by the mining sector to the HIV/AIDS epidemic

Throughout Southern Africa, the mining sector has been at the forefront of efforts to respond to the HIV/AIDS epidemic. Nowhere is this more true than in respect of providing antiretroviral treatment (ART) to infected employees.

Trade unions, like the National Union of Mineworkers (NUM) have also played an important role in raising the profile of HIV/AIDS as an issue and in educating workers regarding HIV transmission risks, often as joint initiatives with mine management.

The MMSD report made important recommendations for future responses by the mining sector to the HIV/AIDS epidemic. These included the following:

- To urgently shift from IEC approaches (information, education and communication) to address the root causes of transmission: poverty alleviation, cultural norms around sex, and social and economic instability.
- To establish an international charter on key prevention and care strategies to be followed throughout sub-Saharan Africa.
- To shift from negative messages to ones that emphasise the need to accept HIV/AIDS and take greater responsibility for personal behaviour.
- To build capacity to deliver community-based interventions by channelling resources into CBOs and NGOs; to allow communities a greater say in the course of interventions; and to provide long-term funding.
- To monitor and analyse HIV/AIDS intervention programme outcomes to develop and improve quantitative understandings of cost-benefit relationships.
- For company stakeholders to continue to take the initiative, but in partnership so as to play a greater role in capacity building and developing best practice.
- To stimulate economic development, particularly in rural recruitment catchment areas; to subcontract services relating to HIV/AIDS care; to retrain medically boarded employees; and to encourage participation in benefit schemes.
- To employ a multi-stakeholder approach to address all aspects of the problem through a combination of measures including GIPA (the greater involvement of people living with HIV/AIDS) and the protection of individual rights.
- To establish alternative lower risk living conditions.
- That treatments must follow a logical sequence within the limits of available resources, with priority given to interventions that address problems with highest morbidity and best cost-benefit in terms of quality of life and ability to live productively.
- In order for drug costs to be affordable to those in employment, to encourage the introduction of mandatory medical benefit schemes for those in employment and to require participation in wellness schemes.
- To produce guidelines for assessing the equivalent value of the non-cash elements of HIV/AIDS interventions, e.g. voluntary work, etc.
- To establish and maintain resource inventories to provide stakeholders with information on available resources.
- To ensure the ability for programmes to incorporate the facility to collect quality research data and for monitoring and evaluation to be carried out in order to develop best practice.
- To build capacity by co-ordinating stakeholders, seconding staff, developing individuals and subcontracting services.



Additional Information

The MMSD report gives an excellent summary of the history of mining in Southern Africa, available on www.iied.org/mmsd/rrep/s_afr.html.

As part of the MMSD process, research topic 2 examined the effect of HIV/AIDS on the mining sector and proposed recommendations for management of the pandemic in alignment with sustainable development in the sector. The report is available on www.iied.org/mmsd/rrep/s_afr.html.

The mining sector is also well covered in a recent document from IOM, SIDA and UNAIDS entitled *Mobile Populations and HIV/AIDS in the Southern African Region: recommendations for action* (May 2003).

UNAIDS publishes regular reports on the HIV/AIDS epidemic, which detail the status of the epidemic in all countries. These reports are available on www.unaids.org.



Footnotes



- ¹ UNAIDS; 2004 Report on the global AIDS epidemic (June 2004), available on www.unaids.org
In sub-Saharan Africa at the end of 2003, between 23.1 and 27.9 million adults and children were living with HIV/AIDS; 3.0 million were newly infected with HIV; and 2.2 million adults and children had died.
- ² UNAIDS; 2004 Report on the global HIV/AIDS epidemic (June 2004)
- ³ Additional information about the epidemics in Southern Africa can be found in the UNAIDS 2004 Report on the global AIDS epidemic, available on www.unaids.org
- ⁴ Source: UNAIDS; adapted from *The business response to HIV/AIDS: impact and lessons learned* (2000) by ILO
- ⁵ HIV/AIDS-related stigma is a real or perceived negative response to a person or persons by individuals, communities or society. It is characterized by rejection, denial, discrediting, disregarding, underrating and social distance. It frequently leads to discrimination and violation of human rights.
(Definition produced from *Stigma-AIDS 2001 discussions and Regional Consultation on Stigma and HIV/AIDS in East and Southern Africa*, 2001)
- ⁶ Available on www.iied.org/mmsd/rrep/s_afr.html



Section One

A Framework for a “Blue-chip” Response to HIV/AIDS



Every organisation operating in Southern Africa is aware of HIV/AIDS and will have taken some steps to address the consequences of the epidemic in their organisation. These steps vary significantly – from ad hoc prevention activities to more considered responses, where the risks are analysed and dealt with in much the same way as other risks to an organisation’s operations.

Regardless of the approach your organisation has adopted, there will always be scope for improvement. The **Guide** is intended to support the development of improved HIV/AIDS competencies in organisations, at every level.

There are many ways to describe a comprehensive and optimal organisational response to HIV/AIDS. For the purpose of the **Guide**, a framework is used that clusters a number of interventions into one of three broad areas, namely:

- Management strategies;
- A workplace (or internal) programme, which has two main focuses; prevention, and care and support; and
- An outreach (or external) programme.

In striving for a “blue-chip” HIV/AIDS response, an organisation adopting this framework would set goals as follows:

Goal of the management strategies

To manage and mitigate the impact of the epidemic through a range of governance, assessment, surveillance, planning and monitoring strategies.

Goal of the workplace programme

To prevent new HIV infections and provide care and support for infected and affected employees.

Goal of the outreach programme

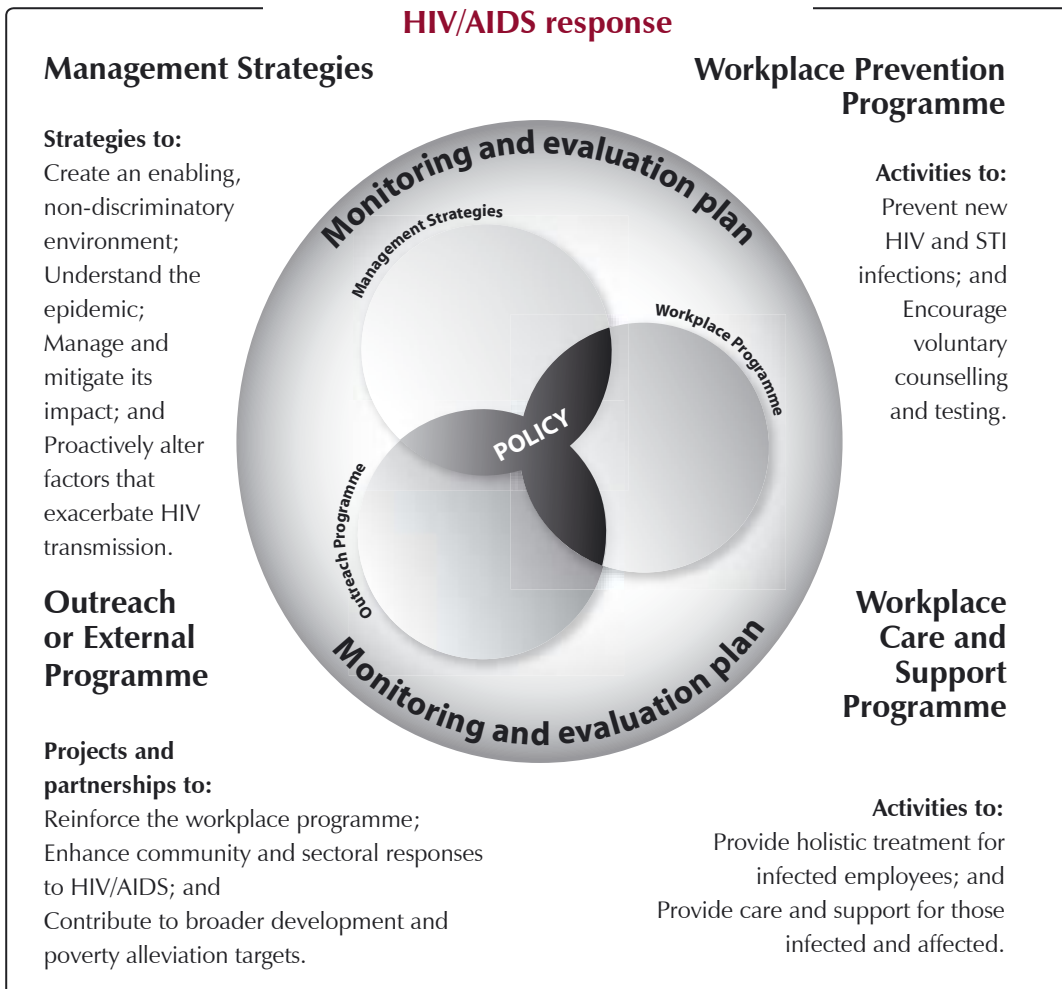
To contribute to broader community, sectoral and societal HIV/AIDS responses, in areas of comparative advantage.

It is important to stress three points:

1. That this categorisation does not mean that there is no interaction, or overlap between the three areas. In fact the opposite is true, as the following examples indicate:
 - The results of behavioural surveillance, such as knowledge, attitudes and practices (KAP) surveys (which appear in the **Guide** as a management strategy) are used to inform the content of workplace prevention programmes; and
 - Peer educators (part of a workplace programme in the **Guide**) frequently use their knowledge and skills in outreach activities with community groups.
2. That large and small organisations can do some, but not all of the same things, as part of their HIV/AIDS response. In many instances, however, where small organisations cannot tackle certain interventions on their own, they can achieve a great deal in partnership with larger organisations, or by finding other creative ways to achieve what large organisations may be able to achieve in more traditional ways.
3. There is no optimal sequencing of interventions, nor is it helpful to see an HIV/AIDS response as a linear process. What is important is that a response should consist of a selection of interventions, from all three areas of the framework, that are identified as priorities for your particular company and context.

The framework, upon which the **Guide** is based, can be depicted graphically as follows:

Framework for a comprehensive HIV/AIDS response





Section One

Roadmap Towards a “Blue-chip” Response to HIV/AIDS

List of elements of an HIV/AIDS response:

- Organisational HIV/AIDS audit
- Workplace HIV/AIDS policy
- Co-ordinator and workplace HIV/AIDS structure
- HIV/AIDS leadership and management commitment
- HIV/AIDS legal compliance
- Behavioural surveillance – the KAP survey
- Biological HIV surveillance
- HIV/AIDS risk and impact assessment
- Managing the human resource implications of the HIV/AIDS epidemic
- HIV/AIDS corporate social investment
- Prevention through behaviour change communication
- Peer education
- Condom promotion and distribution
- STI management
- Safe working environment
- Voluntary counselling and testing
- Prevention of mother to child transmission (of HIV)
- Wellness programme
- Highly active antiretroviral therapy (HAART) programme
- The greater involvement of people living with HIV/AIDS
- HIV/AIDS partnerships and collaborative relationships
- HIV/AIDS networks
- Community entry strategies for HIV/AIDS interventions
- Community outreach projects

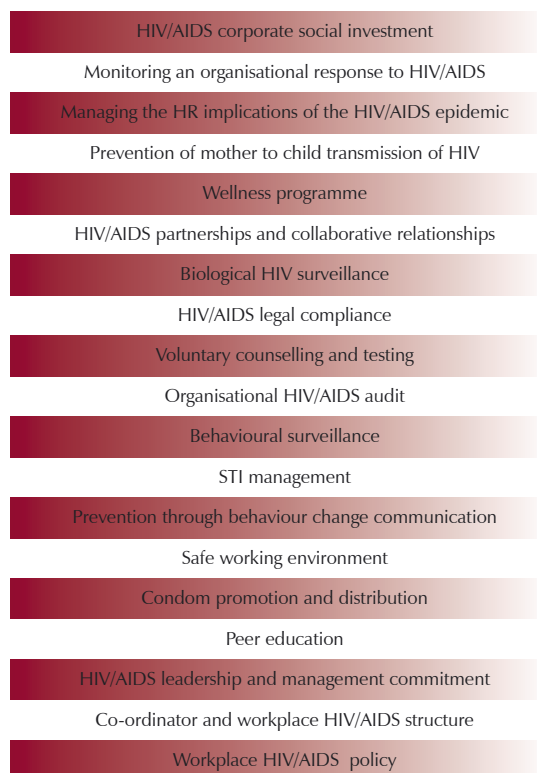
The roadmap, below, is a visual representation of the important elements of an HIV/AIDS response, and a way of positioning an organisation at a point along the road towards a “blue-chip” response to HIV/AIDS, based on the interventions in the **Guide**.

Create your own roadmap, with a selection and sequence of interventions that reflects the priorities that you have set for your HIV/AIDS response. Remember, there is more than one way to reach your destination.

 Blue-chip Response

 Good Response

 Minimal Response



Section One

Quick Reference for Contractors

In South Africa, contractors working on site at a mine are considered, in terms of the law, to be employees of the mine.

The reality for contracting companies

Contracting companies, throughout Southern Africa, whether they are large or small, differ from the mining companies they service in important ways, such as that:

- Union representation tends to be weaker;
- Few provide comprehensive benefits to their staff;
- Salaries are low, certainly lower than in the mining companies; and
- HIV prevalence is often higher amongst contractors than amongst permanent mine employees.

How would you describe your company, compared to the mining company/ies that you service?

These factors, and others, influence the extent to which a contracting company is vulnerable to the impact of the HIV/AIDS epidemic, and the nature of their response to the epidemic.

This quick reference, used in conjunction with the **HIV/AIDS Guide for the mining sector**, is intended as a tool to assist contractors, who are embarking on developing an HIV/AIDS response for their company, or who wish to take stock of their response in order to redirect or strengthen it.

1. Getting started

Answer the following questions – “yes”, “no” or “don’t know”. If the answer to either of them is “yes” or “don’t know” then proceed to the next part.

- Is the HIV/AIDS epidemic negatively affecting your business – in terms of staff turnover, declining productivity, increasing costs, changing markets etc?
- If no, do you believe the epidemic will negatively affect your business in the future?

2. Defining and quantifying the problem

So the HIV/AIDS epidemic **is** likely to impact on your business, but to what extent, and how important is it to understand and quantify the impact? Arguably very important as this will decide what you can and will do about it. So:

- Is there information available that you can use to create a detailed picture of the epidemic in your business? Go to **Managing the human resource implications of the HIV/AIDS epidemic** in the **Guide** for more information.
- Are there initiatives at the mining company that you can participate in, such as an HIV prevalence survey or a risk and impact assessment that will provide additional information? For details on these, go to **Biological HIV surveillance and HIV/AIDS risk and impact assessment** in the **Guide**.
- Having looked at the options, what is the best way to define and quantify the impact of the HIV/AIDS epidemic on your business?



3. Designing a response

The **Guide** sets out a wide range of interventions in three areas:

- Management strategies to manage the impact of the epidemic through governance, assessment, surveillance, planning and monitoring;
- A workplace programme to prevent new HIV infections and provide care and support for infected and affected employees; and
- Outreach activities within the community, sector, or broader society.

In designing your company’s HIV/AIDS response the ideal is to create a minimum but effective package of priority interventions. There are many opinions about what such a minimum package of interventions should consist of, such as the following:

Management strategies	<ul style="list-style-type: none"> • Workplace HIV/AIDS policy • Co-ordinator and workplace structure • HIV/AIDS leadership and management commitment
Workplace programme (prevention, and care and support)	<ul style="list-style-type: none"> • Prevention through behaviour change communication • Peer education • Condom promotion and distribution • Voluntary counselling and testing (VCT) (linked to a wellness programme) • Safe working environment
Outreach or external response	<ul style="list-style-type: none"> • HIV/AIDS partnerships and collaborative relationships

The chances are that you already have some interventions in place, or have tried them at some point, and confirming these as part of the package is a good place to start. The **Organisational HIV/AIDS audit** in the **Guide** can be used to evaluate your past responses against a model response.

In addition, use the audit to determine who else is providing the interventions, as there may be partnership possibilities. For example, VCT is an important intervention, but it is rarely feasible for a contractor to set up and run a VCT service. Instead, if there is a service on the mine, or in the local community, you may be able to negotiate access for your employees to this service.

From the list in the table below, mark the interventions that will constitute your workplace HIV/AIDS programme, indicating those you will implement in-house, those you will outsource, and those which you will implement in partnership with a mining company or local agency, such as a clinic.

Intervention	What		How		
	Yes	No	In-house	Out-sourced	In Partnership
Prevention through BCC					
Peer education					
Condom promotion and distribution					
STI management					
Voluntary counselling and testing					
Prevention of mother to child transmission					
Wellness programme					
Highly active antiretroviral therapy programme					

Finally, remember when designing your response to include:

- Your information needs;
- Mechanisms for implementation, such as an HIV/AIDS committee;
- Engagement with social partners and other significant stakeholders;
- Any requirements, legal or contractual, that have HIV/AIDS implications;
- Cost estimations for each intervention; and
- Systems to monitor the response.

4. Adopting a policy or framework for implementation

Some form of workplace HIV/AIDS policy, whether it be a policy statement, a set of principles or a formal policy is invaluable as a framework or reference for decision making and implementation. Refer to the **Workplace HIV/AIDS policy** in the **Guide** and define the process you will use to develop a policy or framework to guide your HIV/AIDS programme.



5. Implementing your response

Whether it is the formation of an HIV/AIDS committee, starting a peer education programme, strengthening a condom promotion and distribution activity, or any other intervention, there is no need to reinvent the wheel. A couple of decades of experience have clearly defined the critical elements of these interventions, and information about them and tools that can be used, can be found in the **Guide**.

If you experience problems finding resources or service providers, or you need help with particular interventions, look for solutions within your immediate network. Failing this, check the **Guide** and the additional sources of information listed at the end of each intervention, as well as those in Appendix Four.

6. Monitoring your response

Decide what you will monitor, why and how and what you will report on, why and when. Using this information, create a simple and functional monitoring system and make it a part of your existing monitoring systems.

Section One

Template for Customising the Guide

The **Guide** will always be more useful if it has been adapted to suit the context of each organisation. These organisations may be in sectors other than mining, e.g. transport, construction, agribusiness etc., or they may be operating in Regions other than Southern Africa.

The following template identifies those areas where adaptations are most likely to be required.

Section One: HIV/AIDS Guide for the Mining Sector: What, Why and How?

What is the HIV/AIDS Guide for the mining sector?	Change focus from the mining sector to your sector
Why was the Guide developed?	Add the rationale for why your sector requires priority attention
Overview of the Guide : format of the sub-sections or interventions	Amend the score card to reflect a rating system with which you are familiar Replace the red ribbons with symbols that apply to your sector and/or geographical area
The mining sector and the HIV/AIDS epidemic <ul style="list-style-type: none">• The HIV/AIDS epidemic in Southern Africa• HIV/AIDS and the mining sector in Southern Africa	Replace this information with background information about: <ul style="list-style-type: none">• The HIV/AIDS epidemic in your Region• The interactions between your sector and the HIV/AIDS epidemic
Framework for a “blue-chip” response to HIV/AIDS	Change the “blue chip” concept to something that relates to your sector
Roadmap towards a “blue-chip” response to HIV/AIDS	



Section Two: Management Strategies

- Organisational HIV/AIDS audit
- Workplace HIV/AIDS policy
- Co-ordinator and workplace HIV/AIDS structure
- HIV/AIDS leadership and management commitment
- HIV/AIDS legal compliance
- Behavioural surveillance – the KAP survey
- Biological HIV surveillance
- HIV/AIDS risk and impact assessment
- Managing the human resource implications of the HIV/AIDS epidemic
- HIV/AIDS corporate social investment

In all the management strategies:

- Delete examples, in boxes, that do not relate to your sector, and replace with ones that are more relevant
- Review the “Red flags and special challenges” and add/amend/delete to more closely reflect the reality in your sector
- Change the score cards to the format you have decided upon and have described in Section One
- Under “Costs”, add any cost-related information for your sector
- Replace the case studies with case studies from your sector
- Delete non relevant information from the “Additional information” box and add sources of information from your sector and/or Region

Section Three: Workplace HIV/AIDS Programme



- Prevention through behaviour change communication
- Peer education
- Condom promotion and distribution
- STI management
- Safe working environment
- Voluntary counselling and testing
- Prevention of mother to child transmission (of HIV)
- Wellness programme
- Highly active antiretroviral therapy (HAART) programme

Conduct the same review as for the management strategies, ensuring that the information is grounded in the reality of your sector, e.g. the extent to which health services – for STI management, PMTCT and wellness programmes – are available to employees

The provision of antiretroviral therapy to infected employees is becoming increasingly more commonly available in many sectors. When amending the **Guide**, make sure that this section most accurately reflects the current situation in your sector



Section Four: External or Outreach Response

- The greater involvement of people living with HIV/AIDS
- HIV/AIDS partnerships and collaborative relationships
- HIV/AIDS networks
- Community entry strategies for HIV/AIDS interventions
- Community outreach projects

Conduct the same review as for the management strategies and workplace programme, ensuring that the information is grounded in the reality of your sector, e.g. the particular features of your sector will dictate how the sector interacts with the communities in which it operates

Section Five: Measuring and Monitoring an HIV/AIDS Response

Monitoring, evaluating, and recording and reporting an organisation's response to HIV/AIDS

Add/amend/delete information so that this section is relevant to your sector. For example, you may operate in areas where other systems than the NOSA standards and certification are used. If your system has any HIV/AIDS-related standards, these should be documented here.

Appendices

Appendix One:
Comparative country data

Remove and replace (if required) with information that is relevant to your Region

Appendix Two:
Fact sheet on the mining sector in Southern Africa

Remove and replace with information that is relevant to your sector

Appendix Four:
Resources, references and contacts

Add/amend/delete with information relevant to your Region and sector

Appendix Five:
Glossary

Add/amend/delete to reflect terminology used in your Region and sector



Section Two

Management Strategies

Section Two contains a number of **management strategies**. The goal of the management strategies is to manage and mitigate the impact of the epidemic on an organisation through a range of governance, assessment, surveillance, planning and monitoring interventions.

These are:

- Conducting an organisational HIV/AIDS audit;
- Developing a workplace HIV/AIDS policy;
- Appointing an HIV/AIDS Co-ordinator and putting a workplace HIV/AIDS structure in place;
- Demonstrating HIV/AIDS leadership and management commitment;
- Ensuring HIV/AIDS legal compliance;
- Conducting or commissioning behavioural surveillance – the KAP survey;
- Conducting or commissioning biological HIV surveillance – the prevalence survey;
- Conducting or commissioning an HIV/AIDS risk and impact assessment;
- Managing the human resource implications of the epidemic; and
- Corporate social investment that prioritises HIV/AIDS.

Unlike the virus, we have not been aggressive enough. Unlike the virus, we have not been integrated and comprehensive in our strategies. Unlike the virus, we have not been unrelenting in our commitment.

*Graca Machel
at the International AIDS
Conference in Barcelona (2002)*

Section Two

Organisational HIV/AIDS Audit



Briefing Note

What is an organisational HIV/AIDS audit?

An organisational HIV/AIDS audit is a process that provides a “snap shot” of the organisation’s HIV/AIDS programme at a certain point in time.

Why does an organisation need to conduct HIV/AIDS audits?

It is necessary to conduct regular audits in order to track progress over time from a base-line position. In the absence of regular audits, organisational responses tend to be “spray and pray” as opposed to well-considered, planned responses that build on the current reality and past achievements.

Contractors should also conduct base-line and then regular audits, as this is one way of ensuring that resources are targeted and used optimally. Circumstances will dictate if it is preferable to conduct the audit of their own organisational response, or whether to participate in the audits of larger companies with whom they are partnering in joint HIV/AIDS programmes.

What are the elements of an organisational HIV/AIDS audit?

An organisational audit consists of two main components:

1. A descriptive component that:

- Describes the macro-environment within which the organisation operates, including the status of the HIV/AIDS epidemic, and the dynamics that drive the epidemic;
- Describes the organisation’s operations, in terms of its vulnerability to the impact of HIV/AIDS; and
- Provides a profile of the workforce, specifically focusing on factors that may be linked to susceptibility to HIV infection.

2. An analytical component that:

- Critically assesses the organisation’s HIV/AIDS programme, in terms of best practices in the sector and progress against plans; and
- Identifies areas for remedial action and those activities that should be included in the programme in the future.





Red Flags and Special Challenges

Too often an audit is done by a single person, such as a Human Resource Manager, and the chances are that there will be areas and interventions where he/she does not have sufficient in-depth knowledge to do them justice. For an audit to be optimal, a multidisciplinary team – with policy, planning, legal, industrial relations (IR), human resources (HR), health, HIV/AIDS and community outreach experience – should be involved right from the development stage, as well as during the actual audit process. Alternatively, there are a number of organisations that offer HIV/AIDS audits as one of the menu of HIV/AIDS-related services they offer to the private sector.



Tool: Template for an organisational HIV/AIDS audit

Instructions

Use this template to develop an audit tool that is appropriate for your organisation. It is important to invest time and effort in developing a tool that can be used over and over, as this will allow for comparisons to be made when future audits are done.

Decide if the audit will include non-employees working on site, either short-term or long-term. Often company HIV/AIDS programmes are extended to such groups, like contractors, and it is then advisable to include them in the audit.

Constitute a small multidisciplinary team to conduct the audit.

This tool can also be used to monitor an organisation’s HIV/AIDS response, as indicators can be developed related to each of the elements. Different categories under the “STATUS” column could be defined, for example: “non-existent”, “in place” and “evaluated”.

Management strategies

Element	Description	Status
Policy	An HIV/AIDS policy describes the company’s commitment to addressing the epidemic. Monitoring and review mechanisms are institutionalised.	
HIV/AIDS Co-ordinator and structure	Co-ordinator is appointed and structure established with responsibility for planning and implementing the policy and programme, as well as for monitoring and reporting. Depending on the size and distribution of company operations, committees exist at business unit level. Work plan is developed and costed annually.	

Element	Description	Status
Governance, leadership and commitment	<p>HIV/AIDS is a strategic priority.</p> <p>Board member is responsible for reporting on the programme.</p> <p>Strategic decision-making on HIV/AIDS is done at Board level, including decisions on mechanisation, outsourcing, market changes and modifying risk situations, such as hostel accommodation.</p> <p>HIV/AIDS budget is a line item in all business unit budgets.</p> <p>HIV/AIDS KPAs are included in all management JDs and performance appraisals.</p> <p>Corporate social investment (CSI) funds earmarked for HIV/AIDS projects.</p>	
Legal compliance and personnel issues	<p>Review of company policies ensures compliance with relevant laws.</p> <p>HR guidelines cover recruitment, confidentiality and disclosure, protection against discrimination, access to training, promotion, benefits, performance management, grievance procedures and reasonable accommodation.</p> <p>Disciplinary procedures are in place and enforced in instances of breach of confidentiality and discrimination.</p>	
Surveillance and impact assessment	<p>HIV prevalence survey is commissioned and results are used to inform an impact assessment.</p> <p>Employment data is analysed on an on-going basis and trends are reported regularly to management.</p> <p>Analysis of costs (direct and indirect costs) is done on an annual basis.</p> <p>An impact assessment is commissioned, or conducted in-house with models/scenarios developed for the future.</p> <p>Management information system (MIS) is modified (if necessary) to capture and provide HIV/AIDS-related information.</p>	
Skills succession plan	<p>Critical positions have been identified, and interventions put in place that include multiskilling, shadowing, mentoring and bursary provision for students acquiring the necessary technical qualifications.</p>	



Workplace/internal programme

Element	Description	Status
HIV/AIDS prevention activities	<p>Knowledge, attitudes and practices (KAP) survey conducted regularly, to inform the programme and to monitor trends.</p> <p>Awareness activities, using varied techniques, are scheduled on an on-going basis, according to an agenda of priority issues.</p> <p>Training on HIV/AIDS is conducted for managers.</p> <p>HIV/AIDS is included in induction courses.</p> <p>Contractors participate in prevention activities.</p>	
Peer education	<p>Peer educators are identified, and receive initial and on-going training.</p> <p>Peer educators conduct informal sessions weekly.</p>	
Condom promotion and distribution	<p>Condom promotion activities take place regularly.</p> <p>Male condoms are available free of charge, or dispensed for a subsidised fee, from the company clinic and in every toilet facility in the company.</p> <p>Female condoms are available free of charge, or dispensed for a subsidised fee, in all female toilets.</p> <p>Condom uptake is monitored.</p>	
STI management	<p>STI health-seeking behaviours are regularly promoted.</p> <p>STI services are accessible, on site, or at health facilities in the community.</p> <p>STI trends are monitored.</p>	
Voluntary counselling and HIV testing	<p>VCT is promoted on a regular basis.</p> <p>VCT services are accessible, on site, or at agencies in the community.</p> <p>VCT uptake is monitored.</p> <p>HIV/AIDS counsellors are identified, trained, and mentored.</p>	
Infection control	<p>Equipment and training is provided for first aiders according to workplace legislation.</p> <p>Protocol for managing occupational exposure is operational.</p> <p>Starter packs for post exposure prophylaxis (PEP) are available.</p>	

Section One

Section Two

Section Three

Section Four

Section Five

Appendices

Contributors

Element	Description	Status
Wellness programme	<p>Company wellness programme is promoted.</p> <p>Infected employees who enrol in the programme receive nutritional advice and supplements, immune supporting medications, prophylaxis and treatment for opportunistic infections.</p> <p>When appropriate, infected employees, and their immediate dependents, who are also infected, receive highly active antiretroviral therapy (HAART) and medical monitoring.</p> <p>Terminally ill employees, who are dismissed due to incapacity, are referred to community services, such as home-based care (HBC) services.</p> <p>On-going counselling is offered on site, as a dedicated service, or as part of the Employee Assistance Programme (EAP).</p> <p>PMTCT services are available to female employees and the partners/spouses of employees, on site or in the community.</p>	

Outreach/external programme

Element	Description	Status
Partnerships	<p>Partner/stakeholder analysis is conducted.</p> <p>Company is member of business forum that deals with HIV/AIDS.</p> <p>Business partners and contractors are engaged in relation to their own HIV/AIDS programmes.</p> <p>Engagement with local public health providers, and other relevant government departments is on-going.</p> <p>Supplier HIV/AIDS compliance requirements are advertised and enforced.</p> <p>PLWHAs are involved in workplace and outreach activities.</p>	
Development and community HIV/AIDS projects	<p>Company regularly participates in meetings and activities of local multisectoral HIV/AIDS network.</p> <p>Identified staff are trained to work at community level, and are accountable for community-based HIV/AIDS activities.</p> <p>Involvement of peer educators in community HIV/AIDS projects is supported.</p> <p>Company resources are shared with NGOs and CBOs, to strengthen community HIV/AIDS initiatives.</p>	



IFC, in conjunction with Unilever and the Private Investors for Africa (PIA) HIV/AIDS Working Group developed a Corporate Road Map on HIV/AIDS, which is available in the IFC's Good Practice Note: HIV/AIDS in the workplace¹ (see also Appendix Three).

Programme items are listed under 3 headings:




- Awareness, education and prevention;
- Treatment and care; and
- Monitoring and leveraging the programme.



Score Card: Organisational HIV/AIDS audit

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Once-off SWOT analysis of HIV/AIDS programme conducted by HIV/AIDS Committee • Bi-annual review conducted by HR Manager and reported to the Management Committee 		
 Good Response	<ul style="list-style-type: none"> • Comprehensive audit conducted annually • Findings and recommendations presented to the corporate governance body (Board, Proprietors, Managing Partners, etc.) • HIV/AIDS plan amended in light of findings and recommendations 		
 Blue-chip Response	<ul style="list-style-type: none"> • Multi-disciplinary team conducts annual audit of HIV/AIDS programme • Audit report constitutes an input into annual planning and budgeting process • Summary of findings published in company newsletter 		

Costs

There may be costs associated with modifying existing information systems to capture data for the audits. Otherwise there are not likely to be significant costs associated with conducting an organisational HIV/AIDS audit, except in terms of the time of personnel.



Case Study: An organisational HIV/AIDS audit - Unilever

Unilever developed an HIV/AIDS checklist that can be used to audit an organisational HIV/AIDS response. The interventions are clustered into five main areas:

- Policies, responsibilities and management;
- Awareness, education and prevention;
- Treatment and care;
- Impact assessment; and
- External interactions and contributions.

The following table includes all interventions in the “Policies, responsibilities and management” area.

Policies, responsibilities and management

Programme Item	Description	Status	Rating
Policy statement	'A public' policy statement endorsing the company's commitment in respect of HIV/AIDS for internal briefing and, on request, provision to third party.	In draft	*
		Formally adopted	**
		Annual review	***
Board level programme responsibility	The company Board should be clearly identified with the programme, with a Board member formally responsible. Quarterly Board review of the programme and associated strategic decisions.	Board level sponsor/ champion	*
		Board member directly responsible	**
		Quarterly Board review	***
HIV/AIDS committee	Company/National committee responsible for developing the detail of policies and programmes and for on-going review of progress, reporting back to the Board. Dependant upon company size and geography, subordinate committees should be in place for units of >200 people.	Company committee appointed	*
		Company committee meeting quarterly	**
		Unit HIV/AIDS committees appointed	***
Management guide	This document should provide the detail of the HR response to HIV/AIDS. What should and should not be done in respect of employees with HIV/AIDS. May be based upon adoption of third party best practice documents.	In draft or 3 rd party guide adopted	*
		Own guide formally adopted	**
		Annual review	***



Training modules	HIV/AIDS education should be a component for all new employee induction programmes and there should be a training module for managers.	Employee induction module	*
		Plus management training module	**
		Plus >50% managers through training	***
Targeting of high risk groups	High risk groups, such as long-distance drivers and migrant workers should be targeted (for prevention services).	Analysis to identify groups completed	*
		Programmes for these groups in place	**
		>50% trained or analysis has confirmed no specific high risk group in company	***



Case Study: An HIV/AIDS audit for contractors - Finsch Mine

Finsch Mine, a De Beers operation in the Northern Cape Province of South Africa, took part in the piloting of the **HIV/AIDS Guide for the mining sector** during the period February to August 2004. This involved an assessment of the contractors' HIV/AIDS programmes and of their participation in the Finsch Mine HIV/AIDS programme.

Five (5) of the biggest contractors were identified in terms of the length of their contracts as well as the number of employees on site. Their contracts ranged from 5 years to 10 years to indefinite contracts.

An audit was conducted using a questionnaire that was distributed to the management of the 5 contracting companies. Meetings were then arranged with some of the management of the contracting companies to clarify certain issues.

Contractor information

- Total number of contractors on site: 1 369.
- Contractors with the highest number of employees on site:

Contract company #1	298 employees
Contract company #2	209 employees
Contract company #3	170 employees
Contract company #4	137 employees
Contract company #5	164 employees

- Almost no contract employees had access to medical aid benefits except for management and those with administration duties.
- The nearest community health clinic that offered free health services was 25km away in Danielskuil. Alternatively, a contractor employee could go to a local private doctor.

Contractors' HIV/AIDS audit questionnaire

The aim of the audit was to establish a baseline of all HIV/AIDS programmes amongst the participating contractors to ensure the optimum use of resources, to identify gaps and then to decide on possible interventions.

The questionnaire covered:

- An HIV/AIDS policy – on site and/or at Head Office;
- An assessment of how effective the policy was on site;
- HIV/AIDS peer educators on site;
- Their training – when and by whom;
- An assessment of how active the peer educators were;
- If they attended the monthly peer educator meetings;
- If they were conducting sessions with fellow employees;
- If they were participating in campaigns; and
- If employees had ever participated in any of the mine's VCT campaigns or group counselling sessions.

Results of the audit

The findings included that:

- Only one of the participating contractors had an HIV/AIDS policy at Head Office level, but not on site;
- The others did not have a policy, either at Head Office or on site;
- One contractor had previously had peer educators, but, due to separation, they had left the employment of the contractor;
- The peer educators had also not been active after their training;
- A second contractor did not have any peer educators on site;
- The other contractors did not understand what peer education was;
- Although all five contractors had participated fairly well in previous VCT campaigns and HIV prevalence surveys organised by Finsch Mine, their management was not clear of the benefits of having an HIV/AIDS management strategy.

Recommendations

- Contractors that have HIV/AIDS policies at Head Office must follow these guidelines;
- Contractors who do not have a policy must have one or automatically become part of the Finsch Mine policy;
- Master trainers must be trained to train peer educators in-house;
- Primary health care issues must be addressed between contractor company managers, Finsch Mine management and the responsible trade unions;
- An HIV/AIDS centre must be established in the contractor hostel to facilitate access to HIV/AIDS-related services;
- A forum must be created where contractors can participate as equal partners in HIV/AIDS programmes;
- All contractors must have peer educators on site as per agreed ratio (1:40) depending on the number of employees on site;





- Contractor peer educators must attend monthly peer educator meetings during working hours;
- A Health Educator must act as a link between the contractors and relevant government departments on issues such as STI treatment and the ART programme; and
- Safety representatives from the contractors must double as peer educators to ensure efficiency.

Conclusion

From the audit it became clear that contractors had no processes or structures in place to address HIV/AIDS issues. The Head Office policies were concerned with permanent employees, neglecting the employees who work on contract.

The level of understanding and participation was low, but there were many opportunities for the mine and contractors to work towards the same goals. The reality of contractors in the South African economy has to be addressed by all sectors that make use of contract labour.

The audit highlighted gaps and opportunities. The approach will have to include all stakeholders such as contract owners/site managers, contract employees, mine structures (such as Health and Safety and Occupational Health), the Department of Health, employee representative bodies and the local community.



Additional Information

For the full Unilever checklist, go to www.weforum.org/globalhealth/cases.

The NOSA AMS (HIV/AIDS Management System) can be used to conduct an organisational HIV/AIDS audit. The tool is available on www.nosa.co.za.

A generic HIV/AIDS competency assessment framework has been developed by UNAIDS that can be used by any group (whether a nation, district, organisation or community). For further information, contact Geoff Parcell at parcellg@unaids.org.

Techniques for assessing institutional vulnerability are included in the UNAIDS publication, *Guidelines for studies of the social and economic impact of HIV/AIDS* (2000), available on www.unaids.org.

Footnotes



¹ Available on www.ifc.org/ifcagainstaid

Section Two

Workplace HIV/AIDS Policy



Briefing Note

What is a workplace HIV/AIDS policy?

A workplace HIV/AIDS policy defines an organisation's position on HIV/AIDS and spells out the way in which the organisation will deal with the epidemic. Like other organisational policies, a workplace HIV/AIDS policy must be an integral part of the organisation's HIV/AIDS management system, informing the continuous process of planning, implementing, reviewing and improving the processes and actions required to meet the policy goals and targets¹. And, like other organisational policies, it is critical that the workplace HIV/AIDS policy is developed with full participation of the unions.

Key elements of a workplace HIV/AIDS policy

- Addresses stigma and discrimination;
- Confidentiality for infected workers;
- Management response to the epidemic;
- Workplace programmes; and
- Benefits, including treatment and care.

Why does an organisation need a workplace HIV/AIDS policy?

There are many sound reasons why an organisation needs to develop a workplace HIV/AIDS policy. These include that:

- It sends a strong message that HIV/AIDS is a serious workplace issue, and that there is commitment to dealing with it as such;
- It provides a framework for consistency of practice and a foundation for the workplace response activities;
- It protects rights and specifies responsibilities related to HIV/AIDS, equity, non-discrimination and fair labour practices;
- It sets standards of behaviour expected of employers and employees;
- It informs infected and affected employees of assistance that is available;
- It sets standards of communication about HIV/AIDS;
- It ensures consistency with national and international legislation and good practices;
- It involves external stakeholders (customers, clients, suppliers and contractors); and
- It provides a framework for monitoring the workplace HIV/AIDS response.



Contractors are also encouraged to embark on an HIV/AIDS policy development process, or, alternatively, to participate in a sector-wide policy process that will provide them with an enabling framework for their HIV/AIDS programme. A third option is for a contracting company to adopt the policy of the mining company with which it is working.

What should a workplace HIV/AIDS policy contain?

A workplace HIV/AIDS policy should include the following:

Introduction

- Reason(s) why the company has an HIV/AIDS policy;
- The context within which the company operates and that affect the policy;
- Persons covered by the policy (some or all employees and any different provisions for different categories of employees, contractors, etc.);
- Policy compliance with international and national laws and regulations, and trade and/or union agreements; and
- How the policy will be applied.

General considerations

- Statement regarding the intent of the company to have an HIV/AIDS policy for application to company operations;
- Statement of the goal and objectives of the HIV/AIDS policy;
- Statement as to whether the policy is specific to HIV/AIDS or whether it incorporates HIV/AIDS into existing sections on life-threatening illnesses.

Principles

Policies entrench principles as part of an organisation's ethos. A workplace HIV/AIDS policy must reflect a set of principles that are consistent with national and international laws and that describe the organisation's stated position on a range of issues. Typically these are statements that every employee has the right to:

- Equality – in terms of pre-employment practices, promotion, training and access to benefits;
- Non-discrimination and acceptance regardless of HIV status;
- Privacy and confidentiality of medical information; and
- Protection from unfair dismissal.

Structure

This should describe the governance structure that the company will put in place to plan, co-ordinate, implement and monitor the HIV/AIDS response.

Roles and responsibilities

The roles and responsibilities that should be defined in the policy include that:

- HIV/AIDS prevention is the responsibility of all employees, including senior management, supervisors and unions, and that everyone has responsibilities for maintaining an environment that reinforces safe sexual behaviours;
- Managers and employee representatives should play a leadership role in addressing HIV/AIDS, both in the company and in the wider community;
- The company and union/s have responsibilities for providing all employees with timely, accurate, clear and adequate information about HIV prevention, community support services, treatment options and changes in company HIV/AIDS activities; and
- Partners and stakeholders have a responsibility to support and/or participate in achieving the goals of the policy and programmes.

Programme elements

The policy should reflect the framework of interventions that will constitute the organisational response. Typically these will fall into three main categories:

- Management strategies, including employment and personnel issues;
- Workplace or internal activities – prevention, treatment, care and support for employees; and
- Outreach or external activities.

1. Management of the HIV/AIDS epidemic within the company

1.1 The policy should include provision for assessing the impact of the HIV/AIDS epidemic on the company – the human resources, productivity and cost implications – and then procedures to plan prevention and mitigation strategies in response to this evidence.

1.2 The policy should cover all personnel issues, such as:

- Job access;
- Job security;
- HIV testing (no screening for HIV as a condition of recruitment, continued employment, training or promotion);
- Confidentiality and disclosure;
- Protection against discrimination;
- Employee benefits (pension/provident, medical, compassionate leave, death benefits);
- Access to training, promotion, benefits;
- Performance management;
- Grievance procedures; and
- Reasonable accommodation of incapacitated employees.

1.3 The policy should also refer to others that may be in place or in development addressing related issues, such as migrancy, living conditions, etc.

2. Workplace programme

The policy should define the parameters of the workplace programme, which should contain (i) prevention activities and (ii) treatment, care and support activities.

2.1 HIV/AIDS prevention activities should include:

- Awareness activities and support for behaviour change, including condom promotion and distribution;
- Training around prevention, across all levels and from induction to in-service training;
- Peer education;
- VCT;
- STI management; and
- A safe working environment and compensation if infected with HIV as a result of an injury at work.

2.2 Treatment, care and support for HIV infected and affected employees should cover:

- Wellness management, including provision of or assistance in gaining access to life-saving treatments and drugs for HIV and opportunistic infections;
- Counselling and related social and psychological support services for HIV infected and affected employees (and dependents), including support groups and post-test clubs;





- Legal support services for employees (in-house or contracted out) to access legal advice for assistance in safeguarding dependents through the preparation of wills, transfer of property and leveraging of social services (e.g. grants);
- Links with other workplace programmes; and
- Links with and referrals to other agencies.

3. External/community outreach activities

The policy should cover external activities such as:

- Partnerships to enhance broader HIV/AIDS responses;
- Participation in networks of stakeholders responsible for HIV/AIDS-related activities, projects and programmes; and
- Participation with external stakeholders in the common goals of preventing new infections and mitigating the impact of the epidemic.



Red Flags and Special Challenges

The following questions are commonly asked regarding workplace HIV/AIDS policies.

What sort of workplace HIV/AIDS policy should I select?

The decision as to whether your workplace HIV/AIDS policy should be a stand-alone HIV/AIDS policy or integrated into a broader life-threatening illness or disability policy, or a short and succinct statement of intent that is referenced to other organisational policies are decisions that are context-specific, and depend primarily on the precedents that have been set for your organisation in the past. Having said that, most organisations opt for a stand-alone workplace HIV/AIDS policy. This allows for specific issues, such as non-discrimination, to be directly addressed.

NOTE: A multinational company may issue a workplace HIV/AIDS policy to all its operations with instructions that it forms the basis for the development of operation-level policies.

Policy or programme – which comes first?

There are no specific rules about sequence, both are necessary and both are not set in stone and should change over time. The recommendation is that initiating a workplace programme should not wait on the completion of a policy development process, which may take many months, instead the adoption of a set of principles or a policy statement can guide the workplace programme in the absence of a formal policy.

Should the policy be restricted to the workplace, or should it be broader, covering customers, suppliers, partners, surrounding communities?

No organisation is an island and workplace HIV/AIDS policies should also define the context for your organisation's commitment to and involvement in broader external or outreach HIV/AIDS activities.

NOTE: Some policies are sector-wide, binding all organisations belonging to the sector, e.g. the transport sector in South Africa.

Should the policy be accompanied by operational or implementation guidelines?

Yes, policies, by their nature are not detailed. A policy is the WHAT and the guidelines will provide the HOW. The guidelines will facilitate implementation, and can also be useful when developing annual work plans and preparing budgets for the activities.

It's overwhelming, where does one start?

One of the greatest challenges following a successful policy development process is to translate the policy into implementation. It is not necessary, in fact probably not possible, to implement all aspects of a workplace HIV/AIDS policy immediately. Start with the obvious and easier elements and add on others over time.

What will it cost?

Many companies delay embarking on their workplace HIV/AIDS policy process, because of fears of what the cost implications will be. Whilst it is true that there will be costs associated with implementing the policy, there are many cost benefits to early, proactive action, whereas delaying the process can have the opposite effect.

Focusing on stigma and discrimination

Strategies to address stigma are critical for HIV/AIDS programmes – in the workplace and beyond – to be effective. Like gender, stigma reduction should be mainstreamed into every aspect of workplace HIV/AIDS policies, programmes and practices.

- **Stigma** is the holding of derogatory social attitudes or cognitive beliefs, a powerful and discrediting social label that radically changes the way individuals view themselves or the way they are viewed by others.
- **Discrimination** is an action based on a pre-existing stigma; a display of hostile or discriminatory behaviour towards members of a group, on account of their membership of that group.

Stigma is a process that is not random, but systematic, reinforcing existing divisions in society. HIV-related stigma takes many forms – rejecting, isolating, blaming and shaming, etc. Stigma hurts people living with HIV and AIDS and those suspected of being HIV infected. It frequently leads to discrimination and violation of human rights.

The language we use

Powerful metaphors related to HIV and AIDS reinforce stigma and create a *sense of otherness*. Words, like “promiscuous”, assign shame and blame and set a moral tone that reinforces the notion of “them” and “us”. Words such as “victim”, “AIDS carrier” and “sufferer” stigmatise PLWHA and create images of powerlessness. Prejudices are perpetuated by media portrayals of HIV infected persons as helpless and hopeless. Media reporting of HIV/AIDS has also used the language of guilt versus innocence, and the metaphors of war and plague, which compound irrational fears and prejudices.

Causes of stigma

The causes of stigma are multiple and include:

- Ignorance or insufficient knowledge, and misbeliefs and fears about HIV/AIDS;
- Moral judgements about people and assumptions about their sexual behaviour;



- Associations with “illicit” sex and/or drugs;
- Fears of death and disease; and
- Links with religion and the belief that HIV/AIDS is a punishment from God.

Types of stigma

Different forms of stigma have been described, such as:

- **Self-stigma** – e.g. self-hatred, shame, blame;
- **Felt stigma** – perceptions or feelings towards a group, such as PLWHAs, who are “different” in some respect or other; and
- **Enacted stigma** – or actions based on stigma, which is commonly referred to as discrimination.

Stigma and discrimination in the workplace

There are many forms of HIV/AIDS-related stigma and discrimination occurring in workplaces across the world, with perhaps the most prominent discrimination being termination of employment or refusal to offer employment, based on an employee’s actual or assumed HIV status. Other discriminatory practices involve:

- Unequal training and/or promotion opportunities, based on HIV status;
- Inconsistent or absent practices to deal with instances of HIV/AIDS-related discrimination; and
- Breaches of confidentiality, regarding an employee’s HIV status.

The effects of stigma and discrimination in the workplace can be very disruptive. For example:

- They can negatively affect worker morale;
- They can result in reduced productivity;
- They can compromise employee health, in instances where stigma constitutes a barrier to access to treatment and care;
- They can even result in the loss of manpower, if infected employees leave; and
- They will certainly undermine HIV/AIDS prevention programmes.

Addressing stigma and discrimination in the workplace

Workplace strategies to address stigma and discrimination should include the following:

- Conduct an HIV/AIDS policy analysis to assess the extent to which policies address (or perhaps reinforce) HIV/AIDS-related stigma and discrimination;
- Inform employees of HIV/AIDS stigma mitigation policies and practices, so that there is widespread understanding of the consequences of discriminatory behaviour;
- Mainstream HIV/AIDS stigma mitigation policies into other functions, such as into communication strategies and into strategic plans;
- Protect the rights of employees who are infected or assumed to be infected with HIV, and act decisively when cases of stigma and discrimination do occur;
- Encourage sensitivity and understanding among co-workers regarding HIV/AIDS issues;
- Encourage HIV infected employees to disclose their HIV status, within a safe, accepting and supportive environment;
- Provide managers at all levels with clear guidance on which they can base managerial decisions when confronted with issues relating to HIV/AIDS;
- Ensure that mechanisms are in place to protect the confidentiality of information related to employees’ health, including their HIV status;

- Actively involve PLWHAs in workplace HIV/AIDS activities;
- Integrate reporting on cases of stigma and stigma reduction activities into mainstream reporting; and
- Monitor the implementation of HIV/AIDS policies, including stigma mitigation aspects of these policies, and monitor interventions for their sensitivity in relation to stigma.



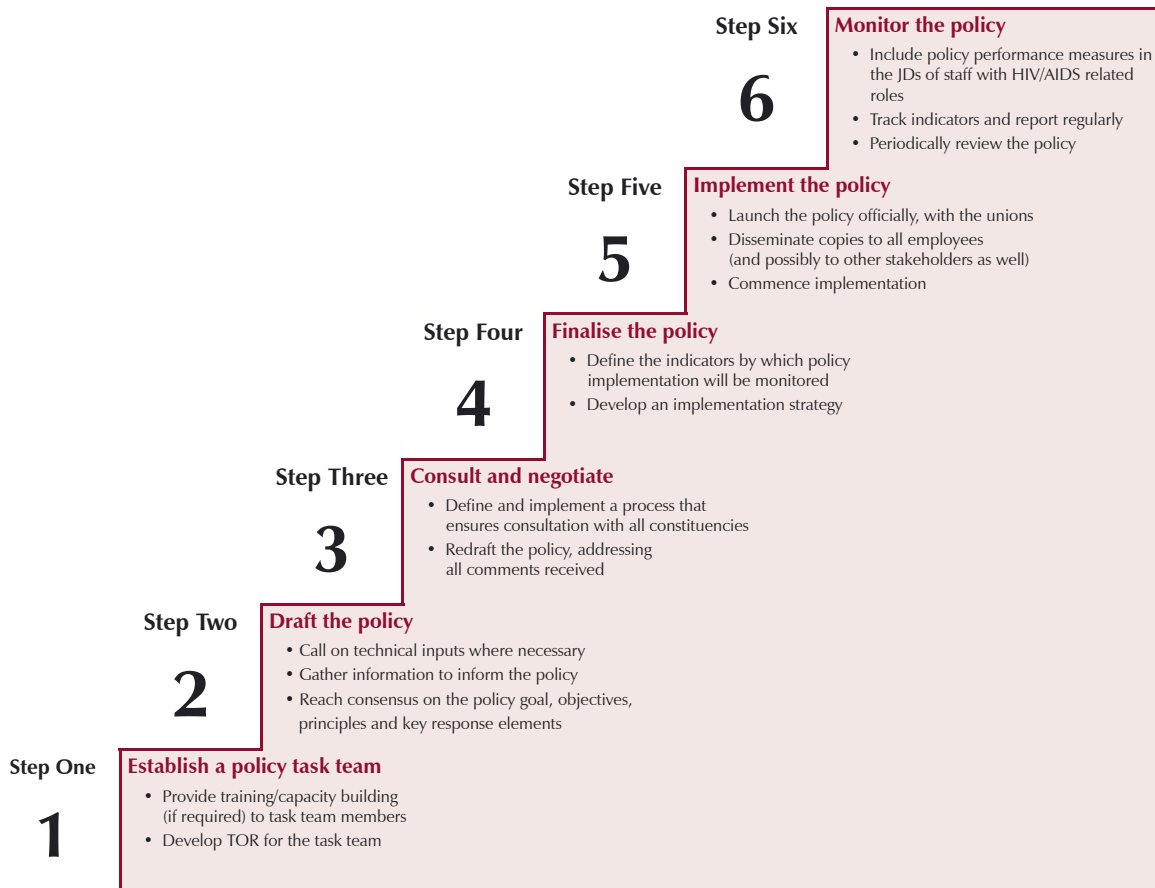
Tool: A workplace HIV/AIDS policy development process

Instructions

The process undertaken to develop a workplace HIV/AIDS policy is arguably as important as the policy itself.

If your organisation has a well-developed and tested policy development and implementation process – that involves the unions – use that process to develop your workplace HIV/AIDS policy, but refer to the one detailed below to check if any steps in your process can be improved.

If, on the other hand, your organisation does not have an established policy development and implementation process, follow the steps described below.








Score Card: Workplace HIV/AIDS policy

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Statement on HIV/AIDS included in occupational health and safety policy Peer educators distribute the statement during their sessions Statement on HIV/AIDS attached to pay slip 		
 Good Response	<ul style="list-style-type: none"> Multi-disciplinary team develop HIV/AIDS policy Policy adopted jointly by management and unions Policy launched and copies distributed to all employees Policy makes provision for HIV/AIDS budget 		
 Blue-chip Response	<ul style="list-style-type: none"> Policy shared with sectoral partners, suppliers and customers Policy reviewed annually and amended in line with latest developments in the HIV/AIDS field Policy implementation measured accordingly to selected indicators 		

Costs

There may be cost implications to the development of a workplace HIV/AIDS policy if technical experts, such as legal experts, need to be retained at points during the development.

There will be implications in terms of personnel time, and there will be costs associated with printing the policy, if distribution to employees and others is planned, and if a launch function is scheduled.

Establishing a cost centre for the organisational HIV/AIDS response is a good way of formalising and being able to track all aspects of the policy implementation.



Case Study: Workplace HIV/AIDS policy - South Deep Mine

The following is an extract from the South Deep Mine HIV/AIDS policy – sometimes called an agreement in the mining sector. It was signed into practice by the National Union of Mineworkers (NUM), the United Association of South Africa and the Placer Dome Western Areas Joint Venture in 2002.

Policy statement

South Africa is facing an HIV/AIDS epidemic of severe proportions. HIV targets the reproductive age group and hence those of working age. The workplace therefore becomes the target of the epidemic.

South Deep acknowledges the seriousness of HIV/AIDS as a reality and fully recognises the tragic social implications associated with this illness as well as the impact thereof upon our operations. The philosophy of South Deep is that it should act in the best interest of all its employees by treating employees infected with HIV/AIDS in the same manner as those employees affected by any other serious or life threatening illness.

Policy principles

1. Individual's HIV/AIDS related information will be dealt with on a strictly confidential basis. Breaches of confidentiality will be seen in a serious light and will be dealt with accordingly.
2. Information about the HIV status of an individual will be managed within the clinical environment according to standard medical guidelines.
 - Employees will not be dismissed or discriminated against on the grounds of being HIV positive. Any necessary termination of service on the grounds of medical incapacity will be dealt with in terms of established medical separation procedures.
 - Where applicable employees who are clinically ill will continue to receive medical treatment or benefits in accordance with the rules of the relevant medical scheme or medical service in which they participate.
 - Once an employee becomes incapable of executing his or her normal duties due to ill health, the provisions of the relevant provident or pension fund will be applicable with regard to the payment of benefits.
 - Appropriate training and protective equipment will be provided to those employees who are employed in occupations which may expose them to the risk of possible infection.
 - Information and education programmes on HIV/AIDS will be provided to employees to make them aware of the dangers of HIV/AIDS and which preventative steps should be taken to avoid being infected.
 - HIV/AIDS testing
 - HIV testing on a voluntary basis will be made available to employees with informed consent. HIV testing is not allowed by the EEA (the South African Employment Equity Act).
 - HIV testing in a clinical environment for diagnostic purposes will be per medical ethical guidelines where practically possible.





- All employment practices that are applied to HIV/AIDS should be consistent with ethical guidelines for good medical and occupational health practice, taking cognisance of prudent policies and relevant international best practices.

Operational guidelines

The company will develop an HIV/AIDS programme with due regard to:

- Statistical surveillance;
- Communication, education, voluntary counselling and testing (VCT) and wellness programmes;
- Effective services for the treatment of STIs;
- Provision of appropriate medical care; and
- Involvement of all stakeholders in programmes and the development of initiatives.



Case Study: Workplace HIV/AIDS policy examples

1. Policy principles

A company can adopt policy principles, such as those below, to guide their HIV/AIDS programme, or a workplace HIV/AIDS policy can be built around such principles²:

Non-discrimination – People with HIV infection or AIDS are entitled to the same rights, benefits and opportunities as people with other serious or chronic illnesses, for example in relation to absenteeism or assessment. Through education and counselling, the company will seek to prevent stigmatisation of those infected, and will not condone any form of discrimination.

Fair employment – Employment practices comply with local laws and regulations and/or the practices of the company, whichever is greater, and where applicable. The company does not require HIV screening as part of pre-employment or general workplace physical examinations.

Gender equality – Equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and to enable women to cope with HIV/AIDS.

Senior management commitment – Senior management unequivocally endorses non-discriminatory employment practices and education programmes or information about HIV/AIDS.

Confidentiality – The company will protect the confidentiality of employees' medical information. An employee who contracts HIV will have no obligation to inform the company but will be encouraged to seek guidance from medical and counselling providers. HIV testing that is carried out for clinical purposes should be performed with the appropriate pre- and post-test counselling; results will remain confidential. Voluntary testing will be approached the same way.



Social dialogue and communication – The successful implementation of a workplace HIV/AIDS policy and programme requires co-operation and trust between employers, workers and their representatives. The company will communicate policies and practices to employees in simple, clear, and unambiguous terms.

Information and prevention – The company will provide employees with sensitive, accurate and up-to-date information about risk reduction in their personal lives. This will include providing workplace education addressing prevention, care and support; training on universal precautions; and regular and confidential access to condoms for all staff. The company will have in place and enforce a procedure for occupational blood exposure.

2. Workplace HIV/AIDS policy³

The following example can be used as the basis for drafting a workplace HIV/AIDS policy.

Preamble

The company acknowledges the seriousness of the HIV/AIDS epidemic; seeks to minimise the social, economic and developmental consequences to the company and its staff; and commits itself to providing resources and leadership to implement an HIV/AIDS and STI programme.

Principles

The company affirms that:

- The policy shall be developed and implemented in consultation with staff and their representatives;
- Staff living with HIV/AIDS have the same rights and obligations as all staff;
- Staff living with HIV/AIDS shall be protected against discrimination;
- HIV status shall not constitute a reason to preclude any person from employment;
- No staff member shall be required to undergo HIV testing. Where testing is done at the insistence of the employee, this will be with his/her informed consent and accompanied by counselling; and
- Confidentiality regarding the HIV status of any member of staff shall be maintained at all times.

HIV/AIDS and STI programme in the workplace

The company shall initiate and maintain a multifaceted response to HIV/AIDS.

Co-ordination and implementation

The company shall appoint an HIV/AIDS Programme Co-ordinator and Working Group to:

- Communicate the policy to all staff;
- Implement, monitor and evaluate the company's HIV/AIDS Programme;
- Advise management regarding programme implementation and progress;
- Liaise with local AIDS service organisations and other resources in the community; and
- Create a supportive and non-discriminatory working environment.

Management of infected employees

HIV/AIDS shall be treated in the same way as other disabling or terminal conditions.



Programme components

The HIV/AIDS programme of the company shall provide all staff access to:

- Information, education and communication activities, including media materials and peer education;
- Barrier methods/physical prevention methods (male and female condoms);
- Health services for the appropriate management of STIs;
- Treatment of opportunistic infections for infected staff, along with testing and counselling services;
- Personal protective equipment for staff who may potentially be exposed to blood or blood products; and
- Support for both infected and affected staff.

Planning

The company shall conduct regular impact analyses in order to understand the evolving epidemic and how it will impact on the future of the company, its structure, operations and functions.

Benefits

HIV infected staff are entitled to the same benefits as all staff.

Budget

The company shall allocate an adequate budget to implement every aspect of the programme.

Interactions with sectoral partners, civil society and government

The company shall try to utilise all opportunities in which it interacts with its sectoral partners, civil society and government to contribute to the mission and objectives of the National HIV/AIDS Programme.



Additional Information

For the full South Deep policy, go to www.weforum.org/globalhealth/cases.

Other company policies are also available on www.weforum.org/globalhealth/cases or in the ILO document entitled; *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual* (2002); available on www.ilo.org.

IFC's *Good Practice Note: HIV/AIDS in the workplace*, available on www.ifc.org/ifcagainstaid situates an HIV/AIDS policy within the other elements of a workplace response.

Information on the development of workplace HIV/AIDS policies can be found in the South African Department of Labour's *HIV/AIDS Technical Assistance Guidelines*, available on www.labour.gov.za.

Footnotes



¹ Most organisations will be familiar with the way in which policy is a major component of management systems, such as environmental management systems. This model – which consists of policy, planning, implementation and operation, checking and corrective action, and management review – can apply equally well to HIV/AIDS

² Examples of policies can be found in resources such as the IFC's *Good Practice Note HIV/AIDS in the workplace*, available on www.ifc.org/ifcagainstaid, SACOB's *SME HIV/AIDS toolkit*, available from carolo@sacob.co.za and the SMARTwork publication, *Workplace Guide for managers and labor leaders: HIV/AIDS policies and programs*, available on www.smartwork.org.

³ Adapted from the South African Department of Health; *Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs* (1997)

Section Two

Co-ordinator and Workplace HIV/AIDS Structure



Briefing Note

A workplace HIV/AIDS response needs to be spearheaded, directed and co-ordinated. For this reason it is necessary to appoint a co-ordinator and to establish an HIV/AIDS structure, or set of structures – all with well-defined mandates and clear lines of communication and accountability.

Appointing a staff person or committee to serve as a focal point for handling all company HIV/AIDS-related activities brings accountability and focus to the process. [...] it is important that they be vested with authority over activities and given a direct line of communication with senior management.

*Extract from IFC's
Good Practice Note:
HIV/AIDS in the workplace*

Contractors may not be in a position to appoint a dedicated HIV/AIDS Co-ordinator, but they should formally nominate a person to lead their HIV/AIDS response. Similarly, they may not create a formal in-house HIV/AIDS structure, but may well be able to participate in existing structures at sites where they are operating.

A useful model for how structures with different HIV/AIDS-related responsibilities and competencies should operate and be linked together has been developed by the IFC.

IFC's framework for co-ordinated action

Maximizing the chances of success through action in four spheres

Due to the complexity of the problem and the pervasive nature of the disease, a company acting alone may be unsuccessful in controlling the impact of AIDS on its workforce as a result of external factors. IFC's experience in working with companies through its IFC Against AIDS programme shows that the most successful interventions often involve coordinated action among four separate but interrelated spheres: Operational, Medical, Managerial, and Community. Within each of these spheres lie particular skills and resources which need to be identified and leveraged if the fight against HIV/AIDS is to be won in the company's area of operations.



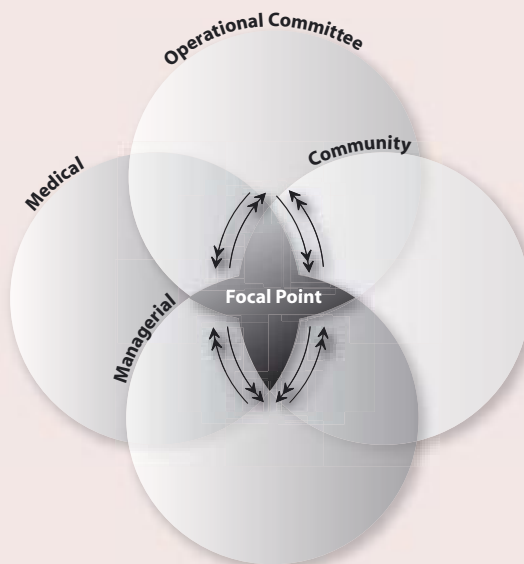
Operational:

Representatives from this sphere include individuals from the operational level of a company. In addition to company employees it may also include peer educators, staff from human resources, contractors, and union representatives.

The Operational Committee can identify:
(i) risks that they see at the working level;
(ii) opportunities that exist for promoting on-the-job education and prevention; and
(iii) specific needs of employees in terms of health programmes and services.

Medical:

The medical sphere comprises clinical staff from the company as well as from public hospitals, NGOs or local health offices. The Committee can identify the general health trends in the area, prioritise concerns and co-ordinate medical programmes and services.



Community:

Representatives drawn from the local community may include prominent citizens such as village chiefs, religious leaders, or school representatives as well as community organisations, women's groups and NGO's. Members from this committee can serve as a liaison between the company and community, strengthening communication and co-operation on efforts to combat HIV/AIDS

Managerial:

Committed leadership is essential for companies to address HIV/AIDS effectively. The Managerial Committee may include senior management representatives and Board members, whose responsibilities include championing the programme, allocating budgetary and staff resources and undertaking a periodic review of the various activities.

What are the core competencies of an HIV/AIDS Co-ordinator?

The person appointed to lead an organisation's HIV/AIDS response should have as many of the following skills as possible:

- HIV/AIDS training and experience;
- Skills in advocacy, networking and co-ordination;
- HR and financial management experience;
- Project management and planning skills;
- Strong communication and people skills; and
- Report writing skills, and monitoring and evaluation experience.

What should the composition be of a workplace HIV/AIDS structure?

A workplace HIV/AIDS structure should include:

- Those who will be involved in the development, implementation, and monitoring and evaluation of the HIV/AIDS policy and programme;
- Representatives from all divisions within the organisation, and, where relevant, from different geographic areas as well;
- Special “interest” groups, such as unions, women and people living with HIV/AIDS; and
- People who have relevant skills that the programme requires.

Companies with operations in different places should consider establishing workplace HIV/AIDS structures at corporate and operational levels, with clearly defined communication and reporting procedures.

Example from Gold Fields HIV/AIDS workforce policy (2001)

It is recorded that a joint Management/Union Plenary Working Group has been established at Group level.

HIV/AIDS structures will be established on the operations and the parties commit themselves to support these structures. Representation will be agreed upon at operational level.

HIV/AIDS Co-ordinators will be appointed in consultation with the agreed structures and shall be trained so as to be competent in their work.



Red Flags and Special Challenges

Amongst the challenges that face an organisation when appointing an HIV/AIDS Co-ordinator and setting up a workplace HIV/AIDS structure are:

- The need to identify and appoint an experienced and skilled person to lead the organisation’s HIV/AIDS response;
- Adequate representation on the structure and support from all stakeholders in the organisation;
- Locating the HIV/AIDS Co-ordinator within the unit or section where he/she will be most effective, and defining communication channels that allow for access to management, unions and the general workforce;
- Defining the strategic and operational functions of the HIV/AIDS structure;
- Providing an adequate budget for implementation;
- Obtaining clear commitment and support from management for participation by nominated employees on the HIV/AIDS structure;
- Ensuring that union representatives are included on the HIV/AIDS structure; and
- Establishing clear lines of communication between the HIV/AIDS structure and all relevant units within the organisation.

Employees with responsibility for their organisation’s HIV/AIDS response almost always describe the multiple barriers that they experience in **getting started**.



These barriers include:

- Denial, at all levels of the problem, or the problem is too big for us, so leave it alone;
- A lack of commitment from top management;
- A lack of support from organised labour;
- No common vision of what needs to be done;
- The lack of a uniform approach to the problem by management and organised labour;
- Apathy from employees;
- Inappropriate attitudes, particularly to PLWHAs;
- Competing demands on their time – the HIV/AIDS portfolio is just one of many;
- The lack of a formal mandate for the HIV/AIDS work that they are expected to do;
- HIV/AIDS is not part of their job description or a key performance area against which their performance will be evaluated;
- Inadequate resources (financial and material) for HIV/AIDS related activities;
- Inadequate information about supportive community services; and
- Inadequate incentives at the operational level to accept and support the programme.

These barriers lead to feelings of frustration and isolation and are the reason why many initial efforts falter and fail. To prevent or deal with them:

- Define the problem – only then can you begin to do something about it;
- Test the environment to assess its receptiveness to change;
- Identify the things that you can do about the problem – have goals and a plan;
- Find supporters and change agents and build a coalition or team to support you;
- Lobby others whose support you need;
- Identify and understand the opposition – what makes them “tick”;
- Identify WHO decides, WHAT they decide and HOW it is decided;
- Don’t be overambitious; start where you have some chance of success and trust the value of incremental actions;
- Never doubt the power of numbers – collect them and use them;
- Select your messages and communicate, communicate, communicate;
- Act – actions speak louder than words;
- Monitor and record – this too can be a powerful advocacy tool; and
- Celebrate your successes and let others share in them too.

This all relates to the need for advocacy. Advocacy is action which aims to change policies, positions or programmes – it puts a problem onto an agenda, provides a solution and builds support for action.



Tool: Checklist of questions relating to the HIV/AIDS Co-ordinator and structure

Instructions

Use the following questions to guide discussions and decisions regarding the appointment of an HIV/AIDS Co-ordinator and the establishment of a workplace HIV/AIDS structure:

HIV/AIDS Co-ordinator

- What skills and experience does the HIV/AIDS co-ordinator need to have?
- Should the person be appointed solely to deal with HIV/AIDS?
- Where will this person best be placed within the organisational structure?

HIV/AIDS structure




- What are the functions of the structure and to whom will it report?
- What skills and expertise are required on the structure?
- What capacity building will members of the structure require to fulfil their roles?
- How can the organisation ensure that unions, women and PLWHAs have a voice on the structure?
- What links will the structure have with other structures and what partnerships should it form to fulfil its functions?



Score Card: HIV/AIDS Co-ordinator and workplace structure

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Occupational Health Nurse is appointed as HIV/AIDS Co-ordinator • HIV/AIDS Task Team is a sub-committee of the Health and Safety Committee • HIV/AIDS is an agenda item at Health and Safety meetings 		
 Good Response	<ul style="list-style-type: none"> • HR Director is appointed as HIV/AIDS Co-ordinator • HIV/AIDS Task Team meets monthly and reports are submitted to management quarterly • Peer educators are represented on the Task Team 		
 Blue-chip Response	<ul style="list-style-type: none"> • Dedicated HIV/AIDS Co-ordinator appointed, with relevant skills, and reporting to the CEO • Members of the HIV/AIDS Task Team receive training on HIV/AIDS, advocacy, counselling and programme management • HIV/AIDS budget, which is a fixed percentage of payroll, is managed by the HIV/AIDS Task Team 		



Costs

There may be significant costs related to appointing an HIV/AIDS Co-ordinator, if it is a dedicated position, and if the person is at a senior level.

The costs related to a functioning HIV/AIDS Task Team are primarily in terms of staff time and HIV/AIDS competency training.



Case Study: Terms of reference (TOR) for a workplace HIV/AIDS Task Team - South African government departments

The following TOR, which were originally developed for government departments in South Africa, have been adapted slightly to be relevant for organisations operating in the mining sector.

1. Proposed structure

Representative(s) from each of the following:

- Employee assistance programme;
- Human resources;
- Trade unions (all trade unions to be represented);
- Labour relations;
- Occupational health and medical services;
- Occupational safety;
- People living with HIV/AIDS;
- Divisional and site representatives; and
- Contracting companies

2. Administrative arrangements

- Cost centre for the HIV/AIDS response;
- Monthly meetings, convened and chaired by the responsible senior manager;
- Secretariat to be provided by the senior manager; and
- Monthly reports to be submitted to management;

3. Terms of reference for the Task Team

The Task Team will be a co-ordinating structure, facilitating implementation and with the following responsibilities:

- Policy development and review: this involves developing policies that enable the company to deal with HIV/AIDS in the workplace and within the community within which the company operates;
- Situational analysis of the HIV/AIDS workplace programme, and identification of priorities and needs;
- Development of an implementation plan for the company, which includes clear objectives and indicators for measurement;
- Development of a system of regular monitoring and evaluation of programmes;
- Implementation of a comprehensive package of HIV/AIDS prevention, treatment, care and support for employees;



- Implementation and/or facilitation of and/or participation in community-based programmes that reduce the spread of HIV infection within the community, and mitigate the impact of HIV/AIDS on individuals, families, and the community at large.

4. Details of the Task Team's role and function

Advocacy

- Support the HIV/AIDS Co-ordinator;
- Provide a focal point for advocacy across the company.

Co-ordination

- Co-ordinate the implementation of both the workplace and community-based HIV/AIDS programmes;
- Enable integration of HIV/AIDS programmes into all other programmes in the company.

Communication

- Provide a regular link with business units/sites and allow for two-way communication on all issues relating to HIV/AIDS;
- Initiate and maintain an HIV/AIDS communication strategy, in association with the PR section and others.

Facilitation

- Form a link between the HIV/AIDS Co-ordinator and management;
- Influence management to ensure execution of the HIV/AIDS implementation plan;
- Facilitate management decision-making on HIV/AIDS programmes;
- Facilitate the allocation of budgets and other resources to the HIV/AIDS programme.

Advisory

- Advise management on HIV/AIDS issues in general and those related to the company in particular;
- Support the HIV/AIDS Co-ordinator with strategic advice;
- Provide management with current information on programme implementation.

Monitoring and reporting

- Monitor and report on the HIV/AIDS policy and programme.



Additional Information

The NOSA AMS defines the standards for an HIV/AIDS management committee, available on www.nosa.co.za, see section 4.4.1.1.

The IFC model is available in the *Good Practice Note: HIV/AIDS in the workplace*, which can be accessed on www.ifc.org/ifcagainstaids.



Section Two

HIV/AIDS Leadership and Management Commitment

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Briefing Note

What is HIV/AIDS leadership and management commitment?

HIV/AIDS leadership and management commitment refers to the visible and vocal presence of decision-makers in leading and supporting all aspects of an organisation's response to HIV/AIDS.

Why is leadership and management commitment important for an organisation's HIV/AIDS response?

One of the most consistently identified factors that is critical for a successful HIV/AIDS response is leadership and commitment from leaders, be they political, government, business, labour or civil society leaders.

What has been less clear is what this leadership and commitment actually is, and what form leadership can take in the workplace. As a starting point, areas in which HIV/AIDS leadership could and should emerge are:

- Corporate citizenship; and
- Worker welfare.

Contractors, like big corporations, also have opportunities to demonstrate leadership and management commitment on HIV/AIDS within their particular spheres of influence. They may align their leadership activities to those of the mining company leadership, or they may select a particular event or issue as a focus of attention.

What are the elements of HIV/AIDS leadership and management commitment?

In a workplace context, HIV/AIDS leadership and management commitment should be evident in three areas:

- **Internally** – leadership on HIV/AIDS issues within the organisation;
- **Externally** – leadership with other stakeholders and in the wider social and development arena; and
- **At a personal level** – by acting as a role model, for example by demonstrating solidarity with people living with HIV/AIDS (PLWHAs).

In all three spheres this leadership and commitment has the potential to:

- Minimise the stigma and discrimination that is so frequently associated with HIV/AIDS;
- Shape the debate about HIV/AIDS;

Strong leadership at all levels of society is essential for an effective response to the epidemic.

Leadership by governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.

Leadership involves personal commitment and concrete actions.

Declaration of commitment on HIV/AIDS
UN General Assembly Special
Session on HIV/AIDS
June 2001



- Exert influence and change the pace of action; and
- Mobilise resources.

Leadership on HIV/AIDS can occur among peers within a sector (company to company, or union to union) and in conjunction with leaders in other sectors.

There are multiple benefits to leadership and management commitment, including:

- A positive public image and publicity for the company;
- Access to concerned decision-makers in other sectors;
- A satisfied and supportive workforce; and
- Greater involvement with communities.



Red Flags and Special Challenges

Leadership challenges include that:

- Verbal commitment is not synonymous with implementation;
- Often commitment is event-based, but not sustained over time;
- Top-level leadership on HIV/AIDS is frequently not mirrored at middle-management level;
- Managers may not have the requisite knowledge or skills to provide meaningful leadership on HIV/AIDS;
- As long as HIV/AIDS is not mainstreamed as a core management function, it is not perceived as important; and
- There are usually no accountability checks in place, against which to measure leadership and management commitment.

Gold Fields, lessons learned

Essential to success are an involved and committed Board, executive and top management, combined with all employees and their representative organisations, and committed to achieving results.



Tool: Menu of HIV/AIDS leadership and management commitment actions

Instructions

Review the following for appropriate and feasible actions that can be employed in your organisation to demonstrate HIV/AIDS leadership and management commitment.

- Educate yourself and your fellow managers about HIV/AIDS;
- Participate actively and visibly in HIV/AIDS events;
- Use public platforms to speak about HIV/AIDS;
- Wear a red ribbon, as a symbol of awareness and solidarity;
- Promote cross-sector HIV/AIDS partnerships;
- Act as a catalyst to bring different organisations together to work on joint HIV/AIDS projects;
- Facilitate the transfer of innovative solutions on HIV/AIDS problems within the organisation and to other stakeholders;
- Prioritise the resourcing and delivery of HIV/AIDS workplace programmes;






- Encourage support for community HIV/AIDS projects within your organisation’s corporate social investment (CSI) programme;
- Demonstrate support for infected or affected employees and their families;
- Support employees who wish to volunteer their time and services to community HIV/AIDS projects;
- Take an open and principled stance on human rights and gender issues;
- Participate in meetings of the HIV/AIDS workplace structure;
- Ensure transparency on HIV/AIDS issues and build trust across all divisions in the workplace; and
- Support the implementation of the workplace HIV/AIDS programme.



Score Card: HIV/AIDS leadership and management commitment

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • CEO participates in World AIDS Day event • HIV/AIDS features in management/union negotiations • CEO attends sector-wide meetings at which HIV/AIDS is discussed 		
 Good Response	<ul style="list-style-type: none"> • HIV/AIDS programme reported on in Annual Report • Senior manager chairs HIV/AIDS workplace structure • HIV/AIDS KPAs included in JDs and performance appraisals of all managers 		
 Blue-chip Response	<ul style="list-style-type: none"> • Organisation receives an award for its HIV/AIDS programme • CEO or COO serves on Board of community HIV/AIDS project • Organisation represented by management at HIV/AIDS conferences 		

Costs

There are very few costs of HIV/AIDS leadership and management commitment, except where this commitment translates into additional resources for HIV/AIDS workplace programmes or for community projects.



Case Study: HIV/AIDS leadership and management commitment - Anglovaal

Anglovaal has attempted to institutionalise leadership and management commitment in their policy guidelines, by defining governance responsibilities as follows:

At the centre:

- Overall responsibility for the implementation of the required interventions lies with the Board.
- The Strategy and Policy Task Team will meet quarterly to set policy and review progress.
- Each divisional Vice President will quarterly submit a progress report to the above Task Team for review.
- The Group Project Co-ordination Team will meet monthly to review the key indicators of the group intervention programmes.

At the operations:

- General Managers will convene an HIV/AIDS Action Committee to implement the HIV/AIDS programme.
- This committee will include as broad a representation of stakeholders as possible.
- A monthly progress report will be submitted through the General Manager to the responsible VP.



Additional Information

FHI's publication entitled *Workplace HIV/AIDS programs: an action guide for managers* (2002) has a chapter on "Company leadership in HIV/AIDS prevention and care". The document is available on www.fhi.org.





Section Two

HIV/AIDS Legal Compliance

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Briefing Note

What is an HIV/AIDS legal compliance review?

An HIV/AIDS legal compliance review is a formal process undertaken on a regular basis to ensure that company policies and procedures with HIV/AIDS implications comply with national and international laws and agreements; and, where deviations are found in any policies or procedures, that appropriate modifications are made.

Why does an organisation need to conduct an HIV/AIDS legal compliance review?

The HIV/AIDS epidemic has, too frequently, resulted in discriminatory and unfair labour practices. These include testing employees for HIV and then denying those who test HIV positive equal opportunities in terms of benefits, promotion or training; discharging employees who are HIV positive; and disclosing confidential information about an employee's HIV status to others within the organisation.

Often these practices, which may be entrenched in one or more company policies, are in breach of the laws of the country, and may result in costly and time-consuming disputes. Conducting an HIV/AIDS legal compliance review, on the other hand, and ensuring that policies and practices comply with the law, will not only prevent such disputes, but will also create an enabling and supportive environment for workplace HIV/AIDS interventions.

Contractors, like all other businesses, are bound by the laws of the country/ies within which they operate. Therefore they have responsibilities to ensure that their policies and procedures comply and that any HIV/AIDS-related decisions are taken with due regard to these laws. Embarking on a process to ensure compliance is likely to be much less costly than trying to resolve a dispute would be.

An employee with HIV should be treated in the same way as any other employee. Employees with HIV-related illness, including AIDS, should be treated the same as any other employees with a life-threatening illness.

Extract from the Code on HIV/AIDS and Employment in the Southern African Development Community

What should an HIV/AIDS legal compliance review consist of?

Step One:	The identification of a senior staff member, with suitable qualifications, or with access to legal expertise, who is tasked to conduct the review.
Step Two:	<p>Collection of all relevant national laws, agreements and codes and international agreements that have been signed by the country. Typically this list would include:</p> <ul style="list-style-type: none"> • The Constitution – which is the supreme law in any country; • The Bill of Rights – which sets out the rights of all citizens, such as rights to equality and non-discrimination, privacy, fair labour practices and access to information; • Common law protections – which typically include the right to privacy and bodily integrity; • National labour legislation – which covers equality and non-discrimination in the workplace through anti-discrimination measures and, in some instances, affirmative action, a safe working environment and compensation for occupationally acquired injuries or diseases; • International agreements, such as the International Labour Organisation (ILO) Convention 111 on Discrimination (Employment and Occupation) (1958), and the ILO Code of Practice on HIV/AIDS and the World of Work (2001); and • Regional agreements, such as the South African Development Community (SADC) Code on AIDS and Employment which was approved by the Council of Ministers in September 1997.
Step Three:	Collection of all company policies, including those dealing with health and safety and employment practices, as well as all union agreements.
Step Four:	Analysis of company policies in light of national and international provisions.
Step Five:	Preparation and submission of report to management and unions, identifying any changes that need to be made.
Step Six:	Amendment of policies, ensuring meaningful consultation with all role players, and adoption of amended policies.
Step Seven:	<p>Identification of indicators to monitor legal compliance. Possible indicators could be:</p> <ul style="list-style-type: none"> • Inclusion of a paralegal module in selected training programmes; • Regular checks of policies, protocols and procedures against a checklist developed for the purpose, and particularly following the promulgation of any new legislation with employment implications; and • Regular reports on compliance to an appropriate management forum and to a management/union forum.



Red Flags and Special Challenges

Ensuring legal compliance is particularly challenging in situations where the relationships with workers are informal, where workers are not unionised, or where workers are employed on a day-to-day basis their labour, such as in the construction industry or shipping operations.

Ensuring legal compliance is just one way of addressing the problem of stigma and discrimination. This is a challenge that cuts across every aspect of a workplace HIV/AIDS response, and that needs to be recognised and vigorously addressed, whenever and wherever it occurs. In order to create an enabling environment where there is zero tolerance for stigma and discrimination, it may be necessary to embark on the following:

- Dissemination of information;
- Coping-skills acquisition for PLWHAs;
- Refining counselling approaches;
- Programmes promoting the greater involvement of people living with HIV/AIDS;
- Monitoring instances of violations of human rights;
- Creating institutional and legal support to enable people to challenge discrimination;
- Legal reform/legal action/public interest litigation;
- Community mobilisation;
- Community education;
- Institutional policy responses;
- The development of administrative and professional guidelines;
- Research; and
- Advocacy.

Stigma is the unfair, uneducated and unholy disgrace we have allowed to develop around the disease. [...] stigma destroys self-esteem, destroys families, disrupts communities and takes away all hope for future generations.

*Njongonkulu Ndungane
Anglican Archbishop of Cape Town*



Tool: Checklist for HIV/AIDS legal compliance

Instructions

Use the following questions as a guide when undertaking a review of company policies.

Do any recruitment procedures, advertising practices and selection criteria exclude, directly or indirectly, job applicants on the basis of their HIV status?

In many countries a job applicant is included in the definition of an employee, and the non-discrimination laws that apply to employees in service also apply to job applicants.

Is any HIV testing currently taking place in the workplace and, if so, is such testing prohibited in terms of any laws?

In many countries medical testing of an employee (including HIV testing) is prohibited except in circumscribed circumstances. The prohibition may even cover questionnaires and other forms of inquiry about possible risk behaviour or HIV status.

Is any HIV testing required as a qualification for benefits or loans, or as a requirement for travel and, if so, is such testing legal?

A number of benefits, e.g. a housing loan, require that the employee take out life assurance, acceptance for which is contingent on a negative HIV test result. Many employees are unclear about the implications of these sorts of procedures and require clear, unambiguous information upon which to make their decisions.

Is medical information about employees, including HIV status, kept confidential?

Because employees have privacy rights, they may not be legally required to disclose their HIV status to their employer or to other employees.

The ILO has produced a Code of Practice on the protection of workers' personal data. This provides, with regard to medical information, that such information should only be collected in the following circumstances:

- To determine whether the worker is fit for a particular employment;
- To fulfil the requirements of occupational health and safety; and
- To determine entitlements to and to grant social benefits.

In all instances such information must be stored in a way in which the privacy of employees is protected.

Are any employees living with HIV being unfairly discriminated against, or denied equal opportunities in terms of any laws?

There should be no discrimination in job classification and grading, remuneration, benefits, and terms and conditions of employment, job assignments, access to facilities at work, training and development, promotion and performance evaluation systems, transfers, and dismissals. There are usually provisions in labour laws that state that it is **not** unfair discrimination to distinguish, exclude or prefer any person on the basis of an **inherent requirement** of a job.

Have basic conditions/minimum standards of employment – working hours, leave, sick leave, compassionate and family leave – been reviewed in light of the likely demands of the HIV/AIDS epidemic?

These could include extended sick leave at a reduced rate of pay, leave to attend funerals, and so on.

Have any employees been dismissed because they were HIV positive?

If disputed, a dismissal solely because an employee is HIV positive or has AIDS is likely to be found to be unfair if it is a dismissal based on discriminatory conduct by the employer. However if an employee with AIDS is dismissed for incapacity it will in all likelihood be found to be fair, provided the correct dismissal procedures have been followed.

Can the organisation's grievance and disciplinary procedures be applied to HIV-related disputes?

The remedies available to employees living with HIV/AIDS should be integrated into existing grievance and disciplinary procedures. This may involve special measures to ensure confidentiality.

Standard Chartered Bank has enshrined the principle of non-discrimination by adopting a code of conduct and measures to discipline those found guilty. Even a joke about someone who is HIV positive can result in disciplinary action.



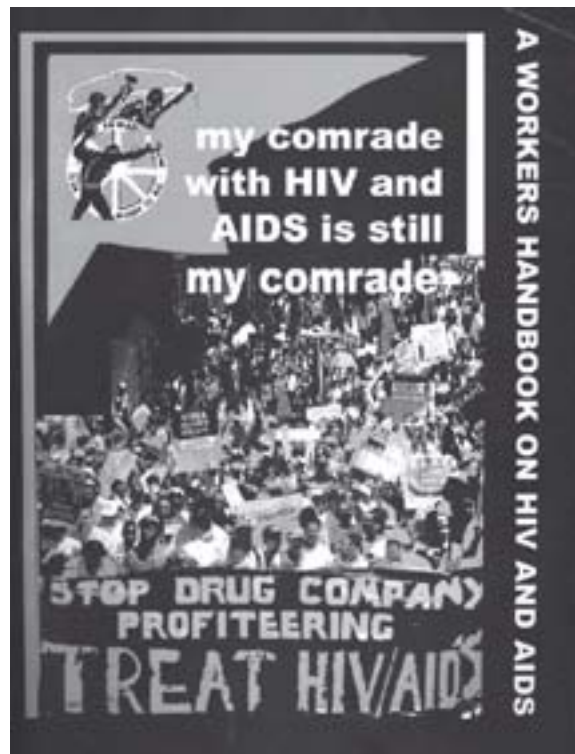
Have all reasonably, practicable measures been taken to create and maintain a safe working environment, where the risk of HIV exposure and transmission is minimised?

Employers generally have a legal duty to ensure that:

- Steps are taken to assess health and safety risk, including the risk of occupational HIV infection;
- The risk of possible HIV infection is minimised;
- Staff training is undertaken on safety steps to be taken following an accident;
- Universal infection control procedures are used in any situation where there is possible exposure to blood or blood products;
- Universal infection control equipment is available for employees at the site of any accident;
- There are systems in place for the safe disposal of sharps and medical waste; and
- Protocols exist for the management of occupational exposure to potentially infected blood or body fluids.

What provision is there for compensation for employees who are injured in the course and scope of their employment, is HIV transmission included in the definition of an occupational injury, and are there procedures in place to adequately prove the cause?

Compensation should be possible, in accordance with the law, where an employee becomes HIV infected following an occupational exposure to infected blood or blood products. The success of a claim for compensation is likely to be reliant on the procedures which are followed immediately following an accident as it will be necessary to show that the occupational accident was the direct cause of the person sero-converting (i.e. becoming HIV positive).








Score Card: HIV/AIDS legal compliance

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> HR department responsible for ensuring that the company complies with the laws of the land Ad hoc discussions at management meetings about new legislation that is promulgated New legislation discussed at meetings with contractors 		
 Good Response	<ul style="list-style-type: none"> Legal and human rights training included in training conducted for managers and supervisors Process to ensure legal compliance is discussed at management/union meetings Procedures to ensure confidentiality are instituted, such as not linking medical records to employee payroll numbers 		
 Blue-chip Response	<ul style="list-style-type: none"> HIV/AIDS legal compliance is included as a KPA for selected managers Legal compliance review is an annual requirement by the Board and shareholders 		

Costs

The costs involved in assuring legal compliance will include the time of the employee nominated to conduct the review and to monitor compliance. In addition, there may be costs associated with “buying-in” legal expertise.



Case Study: HIV/AIDS legal compliance - South African Department of Labour

In 1999, the South African Department of Labour introduced a new law on employment equity. This law was one of the first to address the problem of discrimination on the basis of HIV status.

Since this is a new labour matter, the Minister, after consultation with NEDLAC and the Commission for Employment Equity, issued a Code of Good Practice on key aspects of HIV/AIDS and employment.



The Code is based on five key principles:

- Equality and non-discrimination between individuals with HIV infection and those without; and between HIV/AIDS and other comparable illnesses;
- The creation of a supportive environment so that employees with HIV or AIDS can continue working for as long as possible;
- Protection of human rights;
- Ensuring that the rights and needs of women are addressed in all policies and programmes; and
- Consultation, inclusiveness and participation of all stakeholders in all policies and programmes.

The following extract from the Code defines the measures that must be taken to ensure that there is no discrimination based on HIV status in workplaces.

A non-discriminatory workplace in which people living with HIV or AIDS are able to be open about their HIV status without fear of stigma should be promoted. All recruitment procedures from the advertising and selection processes to the actual appointment need to be carefully screened. Remuneration packages, including employee benefits and terms and conditions of employment should be consistent among all employees. Training and development programmes, performance evaluation systems and promotion, transfer and demotion should be completely devoid of any differentiation between those who are either infected or affected by HIV or AIDS.

In 2002, the South African Department of Labour published HIV/AIDS Technical Assistance Guidelines to complement the Code of Good Practice on key aspects of HIV/AIDS and employment.



Additional Information

The Code and Technical Assistance Guidelines are available on the South African Department of Labour's website, at www.labour.gov.za.

Other important references are:

- UNAIDS; *HIV/AIDS and human rights international guidelines*, available on www.unaids.org;
- ILO; *Code of good practice on HIV/AIDS and the world of work*, available on www.ilo.org; and
- SADC; *Code on HIV/AIDS and employment*, available on www.hri.ca/partners/alp/resource/thesadc

Newsletters of the AIDS Law Project can be subscribed to by e-mailing seloanem@law.wits.ac.za.

Section Two

Behavioural Surveillance – the KAP Survey



Briefing Note

One of the most commonly used methods used to survey behaviour is the knowledge, attitudes and practices (or KAP) survey.

What is an HIV/AIDS KAP survey?

A KAP survey (sometimes called a KABP survey – knowledge, attitudes, behaviours and practices) is a tool to track trends in key knowledge and behavioural indicators over time and to inform HIV/AIDS prevention activities. It is a simple way of gathering standardised information from a large number of people.

In some instances KAP surveys are done in conjunction with biological surveillance, i.e. anonymous testing for HIV, to establish the prevalence of infection in the workforce.



Why does an organisation need to conduct KAP surveys?

In order to develop effective workplace responses to HIV/AIDS, reliable information is needed about the knowledge, attitudes, beliefs and practices of employees, particularly about the sexual behaviours that can spread HIV. Monitoring changes over time in these behaviours and attitudes, by repeating the KAP survey (e.g. every 5 years), and less formally and more regularly to track key knowledge indicators, is essential to maintaining appropriately designed programmes.

Contractors, with employees on site at mines, may be invited to participate in the mining company's KAP survey. In such instances, the survey tool should capture information related to the contractor's employees, and this should then be used to target information and prevention messages.

What are the features and elements of a KAP survey?

In the past many people were deeply sceptical about the validity of self-reported data on sexual behaviour, but there is growing experience that indicates that people do not generally lie when completing KAP questionnaires.

KAP surveys take many different forms, from a simple one-page questionnaire that is administered to participants before and after an HIV/AIDS workshop, to a tool used by peer educators, to focus groups and PRA-type methodologies, to very complex, multifaceted surveys that require specific design and interpretation skills.



Typically the **objectives** of a KAP survey are:

- To gather information on the knowledge, attitudes and behaviours in respect to HIV/AIDS, STIs and TB of employees;
- To identify specific attitudes and risk behaviours which may be associated with the transmission of HIV;
- To gain relevant information to inform and guide the development of a comprehensive HIV/AIDS strategy in a company and to ensure that any implemented strategies and interventions are appropriate for their intended audiences;
- To identify sources of information, means of communication and different health-seeking behaviours;
- To assist in identifying the strengths and any weaknesses, shortfalls or deficiencies in the existing HIV/AIDS initiatives and to then convey these to management and employees. This in turn is aimed at promoting more commitment to the programme by management and employees;
- To determine to what extent managers and supervisors are equipped to deal with HIV/AIDS-related issues at the workplace – on a personal, ethical and legal level;
- To identify if there are any major differences in the KAP profile of various job categories, ages and sexes of employees, in order to better target future interventions; and
- To obtain base line information against which to measure and monitor the efficacy and impact of the company's HIV/AIDS programme in the future.

A typical KAP survey **methodology and design process** consists of the following activities:

- Developing the protocol;
- Negotiating with employee representatives to create an optimal environment for the survey and advising all employees of the survey;
- Defining the sample;
- Developing the research instrument;
- Piloting the research instrument;
- Training those who will administer the research instrument;
- Informing employees of their participation;
- Administering the survey;
- Capturing and interpreting the data;
- Reporting on the findings; and
- Using the findings to inform workplace programmes.

A cornerstone of successful KAP surveys is a consistent **sampling strategy** in repeated surveys. The sample should be selected from across the various job-bands and should be stratified by job grade and/or category.

Not only should there be a consistent sampling methodology, but also consistent data collection methods and established indicators in order to track trends in behaviour over time.

Typically the **research instrument** is a questionnaire that is completed anonymously. Face-to-face administration by an interviewer is sometimes selected as the means of implementation where the respondents have low levels of literacy or where probing and clarification is important.

The questionnaire can comprise a mix of qualitative-type questions, quantitative, fixed-choice (closed) questions, scales and open-ended questions.

The use of standardised questionnaires has many advantages, not only because questionnaire development is a difficult process, but also to allow for comparisons to be made across companies and contexts. It is however still essential to pre-test and adapt the survey instrument for every local setting. This involves translating the instrument into local languages and using the appropriate local terminology to ensure that the original meaning of the question is not lost.

Where this is the selected methodology it is useful to develop a guide for the person/s administering the questionnaire, which goes through the questionnaire one question at a time, explaining in full the rationale behind each question and its intended meaning. This guide can be used in training and during the survey itself, to clarify any ambiguities or misunderstandings that may arise.

A **baseline survey** provides a “snapshot” of worker knowledge, attitudes and practices, before any intervention strategies are initiated. It also serves to benchmark the impact of a long-term comprehensive workplace response, allowing for comparisons with future surveys.

Ethical considerations are very important. Surveys cannot take place without the informed consent of the respondent. Special efforts must be made to ensure that the potential respondents understand their rights, in terms of the research process, the measures in place to ensure confidentiality and any risks involved.

Using the findings – there is no point collecting KAP data unless they are used, and used for the benefit of the people from whom they were collected. It is always best to think about how the findings will be used from the very beginning of the process.

Indicators related to behaviour change can be linked to KAP surveys, such as:

- Knowledge of HIV prevention methods;
- No incorrect beliefs about HIV transmission;
- Reduction in the number of non-regular partners in the last year;
- Condom use at last sex with a non-regular partner; and
- Consistent condom use with non-regular partners.





Red Flags and Special Challenges

Especially for the baseline survey, be sure to include all the aspects about which you require information. For example, do you want to explore employees' perceptions about the company's HIV/AIDS programme, or do you want information about alcohol and drug use practices that may influence risk taking sexual behaviour? This will mean that comparisons can be made on a wide range of issues when repeat KAP surveys are conducted.

Negotiation with trade unions and employee representatives, and agreement from them to participate in a KAP survey, is a fundamental requirement and should never be short-circuited.

KAP surveys that rely on literate respondents are obviously of limited value where many workers are illiterate.



Tool: Checklist of elements to include in a KAP questionnaire

Instructions

When developing or adopting a research instrument for your KAP survey, decide which of the following elements you want to cover and then check that they are all in the KAP instrument/questionnaire.




- Demographic details, age, sex, marital status, job grade/category, etc.;
- Sexual history and practices (including past and current condom use¹ and history of STI infections);
- Knowledge regarding HIV/AIDS, STIs and TB – transmission, prevention and treatment;
- Common myths and misconceptions (such as transmission via mosquitoes);
- Attitudes to people infected with and affected by HIV/AIDS – personal and work-related;
- Awareness of any persons living with HIV/AIDS – in the community or at work;
- Knowledge of basic human and employment rights;
- Knowledge of HIV/AIDS-related services – at work and in the community;
- Access to supplies, e.g. condoms;
- Awareness of HIV/AIDS-related policies, practices and programmes at work;
- Awareness of the impact of the HIV/AIDS epidemic on the company – current and future;
- Knowledge of HIV status (of themselves – a “yes” or “no” answer might be preferable to the actual result);
- Perceptions of risk;
- Perceptions of self-efficacy;
- Information seeking behaviour and main sources of information on HIV/AIDS, STIs and TB;
- Communication about HIV/AIDS – with whom, when and about what; and
- Health seeking behaviour.



Score Card: Knowledge, attitudes and practices

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Peer educators complete a pre- and post-workshop questionnaire during their training Some information leaflets are translated into local languages 		
 Good Response	<ul style="list-style-type: none"> Base-line KAP survey conducted and results used to draw up a set of key messages for the workplace prevention programme Results presented to employees, with the opportunity to interact with them 		
 Blue-chip Response	<ul style="list-style-type: none"> KAP surveys commissioned on a regular basis Workplace HIV/AIDS programme reviewed annually in light of KAP survey results and trends over time Company supports KAP survey in the community KAP survey results used in advocacy and awareness campaigns 		

Costs

Conducting and interpreting a KAP survey requires special skills and experience. They should, in most instances, be outsourced to suitably qualified persons or institutions.

The cost of a KAP survey will vary greatly from context to context and depends on whether it is done in-house or outsourced, the number of respondents, the geographic coverage of the survey, the sampling design, and the frequency and methods of data collection.

An indicative cost of a KAP survey that was outsourced, for a company with 5 000 employees, was about \$ 19 000².

To limit the costs of a KAP survey, staff can be used to distribute and collect completed forms, which are then sent for coding and interpretation.



Case Study: KAP survey - Placer Dome

Placer Dome conducted a KAP survey in 2001, which played an influential role in shaping and reorienting the direction of the HIV/AIDS programme. The survey assessed 170 general workers and 16 supervisors, which corresponds to 4% of all workers.

This process led to key recommendations for the future of the HIV/AIDS programme at South Deep and included:

- Expansion of the existing condom distribution programme especially the access for women to improve availability in terms of time and location;
- Re-emphasizing the correct use and safety of condoms;
- Re-emphasizing confidentiality and the clearly defined disciplinary procedures for dealing with infractions;
- Implementing an aggressive STI programme supported by a dynamic education programme aimed at:
 - Addressing myths and misconceptions based on cultural and gender beliefs; and
 - Emphasizing the implications of maternal transmission.

Building upon lessons and experiences to date, combined with insights that have been gathered through monitoring and assessment, South Deep will be focusing on the following issues in the future:

- Intensifying education;
- Training and deploying peer educators;
- Increasing VCT uptake;
- Providing antiretrovirals to prevent mother to child transmission; and
- Providing a sustainable wellness programme.



Additional Information

Other case studies of KAP surveys are available on www.weforum.org/globalhealth/cases.

Additional information on behavioural surveillance and KAP surveys can be found in the UNAIDS publication; *Guidelines for second generation HIV surveillance*, which is available on www.unaids.org.

Footnotes



¹ Male and female condoms

² Calculation based on breakdown of AVMIN's HIV/AIDS budget, where the KAP survey constituted 8% of the budget.

Section Two

Biological HIV Surveillance - the Prevalence Survey



Briefing Note

What is biological HIV surveillance?

In the workplace context, HIV surveillance refers to the periodic anonymous, unlinked testing of a representative sample of the workforce, to establish the pattern of HIV prevalence in the workforce – the magnitude and distribution of HIV infection in a company.

Example from Konkola Copper Mines plc

An HIV prevalence survey, one of the largest done in a single mining company, was conducted in 2001. Approval for the survey was obtained from the Research and Ethics Committee of the University of Zambia and the University of the Witwatersrand's Committee for Research on Human Subjects (Medical).

A consultative process was carried out with all stakeholders prior to the survey and agreement was obtained from the Mine Workers Union of Zambia to proceed with the survey.

A laboratory-based HIV ELISA saliva test was used and testing was voluntary and anonymous. Of the total workforce, 64% participated and the HIV prevalence rate was found to be 19.6%.

The prevalence survey will be repeated in 2006.

Example from DaimlerChrysler South Africa

The results from the HIV sero-prevalence study are currently being used to make projections on future HIV prevalence levels, to estimate the economic and other impacts of HIV on the company and as a baseline against which to evaluate the DCSA HIV/AIDS programme in the future.

At a more national level, HIV surveillance can also be done in other ways, such as:

- Sentinel surveillance in defined sub-populations, e.g. HIV testing of women attending antenatal clinics; and
- Routine screening of donated blood;



In addition, information on HIV prevalence can be estimated from:

- Targeted research studies of HIV infection rates;
- HIV and AIDS case reporting;
- STI and TB case reporting; and
- Death registration.

Whilst these sources can provide useful information to an organisation, and can be used as proxies, there are always a number of adjustments and assumptions that have to be made when using this data that can be, and often are challenged. The groups tested may be high risk (STI clients), antenatal clients (young, sexually active women), or not necessarily representative of the general population (blood donors or TB patients). As a rule extrapolating these results requires the services of an experienced epidemiologist, and even then the data may not be complete enough for an accurate estimate.

Important adjustments that would need to be made to national data would include:

- That antenatal data, which is the most frequently selected form of sentinel surveillance, is confined to women, usually in the 15-40 year age group and mainly in the 20-35 year bracket. Mining workforces are mainly men and are typically in a wider age range;
- That mining employees are likely to have higher and more stable incomes than the general population; and
- That, if employees live apart from the families for long periods, they may have a higher risk of infection as a result of casual or commercial sexual contacts.

Traditional surveillance typically tracked HIV or STIs, but did not track the sexual practices that lead to HIV/STI transmission. This made it difficult to corroborate and explain HIV/STI trends. More recently, so-called **second generation surveillance** has evolved, which seeks to combine biological and behavioural data. This allows for a more meaningful interpretation of the surveillance results.

Why does an organisation need to conduct surveys of HIV prevalence?

The information from regular or serial HIV surveys allows an organisation to:

- Develop an accurate understanding of the profile of the HIV/AIDS epidemic within the workforce, and its age, gender, job grade, department/section, employee benefit fund, and residence and geographic distribution;
- Plan, using this information, and to generate models of the epidemic and its likely impact on the organisation in the future;
- Track changes, even small changes, in prevalence, and understand the factors responsible for these changes;
- Plan for programmes and services – prevention and care – and target these appropriately; and
- Monitor its HIV/AIDS programme, and measure any successes.

Contractors may not be in a position to commission an HIV prevalence survey. Should they do so, and if their numbers of employees are small, this could create problems with the anonymity of the survey. A possible compromise would be for the contractor to participate in the survey of a larger organisation to which they are providing services.



What are the features and elements of a workplace HIV prevalence survey?

Many of the features of behavioural surveillance are relevant also for biological surveillance. These include:

- Developing the protocol;
- Negotiating with employee representatives to create an optimal environment for the survey;
- Defining the sample;
- Informing employees of the survey and how they may participate;
- Administering the survey;
- Analysing the results;
- Reporting on the findings, which can constitute an important “wake-up call”; and
- Using the findings to inform workplace programmes.

In addition, HIV prevalence surveys provide information for:

- Human resource planning;
- Critical job analysis;
- Establishing trends in the epidemic in each strata (age, job band etc.);
- Employee benefit fund management;
- Budgeting for health care costs; and
- The assessment of utilisation of ART and VCT programmes.

There are important **ethical considerations** associated with conducting HIV surveillance. These include obtaining approval from the ethics committee of a local academic institution that the protocol is ethically sound, and ensuring that participants give free and full consent to participate.

These requirements become clear when HIV surveillance is placed within the context of other HIV testing.

Unlinked anonymous testing (without informed consent)

- Testing of unlinked **specimens collected for other purposes**;
- No personal identifiers or names obtained, no informed consent, no counselling required;
- Coded specimen.

Unlinked anonymous testing (with informed consent)

- Testing of unlinked **specimens collected solely for surveillance purposes**;
- Informed consent required;
- No personal identifiers or names obtained (usually only age, sex and job grade information is collected), no counselling required;
- Coded specimen.

Linked confidential testing (with informed consent)

- Informed consent and pre-test and post-test counselling required;
- Personal identifiers or names obtained;
- Coded specimen; **code linked to personal identifying information.**

Linked anonymous testing (with informed consent)

- Informed consent and pre-test and post-test counselling required;

Anonymous and unlinked surveillance or epidemiological testing is defined in the Code¹ as anonymous, unlinked testing which is done in order to determine the prevalence and possibly incidence of disease within a particular community or group to provide information to control, prevent and manage the disease. The Code states further that such testing will not be considered anonymous if there is a reasonable possibility that a person's HIV status could be deduced in any way from the survey results.



- No personal identifiers or names obtained;
- Coded specimen; **code given to client so that only client can link himself or herself to the result.**

In addition, HIV surveillance should only be undertaken by professionals with qualifications in epidemiology or public health. The tests should be done by qualified and experienced laboratory technicians and the tests utilised should have high sensitivity and specificity and be suitable for such surveillance.

Many **types of specimens** can be used for HIV biological surveillance: whole blood, plasma, serum, oral fluids/saliva and urine. The choice of specimen depends on factors such as logistics, staff (availability and competency) and sites. Saliva tests are usually selected for workplace HIV surveillance, because of the ease of specimen collection.

Specimens must be collected, stored and tested in an appropriate manner in order to obtain accurate and reliable results.

Information that can be obtained from an HIV surveillance exercise includes:

- Prevalence according to:
 - Sex: male or female
 - Age: e.g. <35; 35–49; >49 years
 - Race
 - Job: unskilled; skilled; management
 - Province/region/site;
- Projected prevalence;
- Projected incidence; and
- Projected mortality.



Red Flags and Special Challenges

HIV sero-prevalence studies should never be the first, or even one of the first HIV/AIDS interventions, and participation should never be mandatory, as this could send problematic messages to the employees and the community.

Conducting an HIV prevalence survey is easier in a large organisation than in a small one, as the assurance of anonymity is more credible in larger organisations.

The most difficult aspect of conducting HIV surveillance in the workplace is to obtain the co-operation of workers and to get high participation rates. Failure to obtain participation levels of over 70% will result in the data being biased, unreliable and of limited value. It is also important to assess employee participation by age, job, etc. to understand possible biases.

- The survey is unlikely to be supported if employees cannot understand how the results will be of any benefit to them; and
- Surveys tend to raise suspicions that management is trying, through the survey, to identify HIV infected employees.

Epidemiological testing

1. *Testing programmes for epidemiological purposes will be the subject of appropriate consultation with recognised employee organisations and will be subject to independent and objective evaluation and scrutiny.*

2. *The statistical results of testing programmes will be shared with employees and recognised employee organisations.*

3. *The results of epidemiological studies will not be used as a basis for discriminating against any class of employee in the workplace.*

Extract from the agreement between the National Union of Mineworkers and the Chamber of Mines

Participation in workplace HIV surveillance can be enhanced if:

- Management launches awareness campaigns about the survey;
- Employees, trade unions and staff associations are involved in planning the survey;
- The survey is conducted by an independent third party; and
- Results are shared with all employees.

Unlinked anonymous studies are not considered ethical unless potential participants have independent access to voluntary HIV testing and counselling.

A single prevalence survey is of little use, whereas a sequence of surveys over a number of years will allow for trends to emerge.

Experience has shown that it is difficult to organise and conduct both an HIV prevalence survey and a KAP survey at the same time, despite the temptation to use the same sample and to be able to link the results.



Tool: Checklist for an HIV prevalence survey

Instructions

When embarking on an HIV prevalence survey in your company, use the following checklist as a guide to ensure that you have considered all the important issues:




- There should be an established HIV/AIDS programme in the company and a multidisciplinary task group/committee to oversee the survey;
- The company should know why it wants to do a survey and how it will use the data. The company should list the benefits of doing the survey, both to the company and to its workforce;
- The survey must have ethics approval from an established medical research ethics committee (usually a local medical school);
- The company must decide which strata it would like to capture in the survey i.e. age bands, job bands, department, gender etc.;
- Employee representatives must be consulted and agree to the survey in writing;
- Employees must be informed about the survey and its benefits;
- The consultant doing the survey should be experienced in research methodology and have appropriate qualifications (in epidemiology or public health);
- The measurement tool, i.e. the HIV antibody test, should have high sensitivity and specificity and be shown to match well with blood testing studies;
- The team collecting specimens needs to be experienced in research methodology;
- The laboratory investigation should be done by experienced laboratory technicians who have experience with the HIV antibody test selected;
- A strategy should be in place to communicate the survey results to the workforce, and the results must be given to management and labour simultaneously;
- A personal and confidential HIV test with pre- and post test counselling must be available to any employee who wants to have an HIV test;
- Essential bio statistical analysis must be done;
- An appropriate sample size should be determined prior to the survey; and
- A financial costing for the survey and the expected outcomes must be decided and agreed upon prior to the survey.



Score Card: HIV surveillance

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> National data, such as antenatal data, used to develop a best and worst case scenario of the impact of HIV/AIDS on the company 		
 Good Response	<ul style="list-style-type: none"> Once-off surveillance conducted, and results used to plan for future technical needs Results shared with pension and medical aid providers 		
 Blue-chip Response	<ul style="list-style-type: none"> Surveillance repeated every 2-3 years and results considered for all aspects of strategic and operational planning Biological and behavioural surveillance linked and results used to target HIV/AIDS prevention programmes 		

Costs

Like a KAP survey, an HIV surveillance exercise requires specialist skills and will, in most cases, be contracted out. The cost of the survey will depend on the cost of the tests usually US\$ 3-5 per employee tested and an administrative fee (which will depend on the size of the workforce, number of employees to be surveyed, geographical location, etc.).





Case Study: HIV surveillance study - Aurum Health Research and AngloGold

The following case study describes the process undertaken by a large mining company to conduct an HIV prevalence survey. It does not include information on the benefits to the company that resulted from the process, or the way in which the survey results may have been used to inform the HIV/AIDS programme.

In 1999, Aurum Health Research (AHR) used an anonymous unlinked survey to estimate an HIV prevalence of 24% in employees in the lower pay scales in the Free State region. The employees in these pay scales represent 85% of the workforce in the region.

In 2001, a follow-up anonymous unlinked survey of employees in the same lower pay scales estimated an HIV prevalence of 29%. The second survey was done in collaboration with the London School of Hygiene and Tropical Medicine.

Between June 2000 and April 2001, the research team, using a stratified random sampling method, selected employees visiting the occupational health centre for their mandatory annual medical examination. The survey invited 6 100 employees from both the Free State region and the Vaal River region to participate and had an 87% response rate.

Participants were informed using a video available in two local languages followed by a question and answer session with a nurse. HIV testing was done by means of a urine test.

The study protocol was approved by two independent ethics committees of which one had local labour representation.

Based on the surveys, antenatal data, and extrapolation from comparable reference groups, AngloGold estimated a 2001-2002 company-wide prevalence rate of 25 to 30%. The number of deaths per 1 000 workers had decreased from 13 per 1 000 in 2001 to 4 per 1 000 in 2002. Likewise, the number of ill-health retirements per 1 000 workers had dropped from 19 per 1 000 to 6 per 1 000 in 2000 and 2002 respectively. It is assumed that this apparent paradox can be explained by the increased uptake of voluntary separation packages offered routinely during downsizing and through AIDS-sick employees not returning to the workplace and being dismissed in absentia.



Additional Information

The full AngloGold and DaimlerChrysler case studies are available at www.weforum.org/globalhealth/cases.

The full Chamber of Mines and NUM policy is contained in the ILO manual which is available on www.ilo.org.

Additional information on biological HIV surveillance can be found in the UNAIDS publication; *Guidelines for second generation HIV surveillance*, which is available on www.unaids.org.

Footnotes



¹ The Code referred to is the South African Department of Labour's *Code of good practice on key aspects of HIV/AIDS and employment*



Section Two

HIV/AIDS Risk and Impact Assessment

Section One

Section Two

Section Three

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Section Five

Appendices

Contributors



Briefing Note

What is an HIV/AIDS risk and impact assessment?

An impact assessment, often referred to as a risk assessment, is an exercise to describe the potential or likely impact of the epidemic on an organisation by describing the current situation and modelling scenarios into the future. An impact assessment typically includes costing the impact of the epidemic on all functions of the organisation. It may also cost out various interventions and their cost benefits compared to the cost of doing nothing.

Why does an organisation need to conduct an HIV/AIDS impact assessment?

All organisations operating in the mining sector in Southern Africa are more or less vulnerable to the impact of the epidemic. The impact may be on the company itself or on its business or supply chain. Typically the HIV/AIDS epidemic results in¹:

Workplace impacts

- Reduced productivity;
- Increased labour costs for employers; from health benefits to retraining;
- Reduced supply of labour;
- Loss of skilled and experienced workers;
- Absenteeism and early retirement;
- Stigmatisation of and discrimination against workers with HIV/AIDS; and
- Additional demands on pension, provident, death and funeral benefits;

Societal and national impacts

- Changing consumer behaviour/spending;
- Falling demand, investment discouraged and enterprise development undermined;
- A threat to food security (and agricultural production) as rural workers are increasingly affected;
- Increased demands for health care;
- Contracting tax base and negative impact on economic growth;
- Social protection systems and health services under pressure; and
- Pressure on higher purchase or bank loans and life insurance.

Myth

HIV/AIDS is a soft business issue best handled by the human resource function in the company.

Reality

HIV/AIDS is going to have a significant impact on bottom-line profits and needs to be part and parcel of line management's strategic thinking and decision-making.

*Whiteside, A and Sunter, C
AIDS, the challenge
for South Africa (2000)*



Family and community impacts

- Increased burden on women to combine care and productive work;
- Loss of family income and household productivity, which, in turn exacerbates poverty;
- Orphans and other affected children forced out of school and into child labour; and
- Pressure on women and young people to survive by providing sexual services.

It is much better for organisations to understand how these factors will impact on their operations and to plan accordingly than to wait for the impact of the epidemic to become really obvious and then to try and respond. Conducting an impact assessment therefore allows for a much more proactive response, in particular relating to those factors that can be influenced or manipulated to minimise their impact. In addition, organisations can use the platform created by an impact assessment to initiate interventions – such as HIV/AIDS prevention programmes for employees and contractors, or nutrition and treatment provision for HIV infected employees – that have the potential to significantly change the epidemic’s impact.

NOSA HIV/AIDS specification

The NOSA AMS² requires an HIV/AIDS **determinant identification and risk assessment** as a starting point and important input into the planning of an HIV/AIDS management system and subsequent implementation, evaluation, corrective and preventive action, and review.

The intent is stated as follows:

Identify and assess HIV/AIDS risks through a dynamic and holistic process to facilitate effective risk reduction plans and actions.

Importantly the risk assessment includes “socio-immigration and migrant labour, single-sex hostels, overcrowded housing, poor access to health services, lack of recreation facilities, lack of accurate information, culture, high unemployment, exploitation of women and poverty factors such as TB”.

Contractors, whilst they may not formally commission a risk and impact assessment, should attempt to identify and quantify risk factors, and should build this understanding into their planning – not only for their HIV/AIDS programme, but also in relation to their services, markets, suppliers and so on.

A contracting company may participate in the impact assessment of the mining company it is working for.

What are the elements of an HIV/AIDS impact assessment?

An HIV/AIDS impact assessment consists of:

- Collecting and analysing data;
- Creating models of the impact of the epidemic on the organisation and its structures; and
- Conducting a cost analysis, and monitoring cost impacts.

1. Collecting and analysing data

The data that is available will vary in different organisations, but most companies will be able to provide data on:

- The number of employees, by age, gender, grade and education level;
- The salaries and benefits of contract and permanent staff;



- Measures of productivity;
- The rate of sick leave and compassionate leave usage;
- Medical aid claims;
- Clinic utilisation;
- Early retirements for health reasons;
- Deaths in service; and
- Staff turnover.

Example of data analysis

Those who were separated due to HIV/AIDS took between 11 and 68 more days leave in their final year of service than did employees who were still in the workforce³.

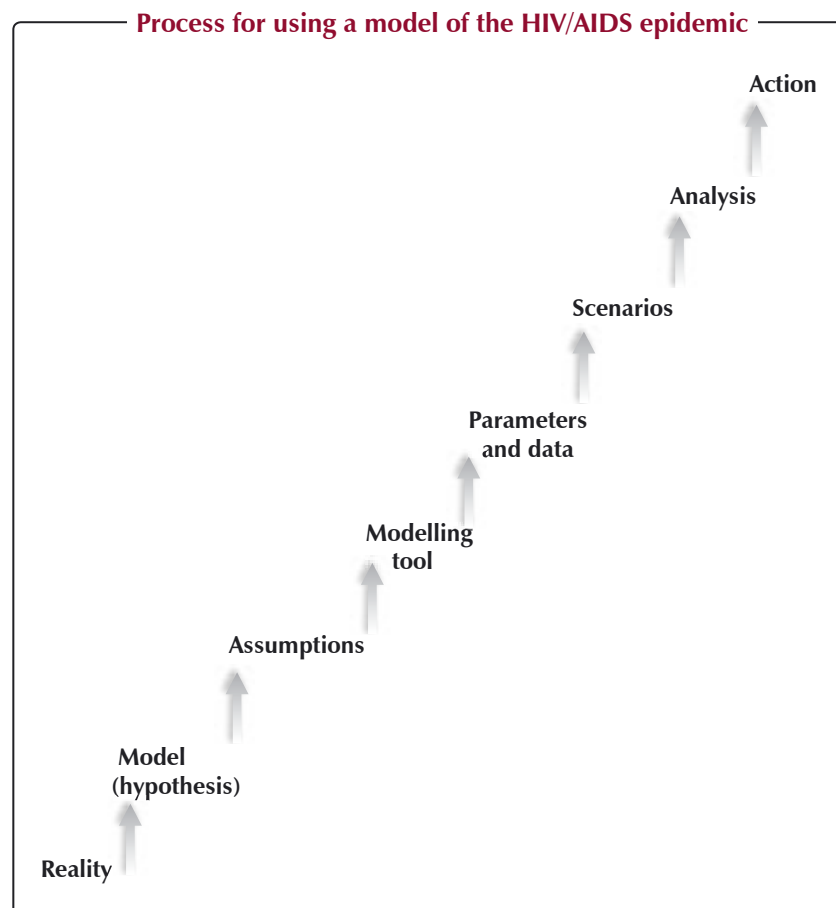
They were 22-63% less productive in their final year of service.

Supervisors reported spending 7-25 days of time per employee with HIV/AIDS, in the employee's last year of service.

It is important to remember the often quoted statements that no data = no decisions; rubbish in, rubbish out; what is measured is managed; and manage HIV, don't let HIV manage you; all of which highlight the critical importance of reliable data for impact assessments.

2. Creating models of the impact of epidemic on the organisation and its structures

As demonstrated in the following diagram, a model is a conceptual framework that attempts to describe reality, and to provide answers to questions about the real world.



Most models have concentrated on predicting the path of the epidemic, though there are some that attempt to measure the impact of certain interventions. These may assist in answering questions such as:

- Is it better to invest resources in one intervention rather than another?
- Which service or combination of services gives the best value for the budget available?
- How should resources be allocated within the competing needs of the HIV/AIDS programme?
- How can an extra investment best improve a programme's performance?

It is important to keep adding real data (such as deaths, costs, known HIV/AIDS cases, etc.) to the model so that, eventually, an organisation will have a data set and epidemic curve of real events and, in time, will no longer need to model the epidemic.

Finally, apart from providing information for planning, models are also a useful advocacy tool.

All models, however, must be used with caution. They are mathematical constructs, not crystal balls, and, apart from their dependence on quality data, they also require a number of assumptions. In addition, the further into the future the model projects, the more these cautions need to be stressed.

3. Conducting a cost analysis and monitoring cost impacts

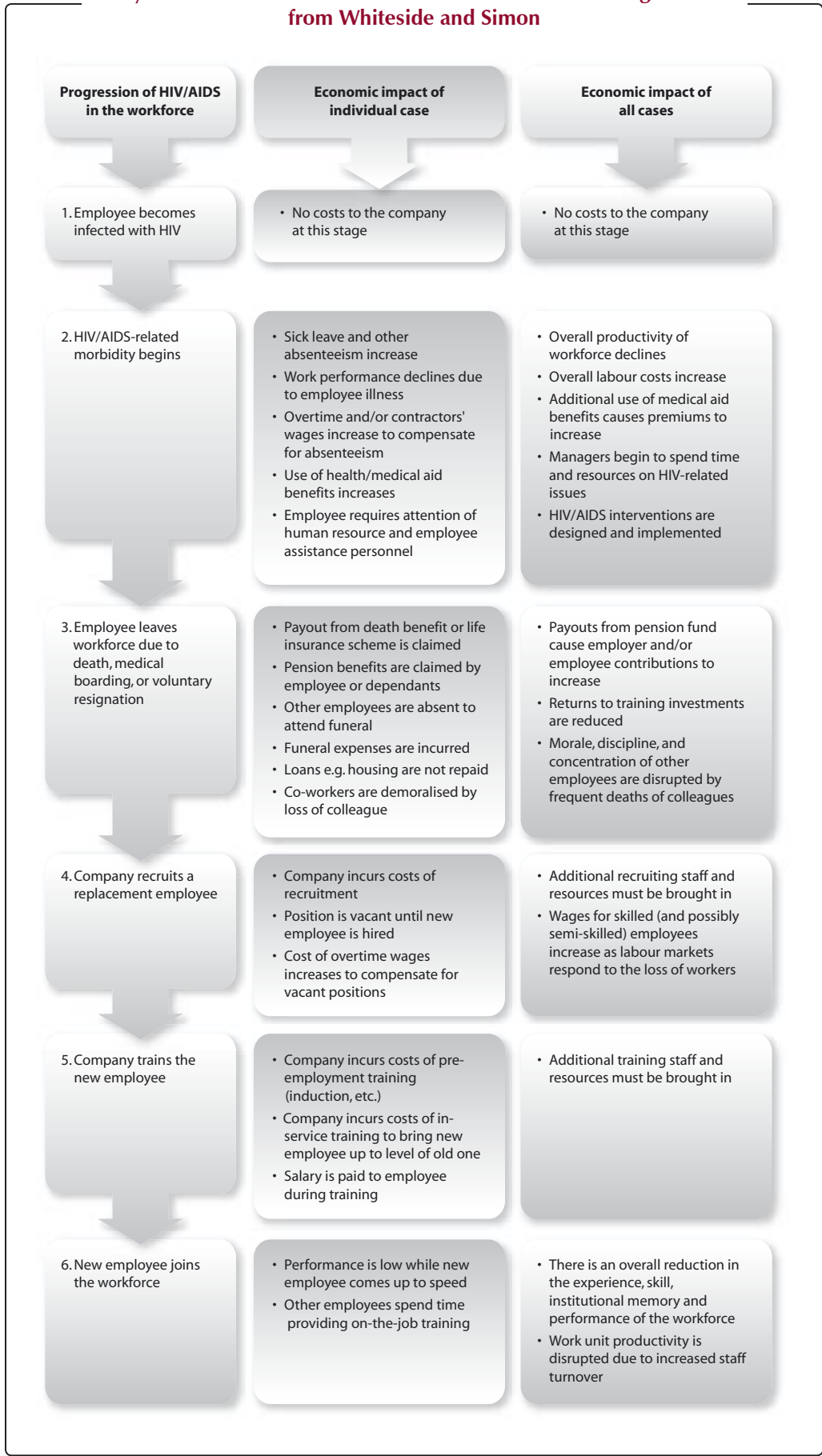
Costing the human resource implications of the epidemic is only one aspect of a cost analysis. It should also consider the goods and services flowing into and out of a sector, the markets, and indeed macro-economic changes that will impact on the organisation.



The following diagram illustrates the human resource costs of HIV/AIDS to an organisation at different points⁴. Similar flowcharts could be developed to assist in costing the other elements.



Analysis of the human resource costs of HIV/AIDS to an organisation from Whiteside and Simon



4. Social impact assessment

Many companies, including contracting companies, are commissioning social impact assessments, recognising that their operations do not occur in a vacuum and may indeed have significant impacts on local communities. There is potential for both the social impact assessments and HIV/AIDS risk and impact assessments to be conducted in ways that complement each other, providing a greater wealth of information and a more in-depth understanding of the contextual factors.



Red Flags and Special Challenges

When conducting an impact assessment it is best to use consultants who have a range of epidemiological, actuarial and modelling experience.

Often the information that is available in an organisation is not in a format that can be used in an HIV/AIDS impact assessment. Organisations need to develop systems that will capture information in appropriate forms.

Validation of the findings of an impact assessment is an important step to ensuring ownership at company level. This should take the form of consultative briefings, which will assist in ensuring that the results are used optimally in planning and programming.

It is often difficult to make comparisons of costs, across organisations, or across time, due to the fact that different elements are either factored in, or excluded, such as recruitment costs, the cost of supervisors' time and so on.



Tool: Impact assessment checklist

Instructions

Use the following checklist when defining the parameters of your organisation's impact assessment. Bear in mind that not all organisations will have access to all this information.

Organisational profile

- Structure of organisation – management/human resource structure (organogram);
- Number of staff – by gender, age, grade, type of employment and type of contract (explain the grading system);
- Number of contractors by gender, age, and type of work;
- Operations, functions and services; and
- Age of organisation (and organisational history).

Nature of work/employee information

- For different types of work in the organisation, how much experience/training is needed?
- Do some types of work require experience gained on the job?
- How easy is it to train or replace individuals in different categories of work?
- Are there key personnel whom it will be particularly difficult to replace?
- Are there key personnel on whom a certain process or activity depends?



Assmang Ltd provide an additional benefit in the form of skills training (computer training, chef's courses, etc.) to the dependents of infected employees who have disclosed.

- Does any of the work demand travel?
- Are certain employees/contractors at greater risk of exposure to HIV/AIDS (such as those who travel or who are based away from home)?

Employee benefits (include grade differentials where applicable)

- What type of the following are provided, to whom, and at what cost:
 - Medical services or medical aid
 - Death benefits
 - Insurance
 - Pension for dependants
 - Other benefits (e.g. housing, transport) especially those affected by illness or death?
- Is there sick leave provision? How much?
- Is there compassionate leave? How much?
- What type of HIV/AIDS prevention programmes are in place?

Management information system

- How does the organisation record:
 - Absence from work?
 - Lateness for work?
 - People leaving work early?
- Does the organisation maintain records of reasons for employees' absence?
- Does the organisation keep records of compassionate leave?
- What is this data used for?
- Where is the data collected and collated? By whom? For how long?

Absenteeism

- Rates or numbers of absences per month, by grade, gender, and age;
- Rates of short-term and extended absenteeism; and
- Reasons for absenteeism.

Sick leave

- Absence by grade and age;
- Diagnosis;
- Number of employees (per month); and
- Number of work days lost per month.

Ill-health retirements

- Numbers per month by:
 - Age
 - Grade
 - Gender
 - Engagement date
 - Level of training
 - Diagnosis at time of departure – i.e. reason for leaving.
- Were any of these key personnel difficult to replace?
- Did any workers receive “continuation health care” or support on retirement, and at what cost?

Mortality data

- Numbers per month by:
 - Age
 - Grade
 - Gender
 - Engagement date
 - Level of training
 - Cause (diagnosis).
- Were any of these key personnel difficult to replace?

Other/undefined turnover

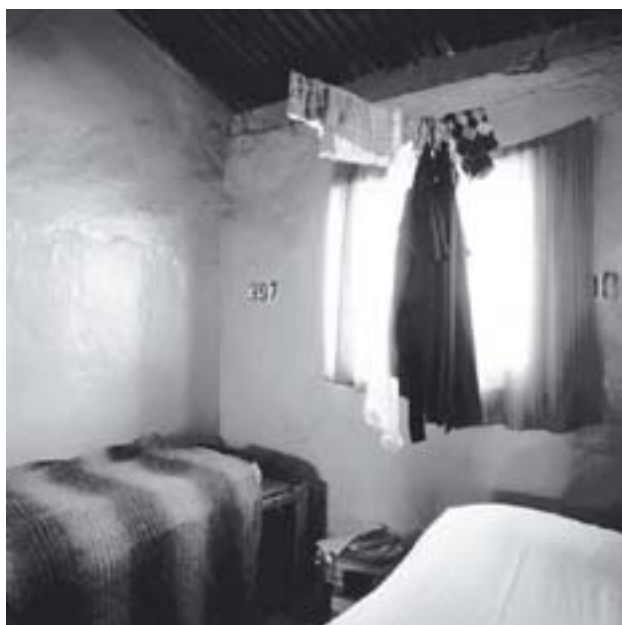
- Numbers of employee departures per month;
- Reasons for departures;
- Do departures correlate with absenteeism – do people leave after extended absenteeism?
- Were any of these key personnel difficult to replace?

Replacement hiring

- How long are posts vacant?
- Is it difficult to find replacement personnel?
- How costly is recruitment, hiring, and training?

Effect on daily operations

- What is the effect on the organisation's daily operations of illness, absenteeism, and turnover of staff and volunteers?
- Are there frequently vacant posts? Are there holes in the management hierarchy or chain of production?
- What is the impact of the loss of experience and need for training?
- Are there problems with a lack of cohesion, or loss of morale?
- What is the impact on the ability of staff and volunteers to perform their duties?
- What is the impact on the organisation's ability to meet its targets?





Score Card: HIV/AIDS impact assessment

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> HR data reviewed and analysed annually for any trends that may indicate HIV/AIDS-related impact 		
 Good Response	<ul style="list-style-type: none"> MIS reviewed and adjusted to ensure optimal data collection for tracking and monitoring HIV/AIDS-related trends Monthly collection of data and quarterly analysis Impact assessment commissioned and results presented to management 		
 Blue-chip Response	<ul style="list-style-type: none"> Impact assessment linked to behavioural and biological surveillance, and composite results fed into strategic and operational planning and budgeting 		

Costs

Impact assessments are costly exercises, but can easily be justified in terms of the information for planning that they provide to an organisation.



Case Study: HIV/AIDS impact assessment - Anglovaal

Anglovaal Mining Ltd (AVMIN) is a company that develops copper, cobalt, nickel, ferrous and precious metals. The company has 8 mining and plant operations in South Africa, Zambia and Namibia. The company has 7 500 workers (5 300 employees and 2 200 contractors). AVMIN generated US\$ 369 million revenue and US\$ 37 million earnings in 2001.

As part of an annual risk assessment, the present value of the average cost of a newly infected HIV employee was estimated in all divisions except for headquarters and Zambia (85% of employees were assessed) in a study with the Boston University School of Public Health.

The results were as follows:

Salary class	Present value of one infection (US\$)
Tier I (unskilled)	\$ 5 774
Tier II (skilled and artisans)	\$ 10 091
Tier III-VI (supervisors and managers)	\$ 32 433
Company average	\$ 8 170

The average cost breakdown was: death and disability (38.1%), productivity losses (41.9%), supervisory time (7.1%), sick leave (6.5%), medical aid premiums (4.5%), recruitment and training (1.9%).

In 2002, AVMIN estimated a future HIV/AIDS liability of US\$ 6.1 million for all HIV infected employees. This assumes an estimated 2002 prevalence of 14.1%; present value per infection of US\$ 8 170; 5 300 employees; and that all infections started in 2002. Additionally, AVMIN estimated that US\$ 805 000 of that liability was assumed through the estimated 99 HIV infections that were acquired in 2002.



Additional Information

The full Anglovaal case study is available at www.weforum.org/globalhealth/cases.

Information on impact assessments and modelling techniques is available in a publication edited by Prof. Alan Whiteside and entitled *Implications of AIDS for demography and policy in Southern Africa* (1998).

The Futures Group International has developed a number of modelling techniques. Their *AIDS Impact Model for Business* is available on www.futuresgroup.com/aim.

Data sets and sources are described in the UNAIDS publication, *Guidelines for studies of the social and economic impact of HIV/AIDS* (2000), available on www.unaids.org.

The NOSA AMS 16001 (2003): *Standard for HIV/AIDS Management System* specification document and guideline document are available on www.nosa.co.za.

Footnotes



¹ See also the information on the HIV/AIDS epidemic and the workplace, in Section One of the **Guide**

² The AMS is available on www.nosa.co.za

³ Other sources quote an average of 55 days in the last 2 years of service

⁴ Adapted from *The response of African businesses to HIV/AIDS*, in HIV/AIDS in the Commonwealth and quoted in Whiteside, A and Sunter, C; *AIDS the challenge for South Africa* (2000)



Section Two

Managing the Human Resource Implications of the HIV/AIDS Epidemic



Briefing Note

What is meant by the human resource implications of the HIV/AIDS epidemic?

Because HIV/AIDS affects the economically active age groups, there are implications for the world of work unlike those associated with any other disease. In addition, the fact that the disease, in an infected employee, remains “invisible” for years and then follows an often unpredictable pattern from symptomatic HIV disease to death means that it is very difficult to plan for an organisation’s human resource needs.

In addition to the predictable effects of large numbers of infected employees – such as increased absenteeism, reduced productivity, and increased demand on benefits, there are systemic effects, such as the loss of valuable, and sometimes irreplaceable institutional memory; factors which are often neglected when considering the implications of the epidemic on human resources.

There are potentially profound effects related to the stigma and discrimination which are associated with HIV/AIDS and which are still pervasive in many workplaces, even in situations where the epidemic has been present for a decade or more. These effects can translate into all forms of workplace disruption, reduced morale and even conflicts – problems that require time and attention if they are to be resolved.

Finally, outside of the workplace, but with significant implications for employees from affected families and communities are the consequences for those who are forced to assume ever increasing social burdens, in the form of supporting orphans or caring for sick family members.

ESKOM example

When ESKOM observed that there were twice as many deaths in service as previously; and that 50% of ill-health retirements were as a result of HIV/AIDS, they tripled their bursary scheme to ensure a consistent supply of suitably qualified technical staff.

De Beers Oranjemund example

HIV/AIDS statistics are displayed regularly, using a template that has been approved by the union.

In a world where there is still prejudice and misunderstanding about HIV/AIDS, confidentiality is a right that protects other rights. Failure to defend the right to confidentiality will drive HIV/AIDS underground, with drastic consequences².



Why does an organisation need to manage the human resource implications of HIV/AIDS?

In order to function, organisations need the right number of people, with the right competencies, in the right places. The HIV/AIDS epidemic poses a threat to demand, supply and quality of human resources that must be managed appropriately.

Contractors are no different, in fact they may be more vulnerable than larger organisations to the loss of a highly skilled employee. They should therefore identify these critical positions and institute plans to ensure that the skills necessary for their operation are retained, should the employees in these positions be lost to the organisation.

Red Flags and Special Challenges

1. Succession plans

Many organisations fail to identify critical posts, which are not only or necessarily senior management posts, nor do they have succession plans in place to replace workers in these critical posts who fall ill, are retired early on medical grounds, or who die.

Several mining companies are investigating innovative methods to reduce the impact of HIV/AIDS on the families of mineworkers who are unable to continue working.

At Lonmin's Western Platinum Operation¹, HIV-positive employees who are faced with medical boarding can nominate candidates as possible replacements. This provides an important opportunity for employment benefits to remain within the immediate or extended family of the affected person. The impact of the loss of income is therefore mitigated. This solution is, however, only likely to be practical for jobs that do not require high levels of skills.

2. Confidentiality

Every person has the right to personal privacy and dignity. Every person has the right to decide what aspects of his or her life are private and what can be made public. Unfortunately this right is frequently abused when it concerns a person's HIV status.

Express and informed consent must be obtained from a person before information about their HIV status is passed on to anyone else. This means that the person living with HIV or AIDS must be informed about the intended use of the information, including who is going to be told.

3. Reasonable accommodation for incapacitated employees

Because of the nature of mine work there are limited options for reasonable accommodation such as shifts to less physically demanding jobs, for incapacitated employees.

4. Benefits

Benefits typically include group life insurance, pensions, death and funeral benefits and medical aid. HIV/AIDS will result either in increased payroll costs or decreased benefits, however the impact on benefits will vary depending on the skill levels and replaceability of employees, the sector the company operates in and the types of benefits provided.



The impact on individual benefits will depend on:

- How the risk benefit is structured;
- Who pays for the risk benefit; and
- Whether the benefit structure or the contribution is fixed.



Tool: HR HIV/AIDS management guidelines

Instructions

Review your human resource systems and procedures to ensure that they adequately integrate the following actions:

1. Succession and skills planning

- Look at your organisation's long-term workforce and succession needs, given that HIV/AIDS will result in high staff turnover, reduced skills levels, declining quality of available recruits, and high competition for skilled personnel.
- Draft plans for ensuring the organisation's medium- and long-term ability to fill positions with quality, skilled individuals; these should include hiring plans, systematic induction processes, and skills development.
- Consider ways to replicate skills and knowledge among multiple employees, so that the absence or loss of any individual can be more easily absorbed. This can be accomplished through co-operative and team-based work processes, multi-tasking, training, learnership programmes and effective information exchange.
- Record institutional knowledge and important processes in a formalised manner, such as through a manual for each position, so that this knowledge is not lost with the loss of an individual employee.

2. HR information systems

- Evaluate and find ways to improve your human resource information systems, so you can monitor the impacts of HIV/AIDS on your organisation. This is particularly important for large or decentralised organisations, where people in management positions may not be aware of how the epidemic is impacting staff and contractors.
- Analyse and interpret information from different sources to create a composite picture of changes in the workforce and of trends over time, using data such as family leave taken for funerals; special leave requests; cost of accidents/incidents; staff turnover; etc. In doing this, it is important that information from different sources is in forms that can "communicate" with other data.

3. Benefits

- Review and, where necessary, remodel benefit schemes;
- Review and, where necessary, amend the services of the medical aid scheme;
- Enhance the process for management of death benefit allocations; and
- Enhance the capacity for managing ill health and early retirement cases.

4. HR policies and practices

Review HR policies, such as sick leave and incapacity policies to ensure that they adequately cater for HIV/AIDS. Develop systems and programmes to manage:

Assmang Ltd has introduced a Succession Candidate system. Two employees are identified and trained for every key position. The HIV prevalence survey results indicate where the loss of staff in key positions can be expected.

- Increased absenteeism;
- Reduced productivity;
- Higher labour turnover; and
- Loss of skills.

5. Reasonable accommodation for incapacitated employees

Review existing measures and, where feasible, create opportunities for:

- Job modifications;
- Flexible scheduling;
- Job sharing;
- Leave of absence;
- Transfers;
- Computer terminals at home;
- Ease of access (e.g. wheelchair ramps); and
- Technological alternatives.

6. Training

Develop an HIV/AIDS training plan that includes:




- Managers, supervisors and personnel officers;
- Employee representatives;
- Peer educators;
- Health and safety officers; and
- Employees who may come into contact with blood and other body fluids.



Score Card: HR HIV/AIDS management

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • HIV/AIDS module included in induction and re-induction courses 		
 Good Response	<ul style="list-style-type: none"> • Critical positions identified • Succession plan developed, in light of results from impact assessment 		
 Blue-chip Response	<ul style="list-style-type: none"> • 2 or more successors trained for every critical position or multi-tasking implemented • Bursaries provided for training in key technologies • Early warning system in place to identify HIV/AIDS cases and to provide back-up to ensure that functions and productivity are not affected 		



Costs

There will be costs associated with many of the HR HIV/AIDS management activities. These include training costs, costs associated with implementing a skills succession plan, the costs of reasonable accommodation, and so on. In comparison, not doing anything could cost more.



Case Study: HR data collection - Debswana

Debswana collects a range of HR data on a monthly basis, which they analyse and compile into an HIV/AIDS Fact Sheet for submission to management on a quarterly basis. The following is a consolidation of the information which they have found to be of use in tracking the HIV/AIDS epidemic at their various operations.

Workforce demographics – by age bracket, gender, job grade and location

- Average workforce
- Average man days worked
- No. on medical aid

Medical retirement – by age bracket, gender, job grade and cause (accidental, HIV/AIDS or other)

Turnover and separation – by age bracket, gender, job grade and cause (normal retirement, transfer within the group, medical retirement, death, resignation, dismissal, localisation and end of contract)

- Turnover (no. of separations)
- Turnover rate
- Total ill health retirements
- ARC ill health retirements

Death data – in-service and out-of-service – by age bracket, gender, job grade and cause (accidental, HIV/AIDS or other)

Leave – by age bracket, gender, job grade and cause and type (sick leave, unpaid leave, compassionate leave and absenteeism)

- Productive % time lost due to illness
- % no. of days lost to leave over the total no. of man days
- Total no. of days
- Total no. of people

Recruitment costs – local and international – and by age bracket, gender, job grade

- Advertising costs
- Relocation costs

Permits and licences
 Agency fees
 Settling in/upset allowance
 Travel and accommodation
 Labour/staff costs

Training costs – apprenticeships and on the job training – and by age bracket, gender, job grade

Labour/staff costs
 General expenses (travel and accommodation, training materials, equipment, tuition/course fees, apprenticeship allowances, etc.)

HIV/AIDS-related data

Sero-prevalence – 2001
 Estimated no. HIV+
 Employees registered on AfA (Aid for AIDS disease management programme)
 % HIV+ employees registered
 Spouses registered on AfA
 Trained counsellors
 No. of employees counselled
 No. of employees tested (voluntary)
 No. of employees tested HIV+
 Trained peer educators
 Peer educator master trainers
 Contributions into the Trust Fund
 ART claims from the Trust Fund
 Condoms distributed
 Condoms distributed per employee/month
 STI cases
 TB cases



Additional Information

Whiteside and Sunter detail the direct, indirect and systemic HR costs, in their book entitled *AIDS, the challenge for South Africa* (2000).

Information on personnel profiling, critical post analysis and various strategies such as out-sourcing and multi-skilling can be found in the UNAIDS publication; *Guidelines for studies of the social and economic impact of HIV/AIDS* (2000), available on www.unaids.org.

Footnotes



¹ Elias et al from the MMSD report (2002)

² From *Positive development: setting up self-help groups and advocating for change. A manual for people living with HIV*; developed by GNP+ (1998)



Section Two

HIV/AIDS Corporate Social Investment



Briefing Note

What is corporate social investment (CSI)?

CSI means achieving commercial success in ways that honour ethical values and respect people, communities, and the natural environment. It also means addressing the legal, ethical, commercial and other expectations society has of organisations, and making decisions that fairly balance the claims of all key stakeholders.

CSI is thus the way a company achieves a balance or integration of economic, environmental and social imperatives while at the same time addressing shareholder and stakeholder expectations – in effect CSI serves as a strategic framework to guide a company’s behaviour by taking into consideration the social, environmental and ethical dimensions of their business practice.

Different terms are used to reflect this (or aspects of this) important function; these include corporate social responsibility, corporate citizenship, business ethics, socially responsible investment, sustainable development, good stewardship and so on.

CSI implies partnerships. Establishing good relationships between corporations, communities, civil society organisations, government authorities and even international donor agencies is not new. What is new is strengthening these relationships to the point where all parties ‘pool’ their knowledge, resources and skills to address complex social problems.

Companies in the extractive industries have traditionally come under pressure from advocacy groups and financial institutions to demonstrate corporate responsibility and accountability through a combination of policy and action. As part of a growing movement towards becoming more open and transparent, a large number of companies are preparing sustainability reports that review a company’s social and environmental performance against established goals and objectives. In its simplest terms CSI revolves around: “what you do, how you do it, and when and what you say.”

“The aim of this Group is, and will remain, to make profits for our shareholders, but to do it in such a way as to make a real and lasting contribution to the communities in which we operate.”

*Anglo American founder,
Sir Ernest Oppenheimer*



Why is it important for an organisation to mainstream HIV/AIDS into its CSI programme?

By having in place a CSI strategy a company is demonstrating that it understands the far-reaching influence of its operations. It is also taking a pro-active stance to identify and assess its social and environmental risks and put in place a strategy to manage their corporate activities that will help to strengthen their reputation as a good corporate citizen. Without a strategy in place to manage and report on the company's contribution to sustainable development, business can become an easy target for high profile campaigns launched by advocacy groups, often on behalf of affected communities. These campaigns typically attract negative media coverage and trigger strong reactions from consumer groups, analysts and regulators, while placing companies in a defensive position in an attempt to avert further damage to their reputation and impact on their bottom line.

Across Southern Africa, companies are engaged in serious efforts to define and integrate CSI into all aspects of their business, with their experiences being bolstered by a growing body of evidence that CSI has a positive impact on business economic performance. Stakeholders – including shareholders, analysts, regulators, activists, labour unions, employees, community organisations and the news media – are holding companies accountable not only for their own performance but for the performance of their entire supply chain on an ever-changing set of CSI issues.

The issues that represent a company's CSI focus vary by business, by size, by sector and even by geographic region. In its broadest categories, CSI typically includes issues related to: business ethics, community investment, environment, governance, social development, marketplace and workplace. HIV/AIDS, as arguably the pivotal development issue in the region, must be one such issue.

Contractors may, or may not, have formal CSI programmes, but all will be approached from time to time to provide support to community initiatives. An appreciation of where and how this support can benefit HIV/AIDS initiatives can make a significant difference to projects that rely on local business for funding and other forms of assistance.

Contractors may participate in the CSI programme of a mining company where they have a presence. This participation could take the form of a commitment of a percentage of their profits being added to the mining company's CSI budget.

What are the elements of mainstreaming HIV/AIDS into CSI grant programmes?

When evaluating grant applications, the following are sample criteria to ensure that HIV/AIDS is mainstreamed into this particular CSI function. Note: some are generic criteria; others are HIV/AIDS specific¹.

- Does the proposed project fit within the objectives of the national HIV/AIDS strategy and programmes?
- Is there a comprehensive business plan?
- Will the project benefit HIV/AIDS efforts?
- How does the project rate in terms of coverage, quality and cost?
- Are the HIV/AIDS mitigation measures feasible?
- Is the project consistent with the priorities of the community and with local development plans?
- Are the community and civil society organisations (CSOs) involved in or contributing to the project? To what extent have the community and CSOs made efforts to address HIV/AIDS in their ongoing activities?



- Does the proposal indicate that various groups in the community participated in identifying the HIV/AIDS problems and prioritising the proposed solutions?
- Can the project be conducted within the time period specified?
- Are HIV/AIDS competent, skilled or trained personnel available, and, if not, does the proposal include provision for these individuals to be trained?
- Are PLWHAs involved, and, if so, in what capacity?
- Will the project link with other projects in the area?
- Are the roles and responsibilities of parties (including families, institutions, community groups, etc.) clearly delineated – for implementing, supervising and monitoring the HIV/AIDS components?
- Is there a reasonable plan for sustaining HIV/AIDS activities at community level?
- Will volunteers be used in the project, and, if so, will they be trained, given incentives, etc.?
- Are staff salaries based on local wages?
- Will procurement procedures interfere with implementation of the project?
- How will on-going operational and maintenance costs be covered to ensure that services are maintained throughout the project?
- Is there a well-defined plan and approach for monitoring and evaluating performance?
- Is the plan addressing the needs of particularly vulnerable groups?



Red Flags and Special Challenges

Sometimes, within the ambit of CSI, companies find themselves under pressure to deliver community services or benefits that are more properly the responsibility of government.

Often CSI-related decisions are taken independently of a company’s main HIV/AIDS priorities, which can result in the effect being less than optimal.



Tool: Mainstreaming HIV/AIDS into CSI functions

Instructions

A CSI strategy ensures that a company’s social investment programme is strategically aligned with their core business interests and that it provides a performance measurement framework for gauging progress towards the goals and priorities they have established for themselves. There are many aspects of corporate behaviour that can be enhanced with a comprehensive CSI strategy including corporate governance, environmental management, stakeholder relations and community development, which all contribute to the company’ ability to retain their social license to operate.

Consider each of the following strategies, which constitute areas where CSI should feature and define how your company will mainstream HIV/AIDS into them.

- **Mission, vision and values statements**

CSI merits a prominent place in a company's core mission, vision and values documents, and HIV/AIDS-related philosophies and commitments should also be reflected in these.
- **Corporate governance**

Many companies have established ethics and/or social responsibility committees of their Boards to review strategic plans, assess progress and offer guidance about emerging CSI issues of importance. These committees should be HIV/AIDS competent, if HIV/AIDS is to feature appropriately as a CSI issue.
- **Strategic planning**

A number of companies are beginning to incorporate CSI into their long-term planning processes. The plans should feature all CSI priorities, including HIV/AIDS.
- **General accountability**

In some companies, in addition to the efforts to establish corporate and divisional social investment goals, there are similar attempts to address these issues in the job descriptions and performance objectives of as many managers and employees as possible. This helps everyone understand how each person can contribute to the company's overall efforts to be more socially responsible, e.g. in terms of contributing to national HIV/AIDS-related targets.
- **Communications, education and training**

When publicising the importance of corporate social investment internally, include the issues that will be the focus of the CSI programme. This is a good opportunity to generate awareness about HIV/AIDS, and to improve knowledge about community HIV/AIDS projects. Communications such as union and SHE briefs, could be used.
- **CSI reporting**

Annual CSI reports can build trust with stakeholders and encourage internal efforts to comply with a company's CSI goals. The best reports demonstrate CEO and senior leadership support; provide verified performance data against indicators; share "good" and "bad" news; set goals for improvement; include stakeholder feedback; and many times are verified by outside auditors. Including HIV/AIDS in reporting processes will create opportunities for debate and will begin to subject this issue to the sort of rigour that is currently missing in most companies.
- **Use of influence**

Socially responsible companies recognise that they can play a leadership and catalyst role in influencing the behaviour of others, from business partners to industry colleagues to neighbouring businesses. This influence can extend to profiling HIV/AIDS in CSI programmes and can promote more considered approaches and support for projects and activities that are developmental and sustainable.



• **Use of existing opportunities**

In CSI programmes, education projects are probably the most commonly supported projects, often receiving the greatest “slice” of CSI budgets. These projects, with a little creativity, can also serve as foundations for HIV/AIDS prevention and/or care and support activities. For example, by integrating life skills into education activities for young people, or utilising schools as centres of support for orphans and vulnerable children.

• **Corporate giving**




This could include the CSI budget, as well as employee giving schemes, providing gifts or resources in kind, or staff secondments to community projects. Each of these could have a strong HIV/AIDS emphasis.



Score Card: Corporate social investment and HIV/AIDS

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Grants to HIV/AIDS projects constitute a proportion of the CSI budget Annual CSI report mentions funded HIV/AIDS projects HIV/AIDS – as part of CSI – included in corporate communications materials 		
 Good Response	<ul style="list-style-type: none"> CSI HIV/AIDS priorities linked to national and local priorities HIV/AIDS included as topic during CSI consultations with stakeholders Employees can name the company’s CSI priorities 		
 Blue-chip Response	<ul style="list-style-type: none"> Employees receive accolades for participating in CSI-funded projects HIV/AIDS is priority CSI issue and features in annual audited sustainability report Local HIV/AIDS project is the company’s “flagship” CSI project 		

Costs

HIV/AIDS-related CSI costs must be considered within the broad CSI budget, and there will often be situations where trade-offs must happen; which will sometimes benefit HIV/AIDS-related activities and sometimes not.



Case Studies: Corporate social investment and HIV/AIDS - Anglo American, RBM and ESKOM

The following case studies, either explicitly or implicitly, contribute to efforts to prevent new HIV infections or mitigate the impact of the epidemic on individuals, families and communities.

Anglo American has a long tradition of social investment and, together with its independently managed subsidiaries, currently allocates some \$ 7 million per annum in supporting community initiatives. These include funding education, income generation, small and micro-business development, health care provision, housing, general development and welfare, in the process making a positive contribution to addressing the factors that drive the HIV/AIDS epidemic.

Individual operations contribute to activities that are intended to directly benefit employees and the immediate surrounding communities.

Richards Bay Minerals (RBM) was established in a largely underdeveloped area, with inadequate infrastructure and facilities, especially in neighbouring rural areas. This led to the formation of a number of community partnerships, with support from RBM, focusing on the provision of schooling, health services, job creation and community development.

These partnerships are based on five principles:

- Meaningful community involvement, adopting a bottom-up approach;
- Partnerships rather than benevolence;
- Development at the pace dictated by the community;
- Skills transference; and
- Ownership and self-sufficiency.

This is an example in which, by addressing development priorities, in a developmental manner, the company is addressing the causative factors of the HIV/AIDS epidemic in the area.

The **ESKOM** Development Foundation has dedicated some ZAR 30 million (over \$ 4 million) to the South African AIDS Vaccine Initiative (SAAVI). "It makes absolute sense that the utility company that powers South Africa should be a power behind the quest for a vaccine."

This example represents a conscious decision to fund and support a specific HIV/AIDS priority, one that hopefully offers a long-term solution to the epidemic.



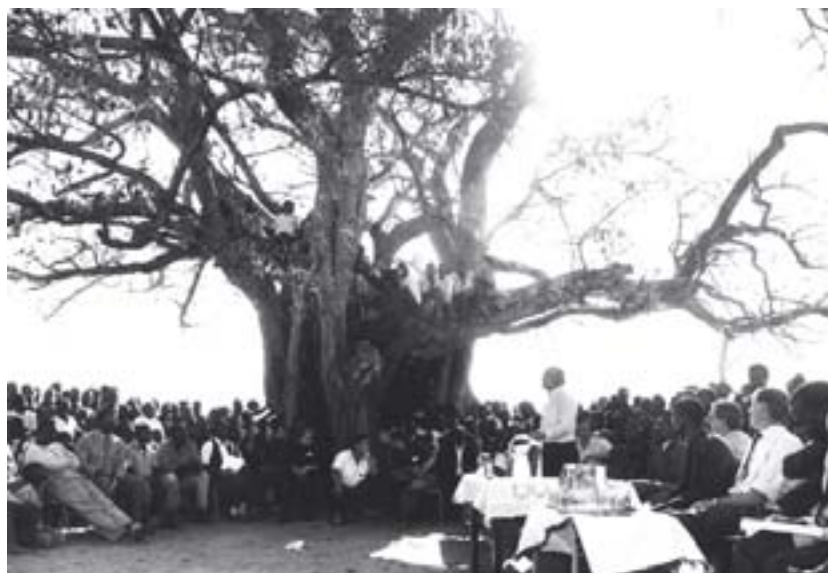
Additional Information

A number of useful documents on CSI can be found on the Business Partners for Development (BDP) website, at www.bpd-naturalresources.org/html/pub_working.html.

Generic information on corporate social investment can be found on www.bsr.org/BSRResources/IssueBriefDetail.cfm?DocumentID=48809.

For more information and access to tools on CSI refer to the following sources:

- World Business Council for Sustainable Development;
- Business for Social Responsibility;
- CSR Europe;
- Conference Board of Canada;
- Canadian Business for Social Responsibility;
- Global Reporting Initiative;
- OECD Guidelines for Multinational Enterprises;
- OECD Guidelines for Corporate Governance;
- <http://strategis.ic.gc.ca/> - Industry Canada;
- United Nations Global Compact; and
- www.ftse.com/ftse4good/index.jsp#.



Footnotes



¹ Adapted from UNICEF, UNAIDS and World Bank; *Draft operational guidelines for supporting early child development (ECD) in multisectoral HIV/AIDS programmes in Africa* (2003)





Section Three

Workplace HIV/AIDS Programme

Section Three contains all the elements of a comprehensive **workplace HIV/AIDS programme**. The goal of the workplace programme is to prevent new HIV infections and provide care and support for infected and affected employees.

The elements are:

- Prevention through behaviour change communication;
- Peer education;
- Condom promotion and distribution;
- Sexually transmitted infection (STI) management;
- A safe working environment;
- Voluntary counselling and testing (VCT);
- Prevention of mother to child transmission (of HIV) (PMTCT);
- A wellness programme consisting of:
 - Nutritional advice and support;
 - Lifestyle education;
 - Treatment of minor ailments;
 - Treatment of STIs;
 - Reproductive health services for women;
 - Prevention and treatment of malaria;
 - Prevention and treatment of opportunistic infections;
 - Antiretroviral therapy;
 - Psychosocial support;
 - Family support;
 - Referral networks and partnerships; and
 - Highly active antiretroviral therapy (HAART) programme

We have lit candles as a signal of hope and memory of our relatives, family members and comrades who have died of HIV and AIDS; and for ourselves who are all infected or affected by this epidemic. All of us are involved and we must fight together.

But our message is of hope, not despair. With education, access to safe sex, counselling and voluntary testing, decent food and treatment for those with HIV, and, above all, openness and mutual support, we will together gain victory.

*Congress of South African
Trade Unions (COSATU)*

Section Three

Prevention Through Behaviour Change Communication



Briefing Note

What is behaviour change communication?

Behaviour change communication (BCC) is a multi-level tool for promoting and sustaining risk-reducing behaviour change in individuals and communities by means of tailored messages and using a variety of communication channels.

Why does an organisation need a prevention programme with behaviour change activities?

Even in situations where HIV prevalence is high, the majority of employees are still uninfected, and prevention efforts should always remain an important component of workplace responses to HIV/AIDS.

But before employees, or indeed any individuals, can reduce their risk and vulnerability to HIV, they must be given basic facts about HIV/AIDS, taught a set of protective skills and offered access to appropriate services and products. They must also perceive their environment to be supportive of changing or maintaining safe behaviours.

Contractors, who have HIV/AIDS programmes in place, will typically have a strong focus on prevention. Rarely, however are the prevention activities based on behavioural theory, or linked to measurable outcomes. Existing prevention programmes should therefore be reviewed, strengthened and integrated into broader HIV/AIDS responses.

What are the objectives of behaviour change and the elements of behaviour change?

BCC strategies in HIV/AIDS aim to create a demand for information and services relevant to preventing HIV transmission, and to facilitating and promoting access to care and support services. Some specific BCC objectives include:

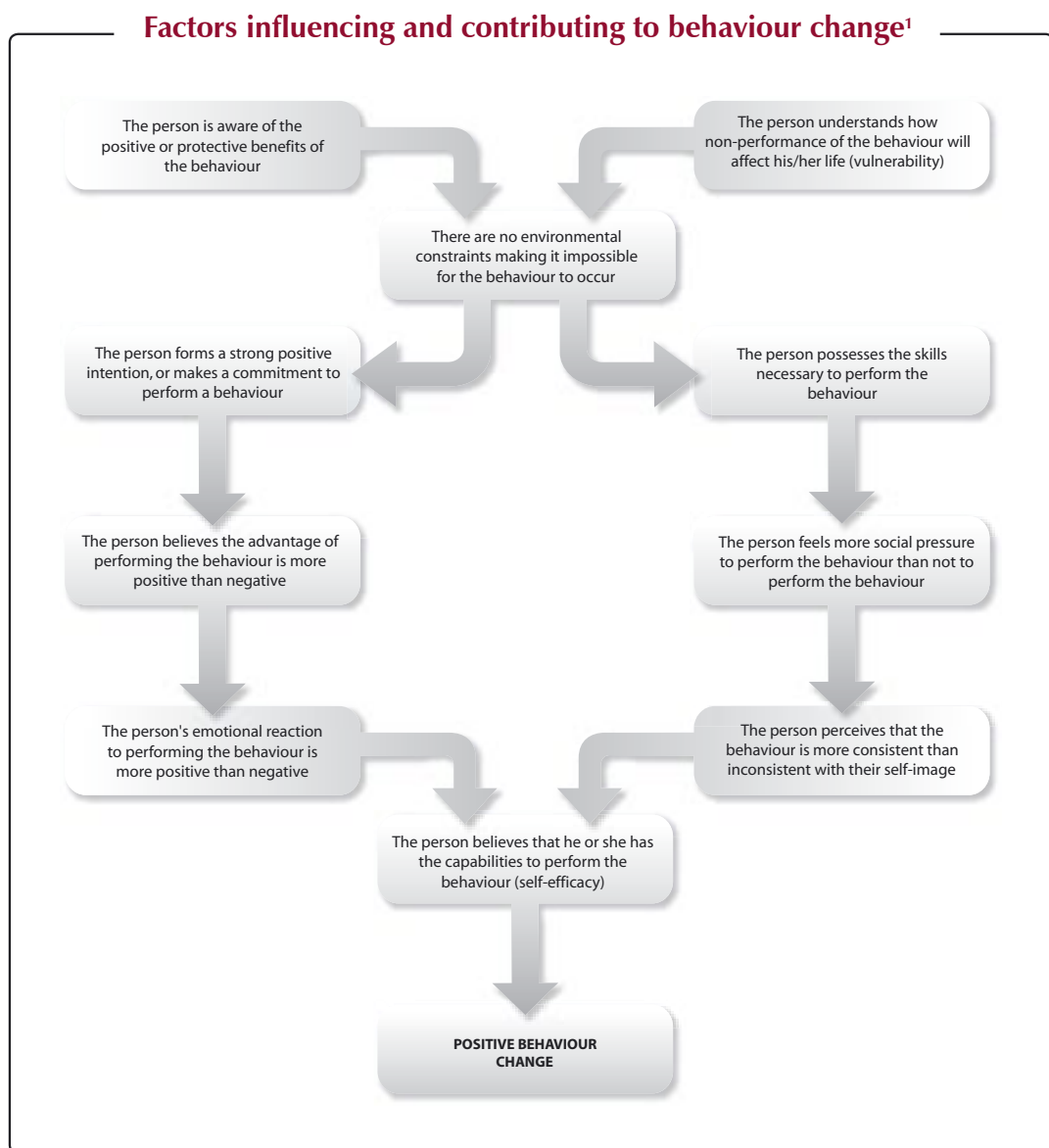
- Increasing the adoption and continued use of safer sex practices;
- Promoting visits to clinics treating STIs and opportunistic infections, including tuberculosis;





- Increasing the demand for VCT, for mother to child transmission (MTCT) prevention services, orphans and vulnerable children (OVC) care and support, support groups for people living with HIV/AIDS, and social and economic support;
- Stimulating dialogue and discussion on risk, risk behaviour, risk settings and local solutions; and
- Reducing stigma and discrimination for those living with HIV/AIDS.

The following diagram describes the complexities involved in initiating and then sustaining behaviour change. It is important to appreciate these factors when designing HIV/AIDS prevention programmes.



Behaviour change is thus influenced by a multiplicity of factors – personal, infrastructural, regulatory and societal – to name but a few.



Red Flags and Special Challenges

When conducting BCC activities it is important to reflect on these challenges:

Are the strategies rooted in the appropriate social and cultural context?

Examples of culturally defined factors that will influence BCC strategies (identified during the piloting of the Guide)

- Women are not able to make decisions without consulting their husbands;
- Dry sex, which can increase HIV transmission risk, is favoured in some cultures;
- Young people cannot address older persons; and
- Condoms are viewed by many as “tools for promiscuity”.

Are the education strategies user-friendly? Do participants feel comfortable engaging in the sessions and talking about HIV/AIDS-related issues?

Do the educational materials look good and attract people’s attention? Is the design and colour attractive? Are they culturally and gender sensitive? Can the participants identify with the materials?

Does the educational material avoid discrimination? Does the material show people of similar racial origin, age, and sexual orientation? Do the illustrations foster stigma or fear? For example, showing a person dying of AIDS might lead some people to believe that all people living with HIV/AIDS are about to die.

Does the educational material generate feelings of fear? Messages such as “AIDS kills” might scare people away, and such scare tactics rarely help promote effective behavioural change. Positive messages often promote changes in attitude and behaviour. However, some illustrations that catch people’s attention, even negative illustrations, can be effective in raising people’s awareness. The key is to know the target group well and choose your messages accordingly.

Does the educational material avoid moralising and preaching? People resist listening to someone telling them what they should and should not do. Such practices often lead the learners to become silent and less likely to engage in open and productive discussions. The best materials provide information in a clear, respectful way and enable people to make their own decisions.

Do the educational strategies build upon already acquired skills, and promote confidence? It is important to build on the expertise of the target group. What do they already feel confident in doing? How can that confidence be translated to other circumstances?

Does it help to build a supportive environment? People learn best when they feel cared for and supported. If people work together toward the same ends, much can be achieved. Does the learning session provide an opportunity for ongoing support for one another?

Do the sessions take place during working hours, and is attendance a part of work obligations?



Who conducts the sessions, is it done in-house, or outsourced? What is the role of the trade unions? If sessions are principally conducted by the trade unions, does this potentially miss non-trade union members?

Is there an overall communication strategy that guides the BCC? Was there input into the strategy from professional communication persons?

Are modern methods, such as radio phone-in shows and SMS (short message service) technology used, to communicate HIV/AIDS information and key messages? Are traditional communication methods used, such as poets, or singing and cultural groups, to relay important messages?

What methods of evaluation of the educational sessions have been considered? Evaluation of participant learning can be done through conducting pre- and post-testing. Observation of practice, and observation or anecdotal reports of behaviour change are other forms of evidence. Have the participants been asked to evaluate the facilitator, and the sessions? What will be done with the evaluation information?



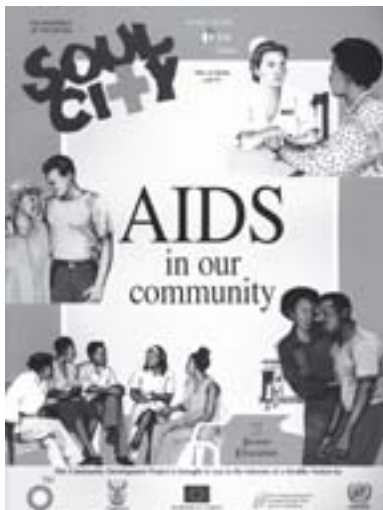
Tool: Principles and rules for behaviour change programmes

Instructions

When developing your organisation's HIV/AIDS prevention programme, ensure that you follow the principles and rules that research and experience has taught us².

- Principle 1:** Promote non-discrimination and openness around HIV/AIDS.
- Principle 2:** Because HIV/AIDS is a preventable disease it makes sense to offer prevention education to all workers and to specifically invest in targeting situations of high risk.
- Principle 3:** HIV/AIDS prevention works – we can change behaviour. But, information alone is not enough to change behaviour. Behaviour change is only possible if we reach solutions by developing our own responses and people need to be taught skills to enable them to put the information into practice.
- Principle 4:** Education needs to be complemented by supportive services.
- Principle 5:** HIV/AIDS programmes in the workplace can help control the epidemic and reduce the impact on businesses.

- Principle 6:** Effective HIV/AIDS prevention yields enormous savings in averted costs.
- Principle 7:** The most powerful change agents are our friends and peers.
- Principle 8:** The involvement of people living with HIV/AIDS is central to an effective workplace programme.
- Principle 9:** HIV/AIDS programmes must be simple, specific, concrete and verifiable. Use core management principles (simplicity, focus, precise targets, strong performance monitoring) and an explicit results chain (required inputs, outputs, outcomes and impacts). Management buy-in will assist at all stages of implementation.
- Principle 10:** Strategies and projects in areas of economic and social development which address poverty, income inequality, the bargaining power of women, housing, migrancy and so on will address the underlying factors which fuel the epidemic.



Research shows that:

- Those who plan and implement HIV/AIDS programmes should develop strategic approaches that view BCC not as a collection of different, isolated communication tactics, but as a framework of linked approaches that function as part of an integrated, ongoing process.
- BCC should be integrated with overall programme goals and specific objectives. BCC is an essential element of HIV/AIDS prevention, care and support programmes, providing critical links with other programme components. BCC should be linked to policy initiatives and service provision.
- BCC should encourage individual behaviour change and also help create environmental conditions that facilitate personal risk reduction.
- Formative assessment or audience research must be conducted to better understand the needs of the target population and the barriers to behaviour change that its members face.
- All BCC in HIV/AIDS should contribute to stigma reduction.
- The target population should participate in every phase of BCC development.
- Using a variety of communication channels is more effective than relying on any one. For example, peer education should be accompanied by mass media, small media, campaigns and other approaches.
- Pre-testing is essential for developing effective BCC materials.
- Monitoring and evaluation should be incorporated at the start of any BCC programme. Evaluation results must be fed back into the programme, to keep it relevant.
- Objectives for change after exposure to the communication should be specified. These may be changes in actual behaviour or shifts in the precursors to behaviour change, such as in knowledge, attitudes or concepts.
- Fear campaigns do not work. They contribute to an environment of stigma and discrimination.
- Because society-wide change is slow, changes achieved through BCC will not be seen overnight.



Score Card: Behaviour change communication

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> HIV/AIDS prevention messages included in induction courses HIV/AIDS posters displayed in the clinic waiting room HIV/AIDS videos screened during lunch break in the canteen 		
 Good Response	<ul style="list-style-type: none"> HIV/AIDS prevention strategy developed and implemented, in line with KAP survey results BCC programme evaluation includes feedback from employees BCC messages complement VCT and wellness programme 		
 Blue-chip Response	<ul style="list-style-type: none"> BCC specialist in advisory capacity to team designing the BCC strategy Sector-specific BCC materials developed and tested, then distributed in different languages 		

Costs

There are costs associated with a BCC programme; however research has shown that investments in prevention **are** cost effective in terms of HIV infections prevented.



Case study: Behaviour change activities - AngloGold

AngloGold (now AngloGold Ashanti) has a comprehensive behaviour change and HIV/AIDS prevention programme.

Each business unit plans a campaign of **mass awareness events** it will pursue each year. Some of the events used in 2002 included: mass meetings to demonstrate VCT, drumming sessions with HIV/AIDS themes, industrial theatre acts, candle-lighting ceremonies, workshops, seminars, mass e-mails, newsletters, pamphlets, etc.

All new employees and employees returning from annual leave undergo **induction training** which includes an HIV/AIDS component. The HIV/AIDS component is taught by qualified training officers and covers the following topics: (1) basic facts about HIV/AIDS; (2) national and company policies and programmes; and (3) referral resources.

In the first six months of 2002, the programme trained 15 623 employees, which corresponds to 36% of employees. Supervisors and management also go through specialised training which covers the same topics as induction training, as well as: (1) a review of performance management processes; (2) the legal framework supporting confidentiality and grievance procedures if it is breached; and (3) incapacitation processes.

317 peer educators (139:1 ratio) are currently active. 182 have been certified and trained internally through a three-day course. The remaining 135 peer educators were trained by various external providers and require an internal refresher course to obtain certification. The goal is to achieve a 100:1 ratio of certified peer educators by the end of the year. The training teaches the following topics and skills: (1) intensive AIDS education; and (2) participative methods, such as picture coding and role playing in generating peer-driven behaviour change.

The peer educators focus on the following activities: (1) providing informal peer education; (2) acting as a resource for other HIV/AIDS training and referrals; and (3) replenishing condom dispensers. The peer educators meet monthly and AngloGold is evaluating methods to monitor performance.



Additional Information

For the full AngloGold case study, go to: www.weforum.org/globalhealth/cases.

ILO; *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual* (2002), available on www.ilo.org, details (in Module 6) the prevention activities that should be carried out to comply with the Code.

Additional BCC information is available on the following websites:

- Family Health International at <http://www.FHI.org/en/HIVAIDS/FactSheets/bcchiv.htm>; and
- UNAIDS at www.unaids.org and search for the Fact sheets on HIV/AIDS for nurses and midwives.

Footnotes



¹ Adapted from Save the Children; *Learning to live: monitoring and evaluating HIV/AIDS programmes for young people* (2000)

² Adapted from the Project Support Group's work



Section Three

Peer Education

Section One

Section Two

Section Three

Section Four

Section Five

Appendices

Contributors



Briefing Note

What is peer education?

Peer education, in its broadest sense, refers to a programme designed to train select members of any group of equals, (office, factory, etc.) to effect change among members of that same group. Peer education is a means whereby the effectiveness of a single trained educator can be multiplied.

In the workplace **peers** are people who are similar to one another in age, background, job roles, status, experience and interests.

A **peer educator** is someone who belongs to a group as an equal participating member, but who receives special training and information so that this person may bring about or sustain positive behaviour change among group members.

In general, peer education is based on behavioural theory which asserts that people make changes not because of scientific evidence or testimony but because of the subjective judgement of close, trusted peers who have adopted changes and who act as persuasive role models for change.

Why does an organisation need a peer education programme?

Peer educators are ready-made experts in communicating with their peers and work colleagues. People are more likely to listen to and follow the advice of their peers, and peers also have a greater influence on co-workers than non-peers, which is a significant factor lending credibility to behaviour change messages.

Contractors can, and often do, have a peer education programme as one of the pillars of their HIV/AIDS response. This may involve finding a suitable training institution to train the peer educators, and providing them with on-going support and resources for their activities.



What should an HIV/AIDS peer education programme consist of?

With specific training and support, peer educators can effectively carry out a range of HIV/AIDS education and other activities with their co-workers.

Peer educators should possess good communication skills that will be enhanced through training. They must be able to see and understand the issues at hand through the perspectives of the group.

Peer education is not a uniform approach, and it is useful to distinguish between peer information, peer education and peer counselling¹.

Different peer education approaches

	Peer information	Peer education	Peer counselling
Objectives	Awareness Information Attitude change	Awareness Information Attitude change Self-esteem Prevention skills	Information Attitude change Self-esteem Prevention skills Coping skills Psycho-social support Problem-solving
Coverage	High	Medium	Low
Intensity	Low	Medium/high	High
Confidentiality	None	Important	Essential
Focus	Large groups Workforce Community	Small groups	Individual
Training required	Briefing	Structured workshops Refreshers	Intense and long
Relative cost	Low	Medium	High
Examples of activities	Drama, special events Material distribution Mobile vans World AIDS Day activities	Repeated group events based on a curriculum	With people living with AIDS Clinic-based counselling



Peer education example

The companies chose peer educators from among their workers, approximately one for every 20 workers on the site. The selection process focused on workers who were team leaders or key workers who were respected by their co-workers and who had at least a secondary school education, an interest in helping fellow workers and good communication skills.

JC Bousfield example

JC Bousfield Ltd. is a heavy haulage company with 150 employees, of whom a number are drivers. Recognising that long distance drivers face high HIV risk situations due to the nature of their work, and to ensure that drivers attend and benefit from the company's peer education programme, memos, such as the following, are issued by the Managing Director:

Subject HIV/AIDS

You are all ordered to attend, without fail, an HIV/AIDS awareness meeting that will take place at the bottom shop on Sunday 12 September 2004 at 10:00hrs. Failure to attend will result in severe penalties.

Compass Group example

The Compass Group is the largest foodservice company in the world, operating in 90 countries, with over 375 000 employees.

CHAPS, the Compass HIV/AIDS Peer Society, is a dedicated peer support group, consisting mainly of catering managers and training officers.

CHAPS is dedicated to providing HIV/AIDS education and support, and to continuously uplifting the staff of Compass Group SA.



Red Flags and Special Challenges

- For a peer education programme to succeed, it needs the support of management, supervisors and employees.
- Peer educators should be appointed from across the entire spectrum of the workforce, including from management.
- A ratio of 1 peer educator to 200 employees is simply not workable. A ratio of 1:20 is probably ideal, and the distribution of peer educators should cover all sections of the workforce.
- The recruitment and training of peer educators takes time. It also takes time to monitor and supervise them once the training period is over.
- A good peer education programme should build in a regimen of continuous training for peer educators to sustain them and help remind them about what they are trying to accomplish, while enhancing their skills to aid them on the way. In addition, they need new materials, methods and messages in order to sustain the interest and involvement of their work colleagues.
- Assumptions that employees who are peer educators are themselves HIV positive need to be guarded against, as these can jeopardise the programme.
- Peer education programmes typically experience a turnover rate of peer educators, so it is usually necessary for the recruitment and initial training phases to be undertaken continuously.
- It is important to use feedback and evaluation results to continuously inform the programme.

A recent project co-ordinated by UNAIDS and the Horizons Project², and implemented with the Jamaican Ministry of Health, PATH, AIDSMark/PSI, IMPACT/FHI, and USAID identified nine priorities for successful peer education programmes.

1. Integration of HIV/AIDS peer education with other interventions. Peer education generates demands for services in the intended audience. Therefore, it should be integrated with or linked to services that provide access to condoms, medical care, voluntary counselling and HIV testing, and STI management. Peer education should also be integrated, where possible, with community health and development initiatives.
2. Finding and keeping peer educators.
3. Training and supervising peer educators.
4. Gender, sexuality, and the socio-cultural context. Peer education programmes must address gender inequalities that affect sexuality and HIV/AIDS transmission and mitigation.
5. Programme activities to foster behaviour change.
6. Care for people living with HIV/AIDS.
7. Stakeholders and gatekeepers, since they are key to the success and the sustainability of the programme, should be involved from the design phase onward in order to address their concerns, needs, and priorities, and to instil a sense of ownership of the programme.
8. Programme sustainability.
9. Evaluation and operations research.



Tool: Peer education guidelines

Instructions

Use the following guidelines when developing your HIV/AIDS peer education programme.

1. Planning a peer education programme³

- Begin with a clearly defined target population. Consider job grade, age, gender, race/ethnicity, sexual orientation, socio-economic factors, etc.
- Include members of the defined population from the beginning of the planning process. Their participation will ensure that the programme is owned by them rather than that it has been foisted upon them by management.
- Set a clearly defined programme with realistic targets, goals and objectives. A time period and the number of people to be reached for each objective will help define the programme and target population, and ensure measurable goals and objectives.
- Plan realistically for evaluation in the time line and budget. Whether a detailed process evaluation or a long-term impact evaluation, it must be planned from the beginning, or data gathered will be partial and inconclusive. Changes in knowledge can be measured by pre- and post testing peer educators and participants. Process evaluation data may include numbers and characteristics of programme activity and participants and post-workshop satisfaction measures, and peer educator journal entries recording activities and referrals.
- Find the right person or people to co-ordinate the programme.



*During the piloting of the **HIV/AIDS Guide for the mining sector**, KCM did supervisory visits to the partner companies that were implementing peer education programmes – to identify any additional training needs. KCM trained the peer educators in the partner companies.*

2. Recruiting and training the peer educator team

- Recruit peer educators from a broad base of potential candidates. Consider opinion leaders, but look also for those who strongly believe in the programme's goals and objectives and want to help achieve them.
- The criteria used in selecting peer educators vary from workplace to workplace. Of course, characteristics that place the peer educator as a member of the target group are always taken into account. Other criteria considered should be:
 - Must have time and energy to devote to this work;
 - Should have enough education to implement the activities of a peer educator;
 - Should have good listening skills, ability to form relationships and encourage others to learn about STIs/HIV/AIDS and change behaviours;
 - Should be enthusiastic and self-confident, exhibit leadership potential and a demonstrated interest in working with peers;
 - Should be respectful, non-judgmental, and committed to maintaining client confidentiality;
 - Should be acceptable to the workers who they will serve;
 - Should be able to establish good relations with both individuals and the group as a whole; and
 - Should serve as a role model and to exercise leadership.
- Decide what incentives the programme will provide for the peer educators.
- Provide sufficient training for the peer educators. Skills development is as crucial as knowledge, and the training methodologies should be interactive, participatory and competency-based. Training empowers peer educators to recognise their capabilities and when to refer a peer to a service or to a professional person.
- In addition to factual information, e.g. HIV/AIDS transmission and prevention, peer education training should address cultural and social factors, sexuality and gender, interpersonal and group communication skills, and legal and ethical issues. To facilitate monitoring, training should also introduce information and record keeping templates and should cover report writing.
- Successful programmes will have ongoing training for the peer educators, times to practise existing skills and to develop new ones, with initial and then ongoing evaluation of competencies. Importantly, training should always take into account the personal development of the peer educator.
- Supervision of peer educators' performance should include both actual peer group sessions and office-based supervisory sessions.
- Staff supervising peer educators must be technically competent, as well as motivational and supportive.

3. Implementing the peer education programme

- Select a curriculum to maximise interactive and experiential learning. Bear in mind that peer educators will gain ownership of the programme when they play a role in deciding which activities and materials to use, or in adapting a curriculum or designing new ways to present the information.
- A schedule of topics that peer educators should cover would include:
 - Transmission of HIV;
 - Prevention of HIV transmission;
 - STIs and TB;
 - How to assess personal risk and formulate behaviour change plans;
 - Safer sex and condom use;
 - VCT, HIV testing facilities and processes;
 - The rights of infected and affected employees (including rights to confidentiality);
 - How to treat a co-worker with HIV/AIDS;
 - Treatment, care and support for infected employees, including good nutrition and ART;





- HIV/AIDS, as part of broad-based wellness programmes;
 - Infection control in the workplace;
 - The workplace HIV/AIDS policy and current programmes;
 - Non-discrimination and equality (in terms of benefits, etc.); and
 - Referral sources and services.
- Research shows peer education to be most effective when part of a comprehensive initiative, so link peer educators with referral resources, community agencies, and programmes with similar goals.
 - Monitor the peer educators' work. After the initial training, peer educators will need ongoing supervision of their work and training. Peer educators should keep a log of informal activities. Monitoring will highlight skills or knowledge that need strengthening. Feedback from fellow peer educators and work colleagues will also help them become more skilful and effective educators.
 - Provide ongoing encouragement and support. Their work is not always easy. Positive feedback and support will help keep them involved, as will encouraging them to support each other.
 - Expect attrition and have a formal structure for recruiting and training new peer educators. Exit interviews will help gauge whether their reasons are personal or programmatic. Involving current peer educators in the recruitment and training of new peer educators will also empower them and help them develop new skills.
 - Provide opportunities for peer educators to give feedback about the programme, its activities, and their own performance. The peer educators usually know what they need to become more effective and to enjoy their work more. This should be done on a regular basis and formally as a participatory review of the peer education programme annually.
 - Finally, promote the programme. Develop literature showcasing services and highlighting accomplishments. Positive stories from the peer educators and feedback from fellow employees will enliven data-based reports.

Finsch Mine example

De Beers' Finsch Mine utilises peer education training as a means to network and build relationships in local communities. This is in line with the Mining Charter, which stipulates that the company shall contribute meaningfully to its neighbouring areas.

Groups trained by Finsch include the youth and interested community members. The training is conducted in their indigenous language (Setswana).

The peer education activities include:

- Basic HIV/AIDS information – to communities where there is very limited access to such information;
- Marketing the company's ART programme – as a number of the dependants of employees are from these areas;
- Organising and participating in events, such as Women's Day and World AIDS Day; and
- Referring community members for testing, counselling and treatment.




The peer educators form a structure, which facilitates continuous engagement with the community after the training. Meetings are held monthly – for refresher training, to address local issues and to identify opportunities for further engagement. One such example has been to develop leadership in community groups to manage local home-based care initiatives.



Score Card: Peer education

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • 1 peer educator trained for each department • Peer educators use interactive teaching and learning techniques (such as role plays and group discussions) • Essential HIV/AIDS prevention messages are repeated in peer education sessions 		
 Good Response	<ul style="list-style-type: none"> • Peer education programme is based on a comprehensive curriculum • Peer educators participate in defining their roles and responsibilities • Peer educators are encouraged to run peer education activities in their communities 		
 Blue-chip Response	<ul style="list-style-type: none"> • Peer educators refer to various service providers (e.g. for HIV testing) • Peer educators are identifiable (e.g. through badges, T-shirts or some form of uniform) • Peer educators receive creative rewards/incentives • Peer educators go on exchange visits to peer educators from other companies • Community members are trained with peer educators and involved in the programme 		

Costs

It is generally assumed that peer education is one of the least expensive strategies to effectively reach a target population. The costs that should be quantified would include the:

- Cost of training, initial and top-up training;
- Cost of time allocated to peer education activities;
- Cost of incentives or uniforms for the peer educators;
- Cost of peer group meetings/sessions; and
- Cost of educational material and condoms distributed.



Case Study: Peer education - NAMDEB

One of the persistent problems faced by HIV/AIDS communication programmes is keeping material interesting and relevant to participants over many months. Too frequently, information is repeated to a point where audiences “tune out.” NAMDEB’s peer educators recognised this potential problem and employees’ need for a wide range of health information.

Although most Namibians know that HIV is transmitted mainly through unprotected sex, many workers are unaware of other health issues and how their own behaviours influence their health. As the workforce showed interest in learning more about other health issues, the peer education programme incorporated these health topics.

The programme annually addresses 10 health topics, making each the focus of discussion for one month. In addition to updates on HIV/AIDS and STIs, topics have included malaria, TB, family planning, healthy lifestyles, child abuse, alcohol and drug abuse, stress and child care. As the topics are known in advance, relevant materials are compiled for distribution to participants.

Peer educators feel confident in this approach, since it maintains the attention of their colleagues, provides them with the opportunity to learn and convey new information and sustains an important programme. The variety of topics also broadens the context of discussing HIV and AIDS, since most of the topics relate to or are affected by the epidemic.

The comprehensive programme has had a positive impact on controlling HIV/AIDS and STIs. Condom distribution, which was said to be minimal before, rose from 6.7 per 1 000 workers in 1990 to 20.7 per 1 000 workers in 1995. For company management, these results indicated that the impact of HIV/AIDS could be contained and managed.

Programmes must be sustained over several years before any impact can be noticed. Thus, there is good reason for peer education components of a prevention programme to remain relevant to the changing and broadening needs of workers.

After the initial success, NAMDEB began to assist other mining companies in establishing similar programmes. The company hired a full-time co-ordinator and enlisted the participation of a dozen other companies, including gold and copper mines, the port authorities and fishing industries. In 1999, the Chamber of Mines assumed support to the other mines and interested companies. One of the mining companies, Okurugu (Fluospar/Solvay), supports the full-time co-ordinator; the Chamber of Mines provides office space and contributes to operating costs. Individual companies contribute to the costs of the co-ordinator and select staff for peer educator training. Condoms are usually provided by the government.

Most companies have also reached out to surrounding communities, assisting in educational events, providing STI treatment for partners of employees, distributing condoms in the community and supporting local women’s organisations or school clubs. In one case, peer educators were given a week off to organise a tour to perform an educational theatre programme for all secondary schools in a remote area.



Additional Information

Most workplace HIV/AIDS references include information on peer education, e.g. the ILO publication entitled; *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual* (2002), available on www.ilo.org.

An informative article on peer education for young people appeared in the *AIDS Bulletin*, Vol.12, No.2 (August 2003). It refers to tools and checklists that are available on www.hsph.harvard.edu/peereducation.



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Footnotes



¹ Adapted from Save the Children; *Learning to live: monitoring and evaluating HIV/AIDS programmes for young people* (2000)

² For the full report entitled *Peer education and HIV/AIDS: past experience, future directions*, go to www.popcouncil/horizons/horizonsreports

³ Adapted from UNESCO; *Peer approach in adolescent reproductive health education: some lessons learned*

Section Three

Condom Promotion and Distribution



Briefing Note

What is condom promotion and distribution?

Condom promotion and distribution aims at encouraging safer sexual practices through raising awareness and opening the debate about safer sex and condom use; and then ensuring that supplies of condoms are readily accessible, when and where they are needed.

Why is it important to have a workplace condom promotion and distribution programme?

Since the earliest days of the HIV/AIDS pandemic, the use of male condoms has been a central component of prevention initiatives.

Male and (more recently) female condoms – when used consistently and correctly – are an effective means of preventing HIV infections, other STIs and unplanned pregnancies among people who are sexually active and need to protect themselves.

When incorporated into a comprehensive set of prevention messages – including reducing the number of sexual partners, practicing mutual monogamy, delaying onset and reducing frequency of penetrative sex and getting treatment for STIs – condom use has resulted in decreases of HIV incidence. And, in various settings, promotion of 100% condom use has contributed to marked reductions in STI rates.

Contractors can usually incorporate condom promotion and distribution activities into their HIV/AIDS programme. Supplies can sometimes be sourced from government (the Ministry of Health). Where these need to be purchased, contractors should explore options of procurement in partnership with bigger companies, in order to benefit from bulk prices.





What are the elements of a successful condom promotion and distribution programme?

Successful condom programmes are characterised by:

- The promotion of both male and female condoms;
- Choices, such as a choice between free condoms and branded subsidised ones;
- Linking condom distribution to education on condom use, and joint decision making between partners on sexual health issues;
- The involvement of peer educators in promoting condom use, incorporating “how to use condoms” in their sessions, and serving as distribution points;
- Well-known, and creative and diverse distribution points that are decided in consultation with the users;
- IEC materials that support the condom programme; and
- Regular monitoring of condom uptake.

Accurate messages about condoms must build on (and not substitute for) a wide range of HIV and STI risk-avoidance and risk-reduction approaches.

Because of the non-clinical nature of condoms, distribution points can include non-traditional sites, such as toilets, canteens, tuck-shops, and clocking stations.

One of the best established methods of condom distribution is what is known as **social marketing** (CSM). This is the marketing of public health goods or ideas through conventional marketing channels. The main objective of CSM projects is to increase the availability and use of good quality, low cost condoms and hence contribute to preventing the transmission of HIV infection. The strategy usually promotes condom use in general and use of the social marketing organisation’s own condom brand in particular.

The strategy also aims to disseminate messages concerning HIV prevention, safe sexual behaviour and correct condom use. These objectives are achieved through fairly standard marketing techniques with the main activities being to conduct market research; to acquire and package condoms; to advertise and promote the product; to train retailers; and to distribute the product.

Other barrier methods

Microbicides, which come in a gel, cream, sponge, suppository or film, are showing promise as effective against STI and HIV transmission. Their role in a workplace HIV/AIDS programme has not been tested.



Red Flags and Special Challenges

Condom distribution is often one of the first strategies implemented by companies, as part of their workplace HIV/AIDS response. The start-up problems they may experience are in relation to:

- Deciding on the location of the distribution points;
- Keeping these stocked; and
- Establishing a system to monitor condom uptake.

The monitoring system should capture information on a regular basis such as:

- Locations of the dispensers;
- State of dispensers (good, damaged, etc.);
- Condom uptake per dispenser and total uptake;
- Cumulative uptake over a defined period, such as a year;
- Informational materials distributed from the dispensers;
- Condom uptake by group (male, female, admin, contractors, etc);
- Condom stock in hand;
- Condom stock to be ordered with pre-set order dates;
- Feedback from peer educators and those responsible for stocking the dispensers;
- Feedback from users (via a suggestion box); and
- Remedial action taken.

Many companies have been disappointed at the lack of condom uptake, following the implementation of a condom distribution programme. This is typically due to the absence of any associated strategies to promote condom use.

In monitoring a condom promotion and distribution programme, it is generally not possible to use indicators such as increased condom use, as this is impossible to measure directly. Proxies for this can however be used, such as decreased incidence of STIs, which implies safer sexual practices, including condom use.





Tool: Model for condom use

Instructions

Consider the following model when developing your condom promotion and distribution programme. What is the behaviour to be changed; what are the determinants (individual and environmental) of the behaviours; and then decide what programme activities – at an individual and environmental level – can be designed to change each selected determinant?

Model for condom promotion and distribution




Behaviour	Individual level intervention areas	Environmental level intervention areas
Increase protection, by increasing the use of condoms	Reduce belief that using condoms affects pleasure	Expand media and folk messages promoting condom use
	Increase belief that most sexually active men are using condoms	Enhance social norms against unprotected sex
	Increase self-efficacy to say “no” to unprotected sex	Establish or expand workplace and community-based condom distribution
	Increase beliefs that having unprotected sex is against personal standards	Improve access to condoms at clinics
	Increase self-efficacy to use a condom properly	Develop user-friendly health services
	Increase feelings of safety when using condoms	Provide information on safe sex through health services
	Increase ability to refuse alcohol or drugs	Implement programme for effective prevention of alcohol use
		Increase peer educators ability and willingness to teach effective sexuality/ STI/HIV education
	Increase parent-child communication about sexuality and condoms	



Score Card: Condom promotion and distribution

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Free condoms available in the clinic • Peer educators demonstrate condom use during sessions 		
 Good Response	<ul style="list-style-type: none"> • Male condoms – free and subsidised – available from multiple points within the workplace • Social marketing awareness materials displayed and distributed • Peer educators monitor condom uptake and report this in their monthly reports 		
 Blue-chip Response	<ul style="list-style-type: none"> • Regular condom promotion campaigns conducted • In addition to male condoms, female condoms available from the clinic and in female toilets • STI statistics analysed and compared to condom uptake trends • Reduction in condom uptake investigated and strategies implemented to address the causes 		

Costs

Many organisations can get free supplies of male condoms from government Health Ministries/Departments. Where this is not possible, or where subsidised condoms are made available as well as free government-issue condoms, there would need to be a budget to purchase these. Plan for about 12-14 condoms per sexually active male per month, and then adjust in line with uptake. Female condoms are significantly more expensive than male condoms.

There are also costs associated with condom promotion, such as posters and pamphlets.



Case Study: Condom promotion and distribution - FB Vending

FB Vending is a company that has been active in the vending industry for over 15 years¹. For the past 5 years FB Vending has also manufactured a specially designed and registered high quality 3-column condom dispenser and distributed these, together with high quality condoms, into the workplaces of South Africa and bordering countries.

FB Vending provides guidance to companies in establishing their condom programmes. The guidance covers the following elements:

1. Establish what your needs are

- Do you need only male condoms?
- Do you need only female condoms?
- Do you need male and female condoms?
- Do you need only condom dispensers?
- Do you need condom dispensers with condoms?
- Do you need to outsource the condom distribution to a specialist company?

2. Quantity and placement

- How many male toilets are there per floor level, building and in total?
- How many female toilets are there per floor level, building and in total?
- How many recreation rooms are there per building and in total?
- How many smoking rooms are there per building and in total?
- Can dispensers be fixed to designated spaces on the walls of the above rooms?

You should install a condom dispenser in at least one male and one female toilet per floor or if your staff complement is small (less than 30), a dispenser in one male and one female toilet for your workplace.

Where there is an on site clinic, condoms should be available free of charge from the clinic.

To get to a total of the number of condom dispensers required, work on 20 staff per dispenser (this way you can fill dispensers once or twice per month).

- Work on 13 condoms per staff member per month;
- Gather gender information on your staff; and
- Include contractors visiting your premises on a regular basis.

3. Dispenser installation

- Install your condom dispensers to coincide with your planned HIV/AIDS awareness programme;
- The dispensers must be installed for maximum visibility and for easy access; and
- Get authorisation beforehand from your maintenance team, architect and/or landlord for your planned installations.

4. Refilling condom dispensers

- Staff such as cleaning staff, maintenance staff, peer educators or specially appointed staff, who will be responsible for filling condom dispensers and collecting condom usage data, must be identified and instructed before condom dispensers are installed and used.



5. Storage of condoms

- Identify suitable storage space for condom supplies. Condoms must be stored in a cool dry place away from any direct sunlight or other weather conditions;
- The condom boxes must be protected from the floor by storing the condom boxes on wooden pallets or similar; and
- Condoms must not be stored with dangerous and hazardous materials or liquids.

6. Condom management

- Condom uptake and distribution can be monitored and controlled manually or with the help of a computer programme.

7. Budget

- Make sure that management is informed of the financial implications of the condom distribution programme.

8. Implementation schedule

- Confirm the procurement process as this will have an impact on your delivery time and on the installation date for the condom dispensers and condoms;
- Set delivery and installation dates in order to keep up with your planned awareness programme and to ensure that promises are kept; and
- The installation team must also be confirmed and be made aware of dates and deadlines.

9. Integration into the HIV/AIDS programme

- Integrating the condom programme into an existing or planned HIV/AIDS programme is very important;
- One idea is to brand the condom dispensers with your company or programme colours, logos and slogans;
- Ensure that your entire staff is aware of the condom distribution programme; and
- Trainers and educators must be well trained on the “how and why” of condom and dispenser use, and they, in turn, must be able to train staff on how to use the dispensers and condoms.



Additional Information

For additional information on barrier methods, go to the Family Health International website at <http://www.fhi.org/training/en/modules/ADOL/goals.htm>.

Information about PSI and SFH, the organisations providing condom social marketing services in most Southern African countries, can be found in Appendix Four.

Footnotes



¹ For more information, contact FB Vending at sales@mrwilly.co.za



Section Three

Sexually Transmitted Infection (STI) Management

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Briefing Note

What is STI management?

STI management is the comprehensive care of a person with an STI-related syndrome or with a positive test for one or more STIs. **Sexually transmitted infections** or STIs are diseases such as syphilis, gonorrhoea, chancroid, herpes, chlamydia, trichomoniasis and Hepatitis B. Symptoms of STIs include ulcers or sores, discharge, burning or pain on passing urine, lower abdominal pain (in women), testicular pain or swelling in men and swelling of the lymph nodes in the groin.

Why is it important to have a workplace STI management programme?

Sexually transmitted infections are among the most common causes of illness in adults in the world and have far-reaching health, social and economic consequences for many countries. In South Africa 15% of adults have an STI in any one year!

The same risk behaviours are involved in both HIV and STI transmission. The presence of an untreated STI, particularly an ulcerative STI, can multiply the risk of HIV transmission during unprotected sex up to ten-fold.

The risk of HIV transmission in the presence or absence of other STIs

No condom, no STI

- Female to male spread 1 : 1 000
- Male to female spread 2 : 1 000
- Male to male spread 1 : 100

No condom, inflammatory STI (discharge)

- Female to male spread 1 : 100
- Male to female spread 2 : 100
- Male to male spread 1 : 100

No condom, ulcerative STI (sore)

- Female to male spread 6 : 100
- Male to female spread 6 : 100
- Male to male spread 3 : 10

Effective management of STIs is one of the cornerstones of STI control, as it prevents the development of complications and sequelae, decreases the spread of these diseases in the community, and offers a unique opportunity for targeted education about HIV prevention.

Contractors that do not have on site health services should establish links with STI services in the community, and should promote early health seeking behaviour for employees with or at risk of STIs, as well as for their partners. Where workers have access to and utilise the health services of the companies where they are providing services, the data available from the clinic (number of clients treated, trends in infections seen, etc.) should be captured and analysed to inform broader HIV/AIDS prevention programmes.

What are the elements of an STI programme?

Few developing country health facilities have the laboratory equipment or skills required for aetiological diagnosis of STIs. To overcome this, a syndrome-based approach to the management of STI patients has been developed and promoted. Syndromic management is based on the identification of consistent groups of symptoms and easily recognised signs (syndromes), and the provision of treatment, according to standardised protocols, that will deal with the majority and the most serious organisms responsible for producing a syndrome.

The elements of STI management include: history taking, examination, correct diagnosis, early and effective treatment, advice on sexual behaviour, promotion and/or provision of condoms, contact tracing and partner treatment, case reporting and clinical follow-up as appropriate. Thus, effective case management consists not only of antimicrobial therapy to obtain a cure and reduce infectivity, but also comprehensive and confidential care of the client's needs for reproductive health.

Appropriate treatment of STI clients at their first encounter with a health care provider is an important public health measure. Ideally the encounter should be in a user-friendly environment, as described below.

Characteristics of user-friendly STI services

Provider characteristics	Health facility characteristics	Programme design characteristics	Other possible characteristics
<ul style="list-style-type: none"> • Specially trained staff • Respect for clients • Privacy and confidentiality • Adequate time for client and provider interaction • Peer counsellors available 	<ul style="list-style-type: none"> • Convenient hours • Convenient location • Adequate space and sufficient privacy • Comfortable surroundings 	<ul style="list-style-type: none"> • Client involvement in design and continuing feedback • Drop-in clients welcomed and appointments arranged rapidly • No overcrowding • Short waiting times • Free service or affordable fees • Publicity to inform and reassure clients • Men and women welcome and served • Wide range of services available • Necessary referrals available 	<ul style="list-style-type: none"> • Education materials available on site and to take away • Group discussions available • Alternative ways to access information, counselling and services



Red Flags and Special Challenges

Employees with STIs are often concerned about confidentiality of their medical records at work and will opt to visit a private practitioner for treatment. There is significant evidence that the STI treatment provided in the private sector (e.g. GPs and traditional healers), is often not optimal and may not fully treat – and cure – the STI. Indeed, in some Southern African countries public sector STI management also falls far short of the ideal. And yet the treatment is standardised, simple, cheap, effective and safe, and can be provided by nurse clinicians.

Contact tracing and partner treatment has always represented a challenge. Treatment of a client with an STI will be of little benefit if his/her partner is also infected, but not treated. Re-infection is then a real possibility.

Many STI symptoms are very mild or asymptomatic and active medical surveillance is required to detect disease in these clients. In particular women may get used to these symptoms, and not seek treatment for them.



Tool: STI prevention and care: essential components checklist

Instructions

Check that your STI programme contains all the elements of a comprehensive prevention and care package.

- Promotion of safer sex behaviour;
- Condom programming – encompassing a full range of activities from condom promotion to the planning and management of supplies and distribution;
- Promotion of health-seeking and safer sex behaviours – and the education of individuals at risk on modes of disease transmission and means of reducing the risk of transmission;
- Treatment and education of the sexual partners of infected individuals;
- Integration of STI prevention and care into primary health care and reproductive health care services;
- Specific services for populations at risk – such as sex workers and long-distance truck drivers;
- Syndromic management of STIs;
- Early detection of symptomatic and asymptomatic infections;
- Access to counselling and testing for HIV; and
- Monitoring trends, using clinic and hospital records.








Score Card: STI management

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Peer educators mention STIs as a risk factor for HIV transmission Public health clinics offer free STI treatment, and employees are given time off to seek medical treatment 		
 Good Response	<ul style="list-style-type: none"> Free STI services offered on site Occupational health nurse is trained to provide syndromic management All STI clients receive a stock of free condoms 		
 Blue-chip Response	<ul style="list-style-type: none"> STI health-seeking campaigns conducted annually All STI clients encouraged to have HIV tests – which are offered as a free service and are accompanied by pre- and post-test counselling 		

Costs



An on site STI management service implies the existence of an occupational health clinic. Where such a clinic exists, treatment of STIs is likely to be one of the services available. Costs associated with such a service would include staffing, and possibly training for the staff, equipment and supplies (including drugs, condoms and information).

The alternative, which is treatment at public or private health facilities, could represent considerable costs in terms of time off work for those employees seeking this care.

This is an instance where STI prevention – and the costs associated with prevention – will be much less than those associated with treatment of STIs and the risk of HIV infection.



Case Study: Successful STI management - Harmony Gold Mining Company and others

The Lesedi Project is supported by Harmony Gold Mining Company, USAID/AIDSCAP, the National Reference Centre for STDs (South African Institute for Medical Research), the Institute of Tropical Medicine, Antwerp, Pfizer Pharmaceuticals, the South African National HIV/AIDS and STD Programme, and the provincial and local health departments. The Lesedi Project began in 1996 around Virginia, a town in the Free State Province of South Africa, with a population of approximately 80 000 people including a workforce of 13 000 miners (90% of whom lived in single-sex hostels).

Periodic presumptive treatment (PPT) refers to regular (periodic) treatment with an antibiotic which is known to be effective against many different STIs. It is presumptive since the patients have not been diagnosed with an STI. On the basis of previous research showing that the majority of the group have curative STIs, it is presumed that they have STIs requiring treatment.

The project ensured that miners who had symptoms of an STI were treated promptly using the syndromic approach. Additionally, women at high risk of STIs, most of whom were sex workers, were given periodic presumptive treatment. Both had access to sexual health advice, counselling and male and female condoms.

The results from the first stage of the project were impressive. In mineworkers, gonorrhoea and chlamydia were reduced by 42% and a 77% reduction in genital ulcers was observed. Among the women, similar dramatic declines in STIs were seen.

A cost-effectiveness assessment was conducted using a computer model to estimate the number of HIV infections that would have occurred in the community. It was estimated that 235 HIV infections were averted (40 women and 195 men), i.e. a 46% decrease in estimated HIV infections. In terms of averted HIV/STI-related medical costs, an estimated US\$ 316 216 (ZAR 2.34 million) was saved. This was a massive saving compared with the relatively small cost of the intervention – US\$ 36 216 (ZAR 268 000).



Additional Information

In 1998, DFID published a Health and Population Occasional Paper entitled *Sexually transmitted infections: guidelines for prevention and treatment*, which details the components of a comprehensive STI programme.

Chapter 12, in Clive Evian's book, *Primary AIDS Care*, deals with STIs in the context of HIV/AIDS treatment and care.

A publication on the diagnosis and management of STIs in Southern Africa is available from the STD Reference Centre at the South African Institute for Medical Research, Box 1038, Johannesburg, 2000.

Other useful documents on STIs can be found on the following websites:

- UNAIDS; at www.unaids.org;
- WHO; at www.who.org; and
- CDC; at www.cdc.gov.

Section Three

Safe Working Environment



Briefing Note

To prevent the transmission of HIV in any work environment, the central strategy is the adoption of universal infection control precautions. Typically these precautions are part of broader occupational health and safety procedures.

What is universal infection control?

Universal infection control is a simple standard of infection control practice used in the care of any person to minimise the risk of transmission of blood-borne pathogens.

These practices were originally devised in 1985 by the United States Centers for Disease Control and Prevention (CDC), largely due to the HIV/AIDS epidemic and the urgent need for new strategies to protect hospital personnel from blood-borne infections. The new approach places emphasis on applying blood and body fluid precautions **universally to all persons** regardless of their HIV status.

Why does an organisation need to implement universal infection control precautions to ensure a safe working environment?

HIV and other blood-borne infections (like hepatitis B) can be transmitted in an accident situation where there is contact with blood. HIV is a fragile virus, meaning it is vulnerable to changes in temperature and other environmental factors, and has been shown not to be viable in dried blood for more than an hour. The risk of a person becoming infected with HIV in such a situation is dependent on factors such as the extent of the contact or the sort of injury that allows blood to enter another person's body. The average risk of transmission is however low; approximately 0.3% following a needlestick-type injury¹.

Preventing occupational exposure to potentially infectious blood and blood products and managing occupational exposures that do occur are important elements of any workplace safety programme.

In most countries, labour legislation requires that employers take measures to ensure that, as far as is reasonably practicable, the working environment is safe and healthy.

This could imply that:

- Employers have a legal duty to apply universal infection control measures in the workplace;
- There must be a clear position on HIV testing following an occupational accident; and

Where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work.

Extract from the SADC Code on HIV/AIDS and employment



- There should be a protocol in place covering the steps to be followed after an occupational accident, possibly including the provision of post-exposure prophylaxis.

Contractors, like all other employers, are obliged to meet certain requirements in terms of safety (including infection control) in the workplace. Contractors should have protocols for the management of accidental occupational exposure, and whilst these may not include the provision of post-exposure prophylaxis, they should include processes to assist employees to access these services elsewhere, e.g. in public sector hospitals.

What should a universal infection control programme consist of?

Measures that should be in place are:

- The education of employees about occupational risks, methods of prevention of HIV transmission, and procedures for reporting exposures;
- The provision of equipment and supplies such as gloves and disinfectants to clean up blood spills; and
- The provision of post-exposure counselling, treatment, follow-up and care.

These measures should apply not only within the operations of the company, but also in any health care facilities – hospitals, clinics, medical posts – that are operated by the company.



Red Flags and Special Challenges

Universal infection control procedures are rarely followed consistently outside of the health care profession.

Workplace safety risk assessments do not routinely include the risk of HIV transmission within the workplace.

Occupational health and safety policies and procedures should be reviewed to ensure that HIV/AIDS-related risks and situations are adequately covered.



Tool: Universal infection control guidelines

Instructions

Adapt the following infection control guidelines for use in your workplace.

1. Prevention of occupational exposure

- Create a safe working environment by identifying any risk situations and minimising such risks;
- Assume that everyone is HIV positive and always take precautions in an accident situation; and
- Ensure that personal protective first aid equipment (such as gloves) is available and that personnel (such as first aiders and health and safety personnel) have been trained about infection risks, infection control procedures and how to use the equipment.



2. Minimising the risk of HIV transmission as a result of occupational exposures

- In the event of accidental contact with blood, follow standard first aid procedures:
 - Wash hands before and after any procedure;
 - Use protective equipment such as gloves;
 - Immediately wash the wound or affected area well;
 - Clean with an antiseptic agent (mucous membrane and eye exposures should be flushed extensively with water);
 - Handle contaminated sharp objects carefully and disinfect them properly;
 - Make sure that any contaminated materials are disposed of safely; and
- Comply with health and safety regulations in terms of recording and reporting incidences.

3. Post-exposure procedures

- Conduct a rapid assessment of the exposure (high or low risk). High risk is usually needle-stick injuries with a hollow bore needle, low risk is usually from blood splashes;
- If there is no record of the HIV status of the source person, an attempt should be made to obtain blood for this purpose – this should be done in accordance with existing guidelines for counselling and testing. Also, check his/her clinical condition for signs of HIV infection or immune deficiency;
- If the source person's HIV status is not known or cannot be established, initiating post-exposure prophylaxis (PEP) should be decided on a case by case basis – depending on the assessment of the risk;
- Initiate PEP with antiretroviral agents, such as AZT and 3TC, as soon as possible after the incident – preferably within 1-2 hours, and definitely within 24 hours. PEP is recommended for any high risk exposure;
- Continue PEP for 4 weeks unless serious toxicities or intolerances occur;
- Provide supportive counselling for the exposed employee, including safer sex counselling and pregnancy avoidance advice for female employees;
- Injured employees should establish their own HIV status at the time of the injury and at 3 months, 6 months and one year later. If HIV positive at the time of the injury then PEP is not indicated; and
- Keep good records of all processes and results, whilst maintaining confidentiality as far as is practically possible.

4. Compensation for occupationally acquired HIV infection

- Occupationally acquired HIV infection from an injury in the workplace is a compensable injury in most countries;
- In the pre-sero-conversion phase, it is usually the duty of the employer to provide for the necessary procedures and costs, such as HIV tests, medical consultations, PEP and counselling;
- If sero-conversion occurs, the infected employee should receive appropriate counselling and treatment;
- Compensation claims should be initiated. For compensation claims to be successful, it is necessary to prove a link between the injury on duty and the HIV infection, i.e. the employee must be able to demonstrate an HIV negative status at the time of the incident (and, ideally, an HIV positive status in the source person).



Travel tips

If you must travel to areas of the world where the safety of the blood supply is not guaranteed, you should follow these measures:




- Before you travel, identify sources of reliable medical help in your destination country;
- Carry sterile disposable needles and syringes for use in the event of a medical emergency;
- Be aware of emergency medical evacuation procedures;
- Reduce your risk of injury by following safety precautions such as using seatbelts and driving carefully; and
- If you are injured and lose blood, consider using a plasma substitute instead of blood. If severe or acute blood loss has occurred, efforts should be made to ensure that the blood has been screened for HIV and hepatitis B virus.



Score Card: A universal infection control programme

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • First aid kits in every unit • First aid kits restocked regularly • First aiders trained in universal infection control procedures • Accident recording and reporting systems in place 		
 Good Response	<ul style="list-style-type: none"> • Awareness campaign conducted • Risk assessments include risks of exposure to blood and blood-borne pathogens • Confidential reporting system in place for occupational exposures 		
 Blue-chip Response	<ul style="list-style-type: none"> • Infection control protocol includes provision for counselling, HIV testing, PEP, and medical monitoring • Starter pack of recommended drugs for PEP available on site 		

Costs

Many of the costs of a universal infection control programme are costs that an organisation is legally bound to incur – first aid and safety costs.

The cost of managing occupational exposures to blood and blood-borne pathogens – assuming that this involves testing, counselling and PEP – although significant, is yet another case of prevention being much cheaper than “cure”!



Case Study: Universal infection control precautions as part of a workplace HIV/AIDS programme - South African Department of Water Affairs and Forestry

In South Africa, the “Working for Water” programme is a national poverty initiative of the Department of Water Affairs and Forestry (DWAF). As part of their HIV/AIDS programme, they have trained safety and first aid officers who take responsibility for ensuring the safety of employees in universal infection control procedures.

In support of their HIV/AIDS programme, they have developed and distributed a number of information pamphlets for employees and other stakeholders, one of which deals with universal infection control precautions. It details:

- Why it is important that these precautions are followed;
- The responsibilities of employers; and
- The first aid steps to follow in the event of a workplace accident.



Additional Information

For detailed notes and a flow diagram on managing occupational exposures see Chapter 15 in Evian, C; *Primary AIDS Care* (2002).

For information on universal precautions (particularly within the health care setting) go to the UNAIDS website at www.unaids.org and search for the *Fact sheets on HIV/AIDS for nurses and midwives*.

See also the IFC occupational health and safety guidelines, on www.ifc.org.

Footnotes

¹ Approximately 1 in 300-330 such exposures will result in an established HIV infection





Section Three

Voluntary Counselling and HIV Testing (VCT)

Section One

Section Two

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Briefing Note

What is VCT?

Voluntary counselling and testing (VCT) refers to confidential HIV testing done on an individual to establish his/her HIV status, and who, after having undergone pre-test counselling, voluntarily consents to the test. VCT also implies that post-test counselling will be provided when the person receives his/her test result.

Sishen Mine example

In 2002, Sishen management received approval to conduct a **Know Your Status Campaign** as part of their ongoing HIV/AIDS response. The results were as follows:

Category	Number	Percentage
Tested	1 723	52% of workforce
Collected results	1 156	67% of those tested
Over 25 years of age	1 504	87.3% of those tested
Under 25 years of age	219	12.7% of those tested
Employees tested negative	1 611	93.5% of those tested
Employees tested positive	112	6.5% of those tested

Why does an organisation need a VCT programme?

Data indicates that the majority of at-risk persons have not been tested for HIV antibodies and a large population of individuals with HIV infection are unaware of their status. Failed early detection of HIV infection prevents any possible early educational interventions or behaviour modification and precludes pre-AIDS treatment with highly active antiretroviral therapy (HAART). Aggressive antiretroviral treatment can significantly improve clinical and health status and reduce viral load, which may diminish patient infectivity and potentially interrupt any future transmission. Continued high-risk behaviour among persons with unrecognised and untreated HIV infection promotes transmission of the virus.



VCT is acknowledged within the international arena as an efficacious and pivotal strategy for both HIV/AIDS prevention and care. It is also an invaluable link between prevention and care.

- VCT is more than drawing and testing blood and offering a few counselling sessions. It is a vital point of entry to other HIV/AIDS services including prevention of mother to child transmission; prevention and clinical management of HIV-related illnesses, tuberculosis control, and psychosocial and legal support.
- VCT provides benefits for those who test positive as well as those who test negative. VCT alleviates anxiety, increases a client's perception of their vulnerability to HIV, promotes behavioural change, facilitates early referral into a wellness programme for treatment, care and support including access to antiretroviral therapy and assists in the reduction of stigma in the community.
- On-site VCT services can enable companies to track employee responses to the HIV/AIDS programme, by monitoring their uptake of the VCT services.

Contractors will rarely be in a position to establish and run a VCT service. They could, however ensure that “knowing your status” is an important message within their HIV/AIDS programme, and that there is support for employees who wish to be tested at services in the community. Some companies will even pay for VCT by means of a voucher system, where the service is not free in the community.

What should a VCT programme consist of?

VCT is a service that can be offered by government, non-government, community and private sector facilities. VCT services need to be accessible and acceptable, which may mean running mobile services and being open after working hours.

Debswana example

Tebelopele is a Setswana word that literally means “forward looking”. **The Tebelopele VCT** initiative in Botswana is a collaborative multi-stakeholder project, established to create a network of free, anonymous, voluntary HIV counselling and testing centres throughout Botswana. The centres have been set up by the BOTUSA project which is a partnership between the Botswana government and the US government.

Three years ago, in view of Debswana's urgent need for VCT centres to complement the mine facilities, and to give employees a choice of service provider (which is really crucial in small communities), a company house was leased, at no rental cost, to the BOTUSA project in Jwaneng; and an eight-man park home was donated for Letlhakane and partitioned to suit the purposes of a VCT service. The Letlhakane service is utilised by both the Orapa and Letlhakane mines and communities.

This is an example of a public-private partnership that benefits not just Debswana but also the communities in which they operate.

The gold standard for VCT follows a regimen of pre-test counselling, testing (as desired by the client and after informed consent is provided), and post test counselling (which may involve one or more sessions depending on the client's needs). Individual risk assessment and risk reduction planning are integral components of pre- and post-test counselling.



VCT must be accessible and affordable for those at highest risk of HIV infection or those suspected to have HIV-related illness.

Sites must be adequately staffed by individuals with high quality training in counselling and testing practices. Management of sites must support staff to sustain high quality service provision, retain skilled staff, and prevent burnout of the counsellors. This also implies setting limits to the number of clients counselled per day. The Zambia Counselling Council sets a limit of 8 clients per day.

A counsellor's role is to:

- Ensure complete confidentiality;
- Provide accurate and relevant information so that the client can make informed choices;
- Give and explore options;
- Recognise and respect the uniqueness of the client;
- Be aware of his/her own beliefs and values; and
- Know when to refer the client for specialised interventions.

Counsellors, to do their work well, need support, such as:

- Back-up support and personal protection, when facing angry clients or potentially violent spouses or relatives;
- Incentives, such as acknowledgement for their role and work;
- Psychological and emotional support, such as debriefing and counselling sessions;
- Retreats (time away) to allow them to replenish their energy;
- Adequate logistic support, such as a counselling room with privacy;
- Professional development and training to keep up-to-date on emerging issues and findings; and
- Networking, exchange visits and counsellor support groups, to keep in touch with their peers.

HIV testing is not easy to administer or interpret, and requires specialised training, and rigorous quality control. Most workplaces will elect to send specimens to a recognised laboratory for testing, however, large companies with well-developed health facilities, may elect to use rapid tests that can be interpreted on site. It is, however, important to stress that confirmatory testing of positive specimens is the recognised standard, and this may involve using a second, different, rapid test or sending the specimen to a laboratory for confirmatory testing (particularly if a second rapid test is negative, i.e. discrepant results).

VCT design must include identifying or strengthening other care and support services, community and hospital referral networks. Integrated approaches can facilitate family planning, STI management, TB referral etc. In developing new VCT sites it is crucial to ensure a standardisation of services in terms of quality of care and support offered to clients. The design and establishment of VCT services must be tailored to take into account stigma reduction and demand creation.

Marketing VCT services is critical. This implies raising awareness of the benefits of VCT, and promoting these services, with appropriate messages for specific target groups, such as migrant workers.

Post-test clubs have proven very successful in many contexts. Admittance is linked to having had an HIV test, not to whether the result was positive or negative.

Many companies have launched VCT campaigns with management taking tests publicly, as a way to promote and destigmatise VCT services. In addition, involving opinion makers, like traditional leaders, in marketing VCT can enhance acceptance and utilisation of the services.

Before the availability of ART there were few incentives for being tested. With the ever-widening availability of treatment, promoting VCT as an entry point to holistic treatment and care has much greater appeal.

Post-test club activities aim at providing support for members, and information on a range of HIV/AIDS-related issues.

Monitoring and evaluation systems should be established from the onset for both counselling and testing components to determine whether it is provided in accordance with a predetermined protocol and that the service satisfies client needs.



Red Flags and Special Challenges

There are many challenges to a successful VCT programme:

- Widespread fear of taking an HIV test;
- Fears about breaches of confidentiality;
- Potential for discrimination and isolation as a result of sharing information about HIV sero-positivity;
- Lack of readily accessible testing opportunities;
- Time delay in receiving results (a problem especially with blood tests);
- The attitudes of health care workers; and
- Lack of access to drug therapies, psychosocial support and clinical care.

The following forms of HIV testing constitute discriminatory practices:

- During an application for employment;
- As a condition of employment;
- During procedures related to termination of employment;
- As an access requirement to obtain employee benefits; and
- As an eligibility requirement for training for staff development programmes.

The following forms of testing are not discriminatory provided they take place in accordance with national standards and policies:

- Within a health care worker/patient relationship (even if it is on the company premises and funded by the employer);
- As part of a voluntary HIV testing and counselling programme;
- Within an unlinked and anonymous surveillance programme; and
- Testing after an occupational accident.



Debates around the offer of **routine HIV testing** have been occurring in many workplaces and should be decided with due consideration of the following facts².

HIV testing and counselling is pivotal to both prevention and treatment. Four types of testing have been delineated by UNAIDS, WHO and others:

- Voluntary HIV testing;
- Diagnostic HIV testing;
- Routine offers of HIV testing by health care providers for clients seen at STI clinics, for pregnant women and in clinical and community-based health service settings where HIV is prevalent and antiretroviral treatment is available, even if the client is asymptomatic (with clients free to opt in or opt out); and
- Mandatory HIV screening for all blood that is destined for transfusion or for the manufacture of blood products.



In all cases the “voluntariness” of testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits.

The following key factors, which are mutually reinforcing, should be addressed simultaneously:

1. Ensuring an *ethical process for conducting the testing*, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;
2. Addressing the *implications of a positive test result*, including non-discrimination and access to sustainable treatment and care for people who test positive;
3. Reducing *HIV/AIDS-related stigma and discrimination* at all levels, notably within health care settings;
4. Ensuring a supportive *legal and policy framework* within which the response is scaled up, including safeguarding the human rights of people seeking services; and
5. Ensuring that the *healthcare infrastructure* is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment, and related services.



Tool: Voluntary counselling and testing

Instructions

When setting up a VCT service, consider the following checklist of requirements.




- Convince decision makers of the need for and value of a VCT service;
- Consider the pros and cons of establishing an on site service, versus outsourcing the service (which is often perceived as making it more accessible and acceptable);
- Select counsellor trainees who have warm and caring personalities, are good listeners, are respected by others, and are motivated and resilient;
- Train them, and follow up the training with supervised practice and ongoing, in-service training;
- Provide regular and structured psychological support to the counsellors;
- Be sensitive to the location and time of services, in terms of accessibility and ensuring that the services do not become stigmatised;
- Have adequate supplies of information materials and condoms;
- Run campaigns to promote the VCT services;
- Provide clients with contacts for and access to both general and HIV/AIDS-related services, including support groups and post-test clubs;
- Ensure that counsellors have information on and mechanisms in place for client referrals – to other counsellors, and for treatment, antenatal care, family planning, social support and orphan care;
- Set up clear counselling standards and protocols, including mechanisms to ensure confidentiality; and
- Set up clear testing standards and protocols, including provision for confirmation of HIV positive tests, and quality control of tests and testing procedures.



Score Card: Voluntary counselling and testing

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Company runs VCT promotion campaign Employees access VCT in the community 		
 Good Response	<ul style="list-style-type: none"> VCT service integrated into clinic services Occupational health and EAP practitioners trained as HIV/AIDS counsellors VCT services free to all employees 		
 Blue-chip Response	<ul style="list-style-type: none"> VCT campaign launched by management taking tests publicly Employees who test positive able to register for wellness programme, which includes ART Structured support programme in place for counsellors 		

Costs

A costing study conducted in Uganda at the AIDS Information Centre (AIC), which is an organisation established in 1990 to provide anonymous, voluntary and confidential HIV testing and counselling services, estimated the unit cost per client in 1997 at US\$ 13.39. This included the Blood Bank costs – of test kits, and personnel (laboratory technicians and phlebotomists), supplies, equipment, and technical supervision, as well as counsellor time and the cost of the facilities, administration, supervision and monitoring. Such studies show that by far the most expensive component of VCT services is the counselling, not the testing.





Case Study: A VCT procedure - AngloGold

AngloGold (now AngloGold Ashanti), as part of their wellness programme, developed the following VCT procedure:

Primary objective of VCT

To promote change in sexual behaviour that reduces the risk of acquiring HIV infection.

Secondary objective of VCT

To identify those who would benefit from specialised HIV/AIDS care, including TB preventive therapy through the Wellness Clinic.

Who is VCT for?

All employees of AngloGold companies and dependents with medical aid. The service may be expanded to include other dependents in the future.

Where will VCT be available?

VCT centres have been identified in each region at:

- Primary Health Centres and Dressing Stations/First Aid Stations located at mine shafts;
- Hospitals; and
- Goldmed A and B clinics.

Who will conduct VCT?

Counsellor – only those who have attended a VCT counselling training course will participate; and

Nurse tester – only those who have satisfactorily completed the rapid HIV testing course, assessment and basic quality assurance test will participate.

Who will supervise VCT?

The Wellness Programme Project Manager, under the guidance of the Wellness Programme Leader, Wellness Programme Doctor and Primary Care Manager.

What will happen at the VCT centre?

HIV testing, accompanied by pre- and post-test counselling, will be available at a single session. Rapid test kits will be used which require finger-prick blood specimens. Strict confidentiality will be maintained by recording blood results only on a coded record card. If a conclusive result cannot be obtained using the rapid test kits, a laboratory test will be offered on a venous blood specimen. Counsellors will offer referral to other appropriate services.

When will a VCT record card be completed?

Every client attending VCT will have a VCT record card completed, even if they decline to be tested. Clients attending for repeat testing will have a new card made each time they attend for a test. A visit for follow-up counselling only does not require a new card.



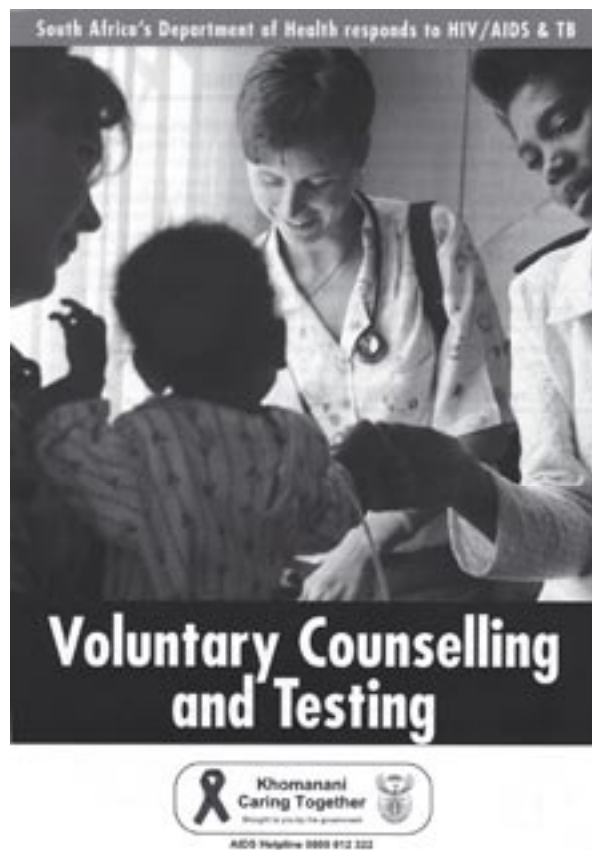
Additional Information

The full case study that includes the step-by-step VCT procedure is available on www.weforum.org/globalhealth/cases.

The lessons learned about running VCT services (at the AIDS Information Centre in Uganda) are documented in a UNAIDS case study entitled *Knowledge is power: voluntary HIV counseling and testing in Uganda* (1999), available on www.unaids.org.

UNAIDS and WHO have issued a policy statement on *HIV testing in the context of wider access to ART* (June 2004). It is available on www.unaids.org.

SaFAIDS published a handbook entitled *Care counselling model* in 1999, which can be used in training counsellors. Copies can be obtained from info@safaids.org.zw.



Footnotes



¹ Adapted from FHI; *Voluntary counseling and testing*, available on www.FHI.org/en/HIVAIDS/FactSheets/vctforhiv.htm

² UNAIDS and WHO; *Policy statement on HIV testing in the context of wider access to ART* (June 2004)



Section Three

Prevention of Mother to Child Transmission (of HIV) (PMTCT)

Section One

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Briefing Note

What is a prevention of mother to child transmission (of HIV) programme?

A PMTCT programme aims to reduce the rate (and overall numbers) of HIV transmission from infected mother to child; and to contribute to improving the health status of children and mothers, whether HIV infected or not. This can be done by preventing unwanted pregnancies, improved antenatal care and management of labour, providing antiretroviral drugs during pregnancy and/or labour, modifying feeding practices for newborns and provision of antiretroviral therapy to newborns.

Why is it important to have a workplace PMTCT programme?

Transmission of the virus from infected mother to child is one of the three main ways that HIV is transmitted. This can happen just before or during delivery or from breast-feeding.

Mother to child transmission becomes a workplace issue because pregnant workers, or the partners of workers, may be infected. The workplace therefore needs to play a role in this important prevention intervention, which constitutes an important investment in the future of any country.

Contractors may employ many women, such as in the foodservice industry. In such instances they will have policies and procedures to accommodate employees who are pregnant, and provision for PMTCT services should be part of these policies.

What should a PMTCT programme consist of?

An obvious starting point is the information and education programme, which should not only help employees understand how this type of transmission takes place, but should also give support to women, and their partners, in making difficult choices about having a child, pregnancy termination and breast-feeding.

Peer educators can inform employees about PMTCT services, and women's workplace groups/clubs can take a lead in promoting and supporting access to PMTCT services.

PMTCT programmes that treat pregnant women in order to protect their unborn children, offer little help to the women themselves.

PMTCT-Plus programmes are designed to link PMTCT programmes to efforts to treat infected mothers, and so increase their chances of survival.

The essential PMTCT-Plus package includes treatment for OIs (opportunistic infections), and ART.

Maternity and paternity leave policies also provide the opportunity for action. These policies may need adaptation to include the special needs of pregnant employees with HIV.

For women workers returning to work after their maternity leave due attention should be given to the issue of infant feeding.

Finally, companies may be able to provide antiretroviral therapy to prevent mother to child transmission of HIV, or may act as an agent to administer state-funded treatment.



Red Flags and Special Challenges

Amongst the many challenges to an effective PMTCT programme are:

- The enrolment of pregnant women into antenatal care;
- HIV testing of pregnant women;
- Involving male partners in antenatal care and PMTCT;
- Hostile spouses, and all too frequent instances of physical abuse;
- The safe and effective provision of ART to pregnant women and newborns;
- Safe and sustainable alternatives to breastfeeding;
- The need to scale up PMTCT programmes to include PMTCT-Plus; and
- Linking PMTCT programmes to other primary health care services as well as to other workplace programmes, such as peer education programmes.



Tool: Checklist of basic requirements for a PMTCT programme

Instructions

If you have responsibility for a PMTCT programme, or for ensuring referrals to a PMTCT programme, the following constitute some of the basic requirements for such a programme:

- Family planning/reproductive health and contraceptive services;
- Antenatal, delivery and postpartum care services that are adequate and accessible, and a functioning referral system in case of complications;
- Information campaigns and community-based efforts to increase acceptance of PMTCT programmes;
- Adequate VCT services, including reliable tests and trained HIV/AIDS counsellors, for all female employees who are pregnant or thinking of becoming pregnant, and their male partners;
- Adequate supplies of male and female condoms;
- An affordable, feasible ART regimen to prevent MTCT;
- Counselling about breast-feeding, including information on alternative infant options;
- Follow-up of all women, children and their families to help them deal with issues such as nutrition; and
- Referral to other HIV/AIDS prevention, treatment and care programmes.



Score Card: PMTCT

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Pregnant employees attend private or public antenatal services in the community – some of which offer PMTCT programmes 		
 Good Response	<ul style="list-style-type: none"> Information about PMTCT is included in workplace HIV/AIDS programmes 		
 Blue-chip Response	<ul style="list-style-type: none"> PMTCT and PMTCT-Plus services offered to HIV infected women at health facilities on site Free or subsidised supplies of formula feed provided for 6 months 		

Costs

The use of nevirapine in PMTCT programmes is cheap and easily implemented. More extensive ART provision during pregnancy is more expensive. This, however, is only one element of a PMTCT programme; other costs to be considered are the costs of testing pregnant women, which includes the costs of training counsellors, and the cost of providing formula feed.



Case Study: Introducing a workplace prevention of mother to child transmission programme; a public/private partnership - Konkola Copper Mines

Konkola Copper Mines (KCM) planned to implement a prevention of mother to child transmission programme from the moment it began drawing up a comprehensive workplace HIV/AIDS strategy and programme.

The strategy was based on the results of a 2001 prevalence study, in which some 7 000 of the Zambian company’s 10 000 employees had participated, as well as an AIDS audit, to calculate the projected cost burden of the epidemic to the company.

“We discussed ARVs at the time. Our dilemma was working out what we could provide, and it was felt that we should target future generations whose care we could accommodate within our existing medical services.”

It took some months for other key elements of the workplace programme to be put in place, including voluntary testing and counselling, an AIDS education programme and peer education. But, once the stage was set, KCM moved swiftly. In 2002, to the delight of the Zambia’s National AIDS Council, KCM became the first private company in the country to follow national recommendations and introduce a PMTCT workplace programme.

How KCM and government became partners in implementation

The mechanisms through which the PMTCT programme could be offered to employees were already in place.

KCM had an established system of health care facilities, which provided medical care for employees and their families, ran education programmes and were well networked with the community. Peer educators in its workplace programme were also perfectly placed to disseminate information about the PMTCT programme, and encourage pregnant women to attend the health services.

What the company lacked, however, was technical expertise in PMTCT. It was around this need that the partnership developed, with government and specifically with the National AIDS Council run by the National Ministry of Health.

The ministry provided a two-week training course for eight midwives and nurses, as well as the paediatricians, obstetricians and medical specialists, who worked at KCM’s two general hospitals and the health centres attached to them.

These trained professionals became the core training team within KCM, and went on to train counsellors around HIV and infant feeding, as well as to sensitise all other health workers at the company’s health care facilities. The medical specialists also went on to become part of Zambia’s core team of national trainers, assisting government to expand PMTCT in other sites throughout the country.

The ministry further supports the programme by providing formula milk and the antiretroviral medication.

What the programme offers

All pregnant women attending antenatal clinics at KCM health facilities are offered sensitisation talks around PMTCT and referred to a trained PMTCT counsellor if they agree to go through the VCT process.

Women who test positive are encouraged to register for the PMTCT programme, and then counselled on HIV, infant feeding options and how antiretrovirals, like Nevirapine, are used to prevent the virus from infecting their baby. Women testing negative are advised on how to prevent becoming infected.

Between May 2002 and June 2004 78% of pregnant women attending antenatal facilities were sensitised to the PMTCT programme and 72% of these opted for voluntary counselling and testing.

Babies on the programme are checked regularly by a paediatrician and tested for HIV at 18 months, the age at which HIV can be best determined by the diagnostic tests currently recommended for infants. Children who are not infected are discharged from the programme; those who are infected are referred to KCM’s Paediatric Specialist Clinics for follow-up care.



“The problem is that once women agree to have the test, husbands think it this means that their wives are HIV positive, and the husbands then get aggressive because they think that it is implied that they, too, are positive.”

Dealing with problems

Generally, women’s first reaction was to agree to VCT, but all would then want to consult with their husbands about the programme.

KCM is optimistic that negative reactions can be overcome. Most husbands are employees of the company, and are reached by the very active workplace programme and the numerous messages around HIV/AIDS which it articulates. There have already been a number of cases where individuals whose wives had been approached regarding PMTCT, were able to voice and resolve their concerns around the programme with peer educators.

KCM believes that – although HIV is still not seen in the same light as a chronic disease such as diabetes – stigma around HIV is generally less in Zambia than elsewhere and people understand company messages that a PMTCT programme is being put in place to protect the next generation because they have already been exposed to messages around HIV.

But, to further promote and strengthen the PMTCT programme, KCM plans to formalise the links between peer educators and health educators and so further assist couples who may need to consider their HIV status in the light of the impending birth of their child.

Way forward

KCM’s PMTCT programme is now well established and the uptake is increasing. The company is looking ahead, to how it can provide antiretroviral treatment to mothers with HIV and not only their babies. Sustainability is the critical element of such an intervention and KCM is examining how to formulate a sustainable treatment plan.

In 2004 its position was that company resources should not be spent on ARV treatment, but that the company should facilitate access to this treatment for its employees, in addition to the numerous other interventions it offers to employees with HIV through its wellness programme. This has been achieved in that KCM’s health facilities now function as a vehicle to distribute ARVs purchased by government and employees pay a fee for their medication.





Case Study: Trade union policy on PMTCT - Sactwu

The following are extracts from the Sactwu HIV/AIDS policy.

Introduction

This policy framework constitutes the basis of Sactwu's HIV/AIDS programme. As a trade union, we recognise that HIV/AIDS is a major challenge in our society. We have the challenge to launch an education programme to contribute to reducing and preventing the spread of HIV/AIDS provide counselling to members who are HIV positive, that will assist them in adapting their lives, and to live positively; and educate workers and the rest of society to ensure that those who are HIV positive are not stigmatised and that we produce a caring supportive environment for HIV positive people, at the workplace, in the union and in the wider society.

We have the responsibility to campaign for treatment and aftercare to be provided to people who are HIV positive, and to interact with government, employers and the donor community to ensure this.

To achieve these goals, Sactwu commits to using its resources, and its collective and advocacy power. Crucially, Sactwu commits to entering into constructive partnerships with a range of other institutions with which we share similar goals.

Nevirapine for pregnant women

Sactwu will offer to provide Nevirapine to pregnant members directed at reducing mother to child transmission, in any province where the state fails to do so, provided the state provides formula feed and the necessary infrastructure to make the provision of Nevirapine effective. Nevirapine will accordingly be provided in those instances where Sactwu reaches agreement with provinces, or possible partners to provide the required infrastructure, that will include appropriate post-natal care for pregnant women as well as follow up care for the mother and baby.



Additional Information

More information on PMTCT programmes is available in the Population Council publication entitled *HIV/AIDS prevention, guidance for reproductive health professionals in developing country settings* (2002).

In Evian, C; *Primary AIDS Care* (2002) Chapter 10 deals with reducing mother to child transmission of HIV.



Section Three

Wellness Programme

Section One

Section Two

Section Three

Section Four

Section Five

Appendices

Contributors



Briefing Note

What is a wellness programme?

A wellness programme is a multi-faceted, multi-disciplinary workplace treatment, care and support programme, into which HIV/AIDS has been integrated, that aims to benefit:

- The organisation, by keeping HIV infected employees healthy and fit to work for as long as possible;
- HIV infected employees, by delaying the onset of illness and AIDS, preventing opportunistic infections and providing a range of treatment, care and support services and options;
- HIV/AIDS affected employees, by providing support services and options; and
- All employees, by creating an enabling, caring and supportive working environment.

The trend in most companies that offer on site health care is to include HIV/AIDS as part of an integrated health promotion and disease management programme. This is optimal, and the wellness programme, that is described in the following pages, and which has an obvious HIV/AIDS emphasis, should be part of an integrated health promotion and disease management programme, and not a stand-alone programme.

Why is it important to have a wellness programme?

There are many reasons why an organisation should establish and implement a wellness programme. These include that:

- Wellness programmes delay the need for ART. Until there is wide-spread availability of ART (antiretroviral therapy) and HAART (highly active antiretroviral therapy), employees with HIV disease will experience ever more frequent illnesses and will become progressively incapacitated. With appropriate prophylaxis these episodes can, to a large extent, be prevented and, if they do occur, they can often be managed at primary health care level (such as at an occupational health clinic).
- Even where HAART is available, there is need for systems for delivery and careful monitoring. Wellness programmes also promote adherence, prevent side effects and the onset of resistance to ARVs.
- HIV/AIDS is a disease with profound psychosocial implications, which, if not managed appropriately, can be as debilitating as the physical effects of the disease.

Contractors should consider ways of enhancing any existing preventive and/or curative services that are available to their employees to cater for employees who are infected or affected with HIV/AIDS. This may require creative partnerships with existing health services or an amendment to benefits (such as access to a health management programme).

What should a wellness programme consist of?

A wellness programme should be situated within a continuum of care that covers:

- Those uninfected but at risk;
- Asymptomatic HIV infected employees;
- Early HIV disease;
- Late stage disease or AIDS;
- Terminal illness; and
- May extend to support for dependants and family members.

Obviously the needs and demands are different at each point along the continuum. The framework below lists some of the key ones.

Framework for a continuum of care

Target group	Needs
All employees	<ul style="list-style-type: none"> • General life skills and HIV/AIDS prevention • STI prevention and care • Promotion of VCT • Access to VCT
Infected and affected employees	<ul style="list-style-type: none"> • Access to HIV testing • Counselling • Support groups and networks of PLWHAs
Infected employees – early HIV disease	<ul style="list-style-type: none"> • Wellness management (including protecting the immune system, safer sex and improved lifestyles) • Prophylaxis for opportunistic infections
Infected employees – late stage HIV disease	<ul style="list-style-type: none"> • Treatment of opportunistic infections • Effective pain relief • Management of symptoms • ART or HAART • Support with succession planning
Affected families	<ul style="list-style-type: none"> • Assistance with material needs and household tasks • Spiritual and emotional support • Advice about wills and inheritance • Preparation for death and the funeral • Support for children orphaned by HIV/AIDS



In the workplace, wellness programmes can be delivered in one or a combination of the following ways:

- Third-party health insurance plans (medical aids);
- Contract with stand-alone HIV/AIDS management programmes; and
- In-house health management.

A wellness programme should consist of the following elements:

1. Nutritional advice and support

Because nutritional difficulties are frequent with HIV disease – malnutrition, malabsorption and oral, oesophageal and gastrointestinal infections – for PLWHAs, good nutritional status is a critical requirement for continued health. Advice includes what foods to eat and not eat, how to use food to boost the immune system, on the one hand, and to fight opportunistic infections, on the other, how to prepare and store food safely, and how to maintain one’s appetite.

Support for good nutritional status takes the form of nutritional supplements, vitamins and trace elements.

2. Lifestyle education

Often referred to as positive living, this is a way of living in which PLWHAs take control of their physical, mental and spiritual health. It involves diet and healthy nutrition, limiting unhealthy practices, such as alcohol consumption and smoking, regular exercise, relaxation and meditation, avoiding stress, safer sex practices to prevent HIV transmission and re-infection, making plans for the future, and sharing problems.

3. Treatment of minor ailments

Minor ailments associated with HIV disease can usually be managed at primary health care level. Traditional medicines are also very effective in treating these HIV-related symptoms and conditions.

4. Treatment of STIs

This should involve STI screening, treatment and education, including HIV/AIDS prevention education, as well as treatment of sexual partner/s.

5. Reproductive health services for women

This includes family planning, counselling about dual protection (against pregnancy and HIV/STIs), PMTCT services, as well as information about and referrals for pregnancy termination.

6. Prevention and treatment of malaria

Recent studies illustrate important interactions between HIV/AIDS and malaria. For example people living with HIV/AIDS in areas of malaria transmission are particularly vulnerable to malaria; malaria results in increased viral loads in persons infected with HIV (thus increasing the risk of HIV transmission); dual infection with HIV and malaria increases the risk of anaemia; and placental malaria infection during pregnancy significantly increases the risk of mother-to-child transmission of HIV.

The use of insecticide-treated nets and preventive treatment should always be considered for persons living with HIV/AIDS where there is a malaria threat.





7. Prevention and treatment of opportunistic infections

The risk of getting sick with TB can be decreased in people living with HIV/AIDS by taking TB preventive therapy. This is possible for other opportunistic infections as well, such as pneumocystis carinii pneumonia.

Knowledge of the signs and symptoms of opportunistic infections, and early treatment seeking behaviour is important.

Tuberculosis (TB) is the most common opportunistic infection and the most frequent cause of death in people living with HIV/AIDS in Africa. TB can be cured as effectively in those who are HIV positive as in those who are HIV negative; using the same drugs for the same amount of time.

The DOTS (directly observed treatment, short-course) strategy is the ideal way to ensure that employees with TB complete their treatment. A treatment supporter can be a health worker, employer, co-worker, shopkeeper, traditional healer, teacher, or community or family member.

Because of the association of TB and HIV, every TB client should be offered HIV counselling and testing by a trained counsellor, and then provided with ongoing counselling and care. This will serve to inform the patient, will result in improved care and will decrease the spread of HIV if clients practice safer sex as a result of counselling.

Example: The objectives of Debswana's disease management programme

- Ensures treatment at the right stage of the disease;
- Ensures use of the correct drug combinations;
- Ensures regular monitoring of patients;
- Affords treating doctors direct and immediate access to consultants for clinical support and advice/support;
- Ensures that treating doctors receive regular continuing medical education (CMEs); and
- Provides drug adherence assistance and support via a toll free line.

8. Antiretroviral therapy (ART)

ART, or more commonly referred to as HAART, is covered in detail in the next part of Section Three.

9. Psychosocial support

Psychosocial support is arguably as important as medical care for PLWHAs. It can take the form of one-on-one counselling or support group activities. Traditional healers can play an important part in providing psychosocial support.

Counselling is defined as a confidential dialogue between a client and a trained counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. Effective counselling requires:

- Self awareness of one's beliefs, values and assumptions;
- A respectful non-judgemental attitude;
- Active listening, including accurate reflection of issues and concerns;



- Asking supportive questions that raise important issues;
- Awareness of one's verbal and non-verbal behaviour;
- Providing practical support, advice and information;
- Discussing options for care, prevention and support;
- Encouraging the person counselled and his/her family to make their own decisions;
- A quiet, private environment; and
- Ensured confidentiality.

In many workplaces, counselling services are part of broader employee assistance programmes (EAP). This tends to minimise possible stigmatisation of the service. For an effective counselling service the following are necessary:

- Careful selection of counsellor trainees;
- Training that includes supervised placement after initial training;
- On-going mentoring to maintain quality of counselling and to prevent burn-out;
- Integration of HIV counselling into related services; and
- Referral systems that link counselling services with medical and other services.

Support groups are groups of people who are facing similar challenges and who have decided to meet regularly to share information, experiences and to help each other. Support groups require:

- Privacy, so that members feel confident to share and disclose often intensely personal matters;
- A time to meet that fits with the schedules of its members;
- A skilled facilitator; and
- Carefully considered membership criteria, norms and methods of operating.

Support groups¹:

- Provide a sense of belonging;
- Facilitate and enable expression and sharing of feelings;
- Relieve stress – by providing members with opportunities to talk about particular concerns, issues or situations;
- Nurture and build members by providing emotional support;
- Facilitate and develop different and/or new ways of doing things;
- Expose members to accurate information regarding HIV and AIDS as well as related topics;
- Promote personal development and build confidence and self-esteem to deal with issues and situations (e.g. increased assertiveness and conflict management skills);
- Prepare members for disclosure, for example to a spouse, family or colleague;
- Educate members in terms of their human and legal rights regarding living with HIV and AIDS;
- Help prevent the increase of HIV infection;
- Build relationships and provide a space to explore relationships with others;
- Facilitate effective communication in all aspects of a member's life;
- Encourage a sense of hope and promote positive living;
- Are a cost-effective way of providing support to many people;
- Serve as a platform to start other activities, such as income generating initiatives; and
- Facilitate/promote networking and referrals.

Post-test clubs are sometimes established by groups of people who have undergone an HIV test. They function to provide support for their members, as well as to provide HIV/AIDS-related information.



10. Family support

The objective of family support is to render holistic support to affected families, in particular for future and succession planning. Some of the issues that need to be provided for are:

- How property or money will be managed in the event that the employee becomes disabled, who will inherit, and should a power of attorney be prepared;
- Decisions about employee benefits and personal insurance;
- Planning for future medical care;
- The drafting of a will;
- Deciding about a living will; and
- Deciding about who will have custody of the children and who will be their legal guardian.

Characteristics of succession planning²

Target groups

- HIV positive parents
- Their children
- Standby guardians

Programme components

- Counselling for HIV positive parents on serostatus disclosure to their children;
- Creation of “memory books”;
- Support in appointing standby guardians;
- Training for standby guardians;
- Legal literacy and will writing;
- Assistance with school fees and supplies;
- Income-generation training and seed money; and
- Community sensitisation on the needs and rights of HIV/AIDS affected children.



11. Referral networks and partnerships

A wellness programme requires partnerships with services and agencies – for any services and support that cannot be provided on site. It also requires the establishment of referral networks to these services and agencies. Home-based care is one of the options for caring for employees with late stage HIV disease, and many companies are entering into partnerships with NGOs providing home-based care services.



Red Flags and Special Challenges

1. Support groups

There are many reasons why support groups falter or fail.

- One of the biggest challenges facing support groups is the issue of confidentiality; this is of primary concern because of the stigma associated with HIV and AIDS;
- People who are not ready to disclose their status may not make use of support groups, for fear of the association with HIV/AIDS;
- Often individuals in the group might be at different places or stages in their lives and their needs might differ from those of other members in the support group;
- Unfulfilled expectations, for food parcels, jobs, money, etc., may result in poor attendance, which can be compounded where members do not easily identify with the other group members, or where prejudice and scapegoating threaten the cohesion of the group;
- A lack of group norms and guidelines can undermine the functioning of a support group, as can the lack of adequate or skilled facilitation, and no or inadequate planning; and
- Unacceptable behaviour in the group (as defined by the group) that is not skilfully handled can compromise the group's effectiveness.

2. Tuberculosis

TB can become resistant to anti-TB drugs if health care workers prescribe incorrectly and if TB patients do not complete their TB treatment. When TB becomes resistant to drugs like isoniazid and rifampicin, it is called multi-drug resistant (MDR) TB. MDR TB is twenty times as expensive to treat as drug susceptible TB, the treatment lasts from 16 to 22 months, instead of 6 months, 30% of cases are fatal and less than half of patients are eventually cured.



Tool: Checklists for post-test counselling³

Instructions

Pre- and post-test counselling are requirements for HIV testing, as are informed consent and confidentiality. The following is a checklist that can guide a counsellor when giving either a negative or a positive HIV test result.

Post-test counselling checklist – introductory discussions

- Counselling requires a relationship. Connect with the client, answer questions, and make sure the client understands the information you are providing.
- Make sure you have the test results.
- Greet the client. Establish rapport.
- Ask whether the client has any questions that have arisen since testing was performed.
- Answer questions and tell the client that counselling will continue to be available to help with important decisions.
- Go over what was said during the pre-test counselling session. Tell the client that you are doing this to make sure he or she remembers important information.
- Ask the following questions:
 - Do you remember the differences between HIV and AIDS?
 - How is the knowledge of your status going to help you?
 - How can you protect yourself further from infection?
 - Who else will be affected by this result?
- Give the client time. Ask the client: “Are you ready to receive your HIV test result?”

Negative result

- State in a neutral tone: “Your test result is negative”.
- Pause and wait for the client to respond before continuing. Give the client time to express any emotions.
- If the client wishes to see the results, provide them.
- Check the client’s understanding of the meaning of the results.
- Discuss and support the client’s feelings and emotions.
- If there was a recent risk exposure, discuss the need to retest.
- Discuss ways to remain negative and assist the client in exploring future risk reduction so that her or his status remains negative, in view of the high risk associated with new infections.
- Discuss the following health promoting and risk-reduction strategies with the client.
 - Good nutritional status;
 - Avoidance of alcohol;
 - Use of condoms; and
 - Limiting the number of sexual partners.
- Talk with the client again about partner testing.
- Inform the client that counselling is available for couples.
- Discuss disclosure.
- Discuss support issues and the availability of future counselling sessions.
- Ask whether the client has questions or concerns. Explain to the client how to contact the clinic/VCT centre in the event that any new concerns arise.
- Remind pregnant mothers that counselling will be available throughout her pregnancy in order to help plan for the future and to obtain the services she may need.



Positive result

- State in a neutral tone: “Your test result is positive”.
- Pause and wait for the client to respond before continuing. Give the client time to express any emotions.
- If the client wishes to see the results, provide them.
- Check the client’s understanding of the meaning of the result.
- Explain that the client’s feelings and emotions may change frequently at this time.
- Discuss disclosure and support issues and subsequent counselling sessions.
- Where appropriate, revisit issues such as:
 - Condom use;
 - Adequate nutrition;
 - Prompt medical attention, prophylaxis and treatment of opportunistic infections;
 - Ways to stay healthy;
 - Treatment options;
 - Management and support systems;
 - Reducing the risk of infecting others;
 - PMTCT issues, such as infant feeding, childbirth plans and antiretroviral prophylaxis; and
 - Screening and treatment for sexually transmitted infections.
- Identify sources of hope for the client, such as family, friends, community-based services, spiritual supports and treatment options. Make referrals when appropriate.
- Ask whether the client has questions or concerns. Explain to the client how to contact the clinic/VCT service in the event that concerns arise.
- Remind pregnant mothers that counselling will be available throughout her pregnancy in order to help plan for the future and to obtain the services she may need.
- Talk with the client again about partner testing.
- If the client already has children, discuss and plan their testing (where appropriate).
- Refer for medical assessment and follow-up.








Score Card: Wellness programme

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Treatment of minor ailments at on site occupational health clinic or at public sector PHC clinic • DOTS for TB treatment in place and treatment completion target reached • EAP at all operations, and EAP practitioners trained in HIV/AIDS 		
 Good Response	<ul style="list-style-type: none"> • Screening for STIs and TB • Prophylaxis for OIs, and nutritional supplements provided and paid for by the company • Support groups meeting weekly, outside of working hours, but utilising company facilities 		
 Blue-chip Response	<ul style="list-style-type: none"> • HAART available on a cost-sharing basis for infected employees with CD4 counts less than 250 • Counselling, including bereavement counselling, extended to dependents • Legal assistance available for succession planning 		

Costs

The diagnosis and treatment of TB is free in many countries, and in such situations, should not represent a cost to companies, other than the time costs of supervising and taking treatment.

Many of the other wellness programme costs will be additions to existing commitments, such as treatment for minor ailments at the occupational health clinic and counselling as part of EAP services.



Case Study: Elements of wellness support and management - Gold Fields

Gold Fields has a comprehensive wellness programme for HIV infected employees. The following is an extract from their VCT and wellness programme.

Note that ALL chronic diseases such as HIV/AIDS, diabetes, hypertension and asthma will be managed in the Wellness Programme. See Chamber of Mines Wage Agreement 2001 clause 3.2.2.3.

1. Health and life style education

Education received at induction and from peer educators will be reinforced, including the value of a healthy diet, regular exercise, no smoking, no alcohol and treatment possibilities.

2. Nutritional and vitamin supplements

Maintaining the vitamin, mineral and other essential nutrient levels of HIV positive people, slows the rate of progression to full blown AIDS. New products suggested by parties will be considered by labour and company health professionals on a scientific basis and may be introduced to the protocols on merit.

3. Sexually transmitted infections (STIs)

- The risk of HIV transmission increases drastically in the presence of STIs, hence the importance of 24 hour access to a STI management programme at every primary health care facility.
- The management of STIs in communities, especially for people at high risk, is of the utmost importance to ensure the sustained reduction of STIs amongst employees.

4. Opportunistic infections (OIs)

- Ensuring optimal functioning of the immune system through a healthy life style and nutritional and vitamin supplements are the most cost effective method of prevention.
- Prevention of OIs such as TB, pneumonia (*Pneumocystis carinii*) and chronic diarrhoea will further be effectively achieved with the responsible use of isoniazide (INH) and co-trimoxazole (Bactrim).
- Those infections not prevented will be timeously identified through regular visits to the Wellness clinics and primary health care facilities, and appropriately treated.

5. Surveillance and treatment of TB

The Gold Fields TB surveillance and treatment programme complies with national guidelines and is regarded as one of the best in South Africa. Directly Observed Therapy (DOT) principles are applied.

6. Minor conditions

These include skin, mouth, ear, nose and throat diseases and will be treated at existing primary health care facilities.

Monitoring

The objectives are to continuously monitor the cost effectiveness of the programme and to enable health professionals to adopt the most appropriate disease management protocols timeously. Monitoring will be ongoing and accurate health records will be kept from day one. The data will be collected and analysed on an ongoing basis. The information will be made available to the GFL HIV/AIDS forum for review.



Case Study: An ID and referral system

Assmang Ltd Beeshoek Mine has established a comprehensive identification and referral process known as the “Safety/Hazard/Socio-economic ID System”. A range of employees, from industrial relations (IR), the unions, the clinic and the wellness team have been trained to observe and identify employees with problems such as substance abuse, trauma, conflict and anger, depression, nutritional deficiencies, stress, excessive sick leave, absenteeism, disciplinary problems, and so on.

Cases are discussed in the Medical or Safety Committee Meetings and one of the regular outcomes is that the employee and possibly also his or her family members are offered counselling. Depending on the cause of the problem, a range of support options is available, from financial training and budgeting assistance, to a nutritional session with a wife, to a stress management session, or marriage counselling. Counselling related to HIV/AIDS has been integrated into this system.

Regular follow-ups with the employee are scheduled. The system now forms part of reporting procedures to IR, the unions, safety, the relevant supervisor and mine management.



Additional Information

Dr Clive Evian has written a book entitled *Primary AIDS Care* for primary health care personnel providing clinical and supportive care to PLWHAs (latest edition published in 2002). The book deals extensively with anti retroviral therapy and is orientated to the health care realities of Africa.

Metropolitan sponsored a booklet entitled *Positive health*, written by Neil Orr, for PLWHAs (undated).

Southern Life developed a booklet on financial planning, entitled *Future positive – financial planning with HIV/AIDS*.

UNAIDS; *Fact sheets on HIV/AIDS for nurses and midwives* (2000) contains information on many components of a wellness programme.

The Canadian AIDS treatment information exchange developed a handbook on living with HIV, entitled *Managing your health* (1999), as well as a number of fact sheets on issues such as drug side effects, and HIV/AIDS and nutrition. All are available on www.catie.ca.

The full Gold Fields case study is available at www.weforum.org/globalhealth/cases.

A manual on nutritional care and support for people living with HIV/AIDS is available on www.fao.org/DOCREP/005/Y4168E/Y4168E00.HTM.

There are a number of publications on nutritional advice and support, such as that developed by the Network of African people living with HIV/AIDS, entitled *A healthy diet for better nutrition for people living with HIV/AIDS* (undated)

In 2004, WHO released a publication entitled *Rapid HIV tests: guidelines for use in HIV testing and counselling services in resource-constrained settings*, which is available on www.who.int/hiv/pub/vct/rapidhivtests/en/.

The report from a technical consultation convened by WHO in June 2004, entitled *Malaria and HIV/AIDS interactions and implications*, is available on www.who.int/hiv/pub/prev_care/en/.

Care and support is covered in the ILO education and training manual, *Implementing the code of practice on HIV/AIDS and the world of work* (2002) (Module 7), available on www.ilo.org.

Footnotes



¹ Adapted from POLICY Project; *Guidelines to establish and maintain support groups for people living with and/or affected by HIV and AIDS* (2003)

² From a Horizons research summary entitled *Succession planning in Uganda: early outreach for AIDS-affected children and their families*. The full report is available on www.popcouncil.org/pdfs/horizons/orphansfnl.pdf

³ Adapted from WHO; *Guidelines for use in HIV testing and counseling services in resource-constrained settings* (2004)

Section Three

Highly Active Antiretroviral Therapy (HAART) Programme



Briefing Note

A highly active antiretroviral or HAART programme is generally part of a multi-faceted wellness programme, however, in light of the global efforts to improve access to treatment for PLWHAs, a separate sub-section is allocated to this important intervention.

What is a highly active antiretroviral therapy programme?

HAART involves treatment with two or more antiretroviral drugs, (ideally with 3 drugs to delay and prevent the onset of drug resistance), for people with advanced HIV disease and evidence of a compromised immune system.

Why is it important to have a HAART programme?

In addition to the other components of a wellness programme, it is important to include a HAART programme because:

- It promotes wellness and offers hope;
- It delays the onset of late stage AIDS disease;
- It prevents disease progression and opportunistic infections;
- It decreases infectiousness, by lowering viral load;
- It greatly improves the quality of life and life expectancy, decreases absenteeism, hospital admissions and the cost of OI treatments;
- It preserves human capital and the skills and knowledge base that are necessary for human and economic development;
- It keeps parents alive, and households intact and economically stable;
- It strengthens prevention through increased uptake of VCT, PMTCT, and behaviour change;
- It promotes openness and reduces stigma; and
- It improves health care worker morale.

Contractors, like all other employers, should become informed regarding treatment for HIV/AIDS, as there is ample evidence that treatment works and is a cost effective strategy as it keeps infected employees well and productive. Partnerships with government or with sectoral or medical aid service providers will probably be the optimal way for contractors to establish a HAART programme.

What should a HAART programme consist of?

The following are the minimum requirements that must be in place:

- Availability of reliable, inexpensive tests to diagnose HIV infection;
- Access to VCT;
- A reliable, long-term and regular supply of quality drugs;



- Support for those enrolled from their social networks, to stay with the treatment regimen;
- Counselling on drug information, financial considerations, adherence, etc;
- Appropriate training for health care providers in treating clients with HAART;
- A protocol that covers when to initiate treatment, drug regimens, medical monitoring, etc;
- Laboratory facilities to monitor clients on HAART, including the early identification of adverse reactions;
- Capacity to diagnose and treat OIs;
- Access to functioning and affordable health care services; and
- Joint decision-making between the health care provider and the client, in all decisions related to HAART.

There is an optimal time to start HAART, often between 5-8 years after the initial infection and then continuing for the rest of the employee's life. Therapy is likely to extend the employee's working life by 5-8 years on average. Some employees will do very well on HAART, but some may not be able to tolerate the medication as a result of side effects or drug toxicity or may not adhere to the medication which will result in treatment failure.

The characteristics of a good HAART programme are:

- It is potent, leading to undetectable levels of HIV in patients on HAART;
- It is an acceptable regimen;
- There are reasonable options for future therapy;
- It is affordable and sustainable; and
- There is patient commitment to life-long therapy.



Red Flags and Special Challenges

The rationale for treatment

There are a number of compelling reasons for providing treatment.

- The availability of treatment offers hope and this, in turn, takes away much of the fear that PLWHAs experience, and enables them to face all of the issues that they need to deal with more readily and effectively;
- It is only when HIV testing is coupled with treatment that people have an incentive to be tested;
- Effective antiretroviral treatment lowers the viral load in infected individuals, which, in turn, has a major effect in reducing the likelihood that they will transmit HIV infection to others;
- Treatment is necessary to save the very fabric of societies. Without treatment, parents will die. Without family support, children will not attend school, will live in poverty and will, themselves be vulnerable to acquiring HIV.
- Treatment is necessary for continuing economic development. Without treatment, millions of adults in the prime of their working lives will die of AIDS and take with them the skills and knowledge base that are necessary for human and economic development.

There are many challenges related to a HAART programme, such as:

- Lifelong treatment;
- Complexity;
- Resistance;
- Adherence;
- Stigma; and
- Toxicity.

In March 2001 Debswana Diamond Company in Botswana became the first employer in Southern Africa to offer employees (including workers on contracts for longer than two years) antiretroviral treatment in order to extend their productive life.

Notably, Debswana did not conduct a cost-benefit analysis prior to the introduction of the scheme, preferring to justify it as "doing what they think is best".

For countries committed to the global 3 by 5 campaign (3 million people on treatment by 2005), there are significant challenges to their health systems, including:

- The cost of treatment;
- Poor or inadequate infrastructure, including laboratory infrastructure and expertise;
- Drug procurement, security and supply management;
- Demands for improved personnel expertise and training;
- Who to treat and who not to treat;
- Integration of the HAART programme with other services; and
- Monitoring and evaluation.

Most, if not all of these are challenges at an organisational or company level as well, but once recognised and addressed, the benefits extend way beyond the HAART programme, to other health services as well.



Tool: Information on HAART for employees¹

Instructions

Communication about a HAART programme is crucial. Use the following to draft an information sheet that can be used by employees who are considering registering on the company's HAART programme.

1. What is HAART?

HAART is the acronym for highly active antiretroviral treatment or therapy. ARV is another acronym for antiretrovirals, referring to the drugs prescribed for HIV positive persons as part of a treatment programme.

2. What do anti-retroviral drugs do for someone who is HIV positive?

The Human Immunodeficiency Virus (HIV) destroys the body's immune system, which normally fights germs and viruses that make you sick. When the body's immune system becomes very weak, you start to get certain illnesses, and you are then said to have AIDS (Acquired Immune Deficiency Syndrome). Antiretrovirals reduce the amount of HIV in the blood. When two or more of these drugs are used together, they are more effective and allow the immune system to heal, thus delaying the onset of "full-blown" AIDS and allowing the HIV positive person to live longer. Antiretroviral drugs are not a cure for AIDS.

3. Will I be able to continue working when on the treatment programme?

The treatment programme, including monitoring and evaluation of the patient and the provision of antiretroviral drugs, is intended to extend the productive lives of employees and spouses or life partners, and thereby importantly extending the life and capacity of the family unit.

There may initially be side effects experienced from the antiretroviral drugs but once past this period, then you should be able to return to work and function normally.

As with any other chronic illness, employees must accept responsibility to ensure that their lifestyle is healthy and supports the effectiveness of the treatment programme. This includes a nutritious eating plan, lots of exercise and rest and avoiding harmful substances.



4. What happens if I register on the programme and then don't follow the specified treatment regime?

The HIV infected person's willingness to accept and adhere to a complex and costly regimen of drugs is essential before embarking on a treatment programme. Without this commitment there is little chance of success. Commitment to a treatment programme is life-long.

The most common reason for failure of drug regimens is poor adherence to treatment. Poor adherence to the specified drug regimen can lead to drug resistance. Also, the number of drugs currently available to treat HIV/AIDS is limited and because the drugs are typically used in combination, the treatment options are limited.

When you and/or your spouse or life partner register on the treatment programme you accept responsibility for adhering to the treatment programme prescribed by the treating doctor. This includes the regular monitoring and testing which is required and taking the drugs as advised. If a patient has a continuous record of poor compliance, he/she can be removed from the programme.

5. What measures are in place to ensure that a patient is complying with the treatment plan?

Treatment support counsellors will make contact with the patients at regular intervals to ensure that they are taking the medication as prescribed and are coping with any side effects.

In addition, data will be monitored with regard to the provision of medication and clinical data specific to the patient. If there is any indication of non-compliance, the treatment support counsellors will be in touch with the patient to offer support and assistance. Various interventions can be employed to facilitate adherence but if non-compliance remains a problem, treatment may eventually be withdrawn.

6. Are the drugs toxic and will I become ill from taking the drugs?

There can be side effects from taking the antiretroviral medication. The severity of the reaction will depend on the patient and the combination of drugs prescribed. You are encouraged to discuss the drug reactions with the treating doctor as soon as possible or to call the help line for clinical and emotional support.

An HIV infected person should pay special attention to his/her health and wellness, particularly when taking anti-retroviral medication. This would include proper nutrition, adequate rest and relaxation, avoiding stress and substance abuse.



7. Will someone who registers on the programme automatically receive anti-retroviral medication?

No, a drug regimen will only be prescribed when certain criteria are indicated in the patient (particularly the CD4 count) and the treating doctor will decide when this is appropriate.

Recently published international guidelines propose starting HAART at a later disease state than was formerly the case. The changes were made because it is increasingly recognised that the long term toxicity of HAART can be dangerous, drug combinations and options are limited and virological resistance is increasing.

8. Who decides when the patient will receive anti-retroviral medication?

The treating doctor decides when the patient should be treated, based on the patient's symptoms and CD4 count. The doctor also has access to specialist advice on the treatment of HIV.

9. Why are drugs only prescribed when the CD4 count is below 250, why not below 500?

There are a number of reasons for only prescribing treatment below a CD4 count of 250:

- There are only 14 different anti-retroviral drugs registered for HIV treatment and these are often used in combination. A patient may develop drug resistance after having been on a specific treatment programme for a while and will need to change drugs. This limits the number of options for a patient and may mean that the patient becomes resistant to all the registered drugs before becoming really ill.
- Once a patient begins taking anti-retroviral drugs it is a lifelong commitment and at least 95% adherence is required for the drugs to be effective. Hence it is better not to commence drug therapy too soon.
- Starting treatment at this specified CD4 count is in line with global best practice.

10. Why do the treatment regimens normally include a combination of drugs?

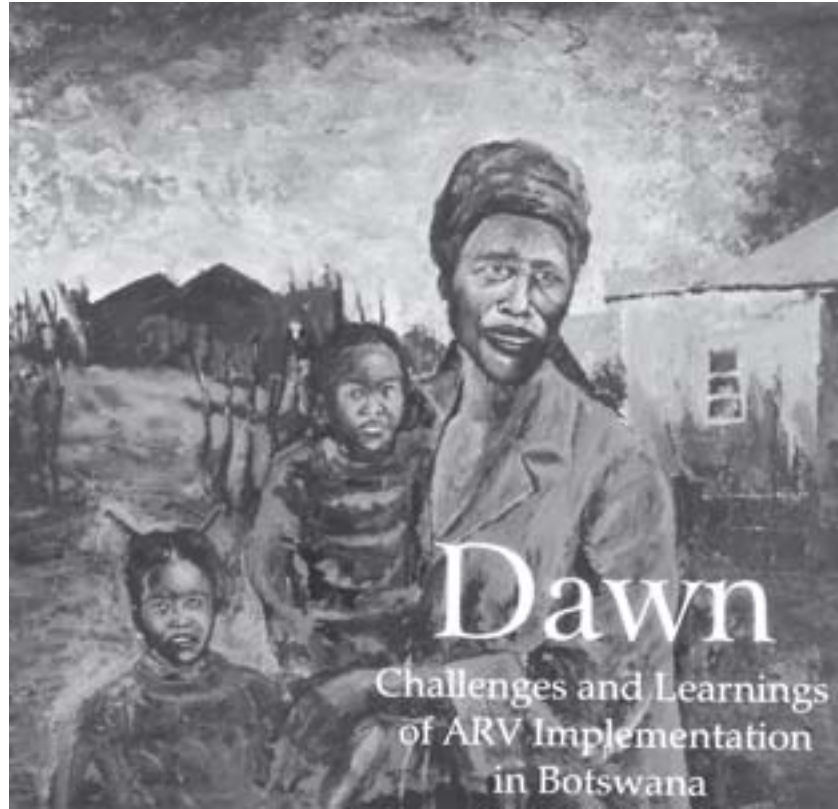
Anti-retroviral drugs are normally combined in order to delay or prevent the emergence of HIV resistance. A number of different combinations have been shown to be effective in reducing the number of opportunistic infections and other HIV related conditions, and in delaying the onset of AIDS.

11. Do HIV infected employees have access to a wellness programme?

All employees will have access to a comprehensive wellness programme, which focuses on the physical and psychological components of wellbeing.

The wellness programme includes:

- Regular medical surveillance as part of occupational health programmes;
- Access to specialist physicians where necessary and geographically possible;
- The Employee Assistance Programme which offers counselling for employees and their families;
- Access to free voluntary counselling and testing (VCT);
- HIV/AIDS education and awareness programmes;
- Access to information on general healthy living, including rest, fitness and nutrition; and
- Disease surveillance and management programmes, e.g. TB control.



Tool: Minimum requirements for introducing HAART

Instructions

The wellness programme tool could be one of any number, but, in light of the ever-increasing emphasis on the provision of HAART, a tool on the minimum requirements that must be in place before introducing HAART has been selected.

If a company plans to provide HAART for HIV infected employees, the following are the minimum requirements that must be in place.




- Availability of reliable, inexpensive tests to diagnose HIV infection;
- Access to VCT;
- A reliable, long-term and regular supply of quality drugs;
- Support for those enrolled from their social networks, to stay with the treatment regimen;
- Counselling on drug information, financial considerations, adherence, etc;
- Appropriate training for health care providers in treating clients with HAART;
- A protocol that covers when to initiate treatment, drug regimens, medical monitoring, etc;
- Laboratory facilities to monitor clients on HAART, including the early identification of adverse reactions;
- Capacity to diagnose and treat OIs;
- Access to functioning and affordable health care services; and
- Joint decision-making between the health care provider and the client, in all decisions related to HAART.



Score Card: HAART programme

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Infected employees on medical aid can access HAART, up to the limit set by the medical aid • Peer educators cover information on HAART in their sessions 		
 Good Response	<ul style="list-style-type: none"> • HAART available on a cost-sharing basis for infected employees and one spouse with CD4 counts less than 250 • On-going VCT campaign, linked to company policy to provide HAART • Health centre staff trained to administer HAART 		
 Blue-chip Response	<ul style="list-style-type: none"> • VCT uptake doubled and associated percentage of employees registered on HAART programme • Company participates in treatment literacy activities in the community • Contractors included in HAART programme 		

Costs

The cost of the HAART is coming down and more and more drug combinations are becoming available, which is likely to decrease the price further. In one programme a comparison of the cost of the drugs and laboratory monitoring shows a decrease from ZAR 53 000 p.a. in 1999 to ZAR 14 000 p.a. in 2003.

AngloGold estimated that it would cost US\$ 244 per client per month to provide employees with HAART during a trial running from November 2002 to December 2003. Harmony budgets ZAR 1 000/mth per client. Other programmes estimate the annual cost of treatment at US\$ 500 per annum, and the cost of first-line drugs at ZAR 350/mth.

A study in Zambia quantified the cost of providing ART at US\$ 488 per person p.a. for first line HAART, or US\$ 408 for a more basic monitoring protocol. Drugs are responsible for 57% of the total cost and monitoring tests for 36%. VCT will cost US\$ 3.64 per person. The training of health workers to deliver ART was calculated at US\$1 million p.a. for 4 years.



Case Study: Disease management programme - De Beers

The following section appears in the De Beers policy. The policy was negotiated with the National Union of Mineworkers.

Components of the disease management programme

The effective management of HIV/AIDS requires an integrated strategy, the key components of which are:

• Prevention	Through in-house education, training and distribution of contraceptives as well as support for community efforts
• Counselling and testing	Voluntary, and available to employees and their spouses/life partners within defined conditions
• Surveillance and research	Regular collection of pertinent data which can help to track the incidence and transmission of HIV/AIDS
• Employee counselling	Confidential, facilitated by the company, and aimed at infected employees
• Medical treatment	Feasible, sustainable, and limited to South African employees and their legally married spouses/life partners.



Additional Information

Criteria for assessing if a site or programme can effectively initiate ART have been developed and are available on www.developmentgateway.org/download/194772/Readiness_Tool_final.pdf.

The ART protocol used by Anglo American is available on their website at www.angloamerican.co.uk/hiv/aids/downloads/ART%20GUIDELINES%20oct02.doc.

The Zambia ART costing study by Kombe, G and Smith, O is entitled *The costs of ART in Zambia* (October 2003).

Doctors Without Borders (MSF) have compiled a document with the prices of ARVs, available on www.doctorswithoutborders.org

Footnotes



¹ Adapted from the De Beers Antiretroviral (DART) Programme information package





Section Four

Outreach or External Response

Section Four contains the elements of an organisation's **outreach or external response** to the HIV/AIDS epidemic. The goal of an organisation's outreach or external programme is to contribute to broader community, sectoral and societal HIV/AIDS responses, in areas of comparative advantage, by, for example:

All sectors and spheres of society have to be involved as equal partners. We have to join hands to develop programmes and share information and research that will halt the spread of this disease and help develop support networks for those who are affected.

*Address by President
Nelson Mandela
to the World Economic
Forum, Davos (1997)*

- Adopting and implementing the principle of the greater involvement of people living with HIV/AIDS (GIPA);
- Initiating and/or participating in HIV/AIDS partnerships and collaborative relationships;
- Playing an important role in HIV/AIDS networks;
- Developing and utilising skills to enhance community-level entry for HIV/AIDS interventions; and
- Contributing, in diverse ways, to community outreach projects.

Section Four

Greater Involvement of People Living with HIV/AIDS (GIPA)



Briefing Note

What is the greater involvement of people living with HIV/AIDS (GIPA)?

In 1994, at the Paris AIDS Summit, 42 governments declared that the principle of greater involvement of people living with or affected by HIV/AIDS (GIPA) is critical to ethical and effective responses to the epidemic. This means:

- Recognising the important contribution that PLWHAs can make in any response to the epidemic; and
- Creating the opportunity for their involvement and active participation.

Why does an organisation need to adopt and embrace the GIPA principle?

There is a clear business case for GIPA, particularly in terms of ensuring the relevance and sustainability of an organisation's response to HIV/AIDS.

Successful GIPA initiatives have resulted in a decrease in stigmatisation and discrimination, a personalising of the reality of HIV/AIDS and an improved environment for prevention and care.

Specifically, GIPA fieldworkers appointed in companies have:

- Acted as role models, giving a face to HIV and normalising HIV infection;
- Helped develop, improve and communicate workplace HIV/AIDS policies;
- Contributed towards a more productive, less stressed workforce;
- Created a supportive work environment for PLWHAs; and
- Facilitated the implementation of workplace programmes, by improving the effectiveness of peer education, providing formal or informal counselling and extending activities into surrounding communities.

Contractors may not be in a position to employ a person living with HIV/AIDS as part of their HIV/AIDS programme, but there are other ways to harness this powerful force to enhance their programme, such as by involving infected employees who have disclosed in programme activities.

In the context of HIV, the issue of a “human face” goes beyond welfare to include the experience of those affected – their joys, sorrows, sense of identity and their need to be accepted as part of the community.

Giving HIV/AIDS a human face therefore includes the individuals affected showing the rest of the world that, beyond the grim statistics, they are humans – fathers, mothers, sons, daughters, nieces, nephews, grandmothers and grandfathers who aspire to living a full life.

UNAIDS; Enhancing GIPA in sub-Saharan Africa

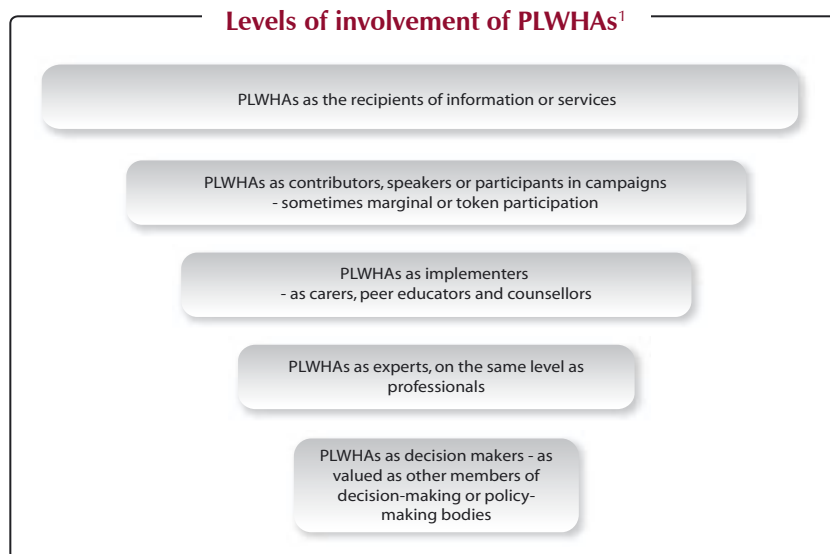


This is one component that quite clearly spans both an internal, workplace response and an outreach, or external response.

Workers who are HIV-positive and are willing to take part in education and training activities have a vital role to play in ensuring the development of effective programmes, and strengthening the credibility of prevention messages.

What does GIPA involve?

The involvement of PLWHAs can be at multiple levels:



The message is that PLWHAs can be a valuable part of a workplace response, both within the organisation (as part of the workplace programme) and externally as part of the organisation’s community participation activities.

Example of the benefits of GIPA in an HAART programme²

- Active participation of clients in their own treatment encourages closer co-operation with health workers and better feedback on the effects of the treatment;
- PLWHAs who are successfully on ART are powerful advocates and educators for others considering treatment;
- People newly diagnosed with HIV, or starting ART value counselling from other PLWHAs who have had similar experiences;
- PLWHAs have first-hand experience of what makes (or doesn’t make) a service client-friendly;
- Experienced PLWHAs can be involved in selecting clients for treatment, alongside physicians and other community members, ensuring equity in selection when resources are limited;
- Selected PLWHAs can be trained to assist in the education of clinical and support staff, to ensure that training is grounded in real-life experiences, and equips staff to offer appropriate treatment and support; and
- The visibility of PLWHAs who are using treatment successfully is a powerful tool for combating stigma and encourages people to come forward for HIV testing, counselling and treatment.



Red Flags and Special Challenges

Some organisations, perhaps despite the best of intentions, have involved PLWHAs simply in a token manner – the PLWHA ticked off a checklist as having been invited to the meeting, or as having been consulted in the policy development process.

This is contrary to the spirit of GIPA, as these attempts can hardly be considered “meaningful involvements” and the end results will certainly be less effective and relevant than if the process was more meaningful.

Important lessons that have emerged from successful GIPA projects include³:

- Selecting candidates according to their skills;
- Selecting candidates from partner organisations or from local support groups;
- Cultivating additional skills to enable the GIPA fieldworker to operate in a formal workplace;
- Building in performance appraisal, and skills-based or performance-based remuneration;
- Clarifying job descriptions;
- Developing a GIPA message around living positively with HIV;
- Providing health care and emotional support; and
- Setting up a positive environment and methods of redress to support and sustain the GIPA initiative.



Tool: Checklist to improve an organisation’s GIPA response

Instructions

In the UNAIDS document entitled: From principle to practice: greater involvement of people living with or affected by HIV/AIDS (1999), a number of suggestions are made of how an organisation can enhance its GIPA response. Consider if and how your organisation can adopt and implement the following:

- Peer educators who are themselves HIV positive, are nominated, trained and deployed;
- Support groups are established and run by appropriately skilled and supported PLWHAs;
- Advertisements for staff state that HIV positive persons are welcome to apply for employment within the company;
- Senior management collaborates regularly and publicly with PLWHAs in creating HIV/AIDS plans for the company; and
- Training for PLWHAs on personal empowerment, communication and presentation skills, HIV/AIDS facts, the legal aspects of HIV/AIDS, and skills for organising and conducting policy dialogue is conducted to enable them to more effectively contribute to the company’s HIV/AIDS response.



Score Card: GIPA

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Speaker from local PLWHA organisation invited to address workers on World AIDS Day 		
 Good Response	<ul style="list-style-type: none"> • Employees living with HIV/AIDS, who have disclosed their status, serve on policy making committees to ensure that PLWHA issues are taken into account 		
 Blue-chip Response	<ul style="list-style-type: none"> • PLWHA employed and trained to head the company HIV/AIDS programme 		

Costs

Many of the companies who have benefited from GIPA field worker placements, that were originally sponsored by UNAIDS, have gone on to create permanent positions for PLWHAs, particularly within their HIV/AIDS programmes.

In other instances, as described below, an employee, who has disclosed his/her status, becomes involved in, if not pivotal to, the company’s HIV/AIDS programme.

In 1997, Alan held the position of District Manager in a hospitality company employing 9 000 people. Alan disclosed his HIV status on World AIDS Day 2000. In January 2001, Alan was appointed as Group National HIV/AIDS Manager.

Alan’s company took an interesting approach to his position by negotiating with the provident fund to share 50% of his employment costs, as his work would benefit the fund.



Case Study: GIPA field worker placement - ESKOM

Mazwi Mngadi, 24, is a dynamic young man who works on the Horizons intervention study at ESKOM sites throughout KwaZulu-Natal, South Africa, serving as an HIV/AIDS workplace counsellor, educator, and activities co-ordinator – and presenting a positive image as someone living openly with HIV/AIDS. He volunteers much of his free time to the Treatment Action Campaign and other South African HIV/AIDS activist organisations.



MM: I lead educational sessions on HIV/AIDS with groups of workers and provide training for peer educators and for new trainers. I give out a lot of condoms and make sure that “condom cans” are kept full. I also offer counselling to individual workers and their families and partners, often in their homes. I’ve distributed a booklet about my own story at the dozens of ESKOM plants and substations in KwaZulu-Natal, so I’m well known within the workforce. A lot of workers, even those who haven’t been tested, are afraid to speak to me in public for fear of being identified as HIV positive, but I circulate my phone number, so instead they phone me to talk about their concerns and get advice. These calls are strong evidence to me that my presence at ESKOM makes a big difference.

Just a few months ago we created a confidential support group for workers with HIV/AIDS that meets outside of ESKOM, after work hours. So far, there are about six workers who participate, and we share our personal stories and our problems, and I usually invite a speaker to talk about such topics as nutrition and treatment of opportunistic infections. We also discuss what’s happening around the country. One of the most common problems is being afraid to tell partners that they’re HIV infected.



Additional Information

The full interview with Mazwi Mngadi is contained in the Horizons Report (June 2003), available on [www.popcouncil.org/horizons/newsletter/horizons\(6\)](http://www.popcouncil.org/horizons/newsletter/horizons(6)).

The following are available on the UNAIDS website at www.unaids.org

- *From principle to practice – greater involvement of people living with or affected by HIV/AIDS* (1999); and
- *Enhancing the greater involvement of people living with HIV/AIDS in sub-Saharan Africa* (2000).

Footnotes



¹ From UNAIDS: *From principle to practice – greater involvement of people living with or affected by HIV/AIDS* (1999)

² Adapted from a draft toolkit for programme managers developed by the International AIDS Alliance and WHO, entitled *A public health approach for scaling up ARV treatment* (2003)

³ From UNAIDS; *The faces, voices and skills behind the GIPA workplace model in South Africa* (2002)



Section Four

HIV/AIDS Partnerships and Collaborative Relationships



Briefing Note

What is a partnership?

Partnerships are voluntary collaborations that build on the respective strengths of each partner, optimise the allocation of resources and achieve mutually beneficial results over a sustained period. They imply innovative interaction and linkages that increase resources, scale and impact. They also imply a preparedness to share benefits and losses.

Partnership examples

South Deep will work with municipal authorities to ensure that ill-health retirees have reasonable access to required services including: water; sanitation; and clinics and hospitals.

Anglo Platinum is working closely with the local authorities to set up services and to build houses to replace informal settlements.

They are about communication, consultation, co-ordination and collaboration and usually involve written agreements that specify the purpose and duration of the partnership, the formal governance structure, roles and responsibilities of the various participants as well as exit arrangements.

There are different kinds of partnerships, such as:

- Public/private/NGO partnership combinations or tripartite partnerships (government, business and labour);
- Operational partnerships, around a specific programme;
- Policy and strategy partnerships, which typically deal with new challenges that cut across sectors; and
- Advocacy partnerships to promote action on key issues.

Some partnerships evolve to encompass a combination of the above.

Why does an organisation need to build HIV/AIDS partnerships?

Building HIV/AIDS partnerships is about working with others to achieve what we cannot achieve on our own, or because we do not have the necessary expertise. A partnership is a relationship in which people and organisations combine their resources to carry out a specific set of activities that address one or many aspects of the HIV/AIDS epidemic.



The benefits of an HIV/AIDS partnership include:

- The resource commitments that are made by each party:
 - Funds or finance;
 - Staff time;
 - Expertise;
 - Local knowledge;
 - Technical equipment; and
 - Mediation skills.
- A wider response – with different types of organisations and sectors involved;
- Influence with and access to key individuals and places, willingness to adopt a leadership role and capacity to leverage resources from others;
- A more co-ordinated response – including better referral between organisations;
- A larger response – financial, political, technical, practical and in-kind support;
- Better support and policies for PLWHAs and their families;
- Stronger services and increased access for vulnerable communities;
- Fewer constraints;
- More creative and effective HIV/AIDS programmes;
- Opportunities to develop knowledge and skills; and
- Shared lessons and experiences.

Coalitions of businesses are one form of HIV/AIDS partnership, to work together to pool data and talent to accelerate and streamline HIV/AIDS responses. Similarly, public-private HIV/AIDS partnerships can be more efficient than if they work independently.

Contractors, even small companies or those operating in a less formal manner, such as small scale mining companies¹, identify the importance of forming HIV/AIDS partnerships, to benefit both their response and the response of their partners. There will usually be good precedents for this kind of partnership, which can be used as a model for an HIV/AIDS partnership.

Who are the potential HIV/AIDS partners and how should HIV/AIDS partnerships operate?

Debswana example

... suppliers that provide goods and services to Debswana must have their own workplace policy and programme, as well as be supportive of Debswana's community HIV/AIDS initiatives. Suppliers are audited on a periodic basis.

1. Suppliers, customers and contractors

Large companies have a number of relationships with suppliers, customers and contractors, many of which are smaller, informal enterprises.

Those large companies should identify all small enterprises with which they have production relations. The aim then would be to convince the firms which supply them with goods and services to participate in their workplace HIV/AIDS programmes, or to develop their own programmes, possibly assisted by the large company.

Staff who visit suppliers, contractors and customers could distribute literature on the basics of HIV/AIDS. They could receive special training so that they can discuss and explain issues. Staff in purchasing and sales departments are perhaps not normally



involved in the company's HIV/AIDS response, but they could have a huge impact. They meet customers and suppliers regularly, get to know many of them, and understand their problems. They are more likely to be trusted than strangers.

Suppliers and customers could also be invited to in-house training and information sessions on HIV/AIDS. This would involve little additional cost, and strengthening the relationship between the company and the customer/supplier could be good for business.

2. Local small businesses

Around every large organisation there will be a cluster of small businesses, not necessarily with any kind of formal relationship, but dependent on the existence of the company in some way. For example, there may be stalls nearby selling food and drink to workers. There are cleaners and security guards. Workers travel to and from work on mini-buses and other forms of informal transport. Here again, the influence of the larger organisation can be used to get the HIV/AIDS message across.

3. Trade unions

The same principle applies to workers' organisations, that could extend an invitation outside their own membership, to organisations sharing a common goal.

4. Membership organisations

Then there are numerous membership-based institutions such as community associations, credit unions, co-operative societies, and mutual insurance schemes. Large employers or employers' organisations can work with these in a number of ways. They can sponsor or "adopt" an HIV/AIDS programme for such associations, or partnerships can be set up to help companies implement activities for the local community.

5. National and international organisations and research institutions

At national, and indeed at international level, the mining sector can and has contributed to advancing the frontiers of knowledge and research on HIV/AIDS.

6. Government

Mining companies can use their existing relationships with government as an opportunity to develop HIV/AIDS partnerships that benefit both parties.

Debswana example

In April 2003, Debswana entered into a partnership with the Ministry of Health, offering the use of the Debswana medical facilities and staff for the rollout of the government ART programme.

The **benefit to government** was that ART access was extended to more citizens, without the cost of additional staff or infrastructure.

The **benefit to Debswana** was (i) that infected dependents (children), who are not covered by the company's programme, are now catered for; (ii) ART drugs can be purchased at government tender prices; and (iii) government laboratories can be used for blood tests (reducing the costs associated with using private laboratories).

Aurum Health Research, sponsored by AngloGold, exemplifies effective interaction between the mining and the scientific community as well as resource mobilisation from local and international donors.

7. People living with HIV/AIDS

And finally, there are associations of people living with HIV/AIDS, who are a valuable resource in helping to develop programmes of prevention and care for both informal and formal workplaces.

The golden rules for initiating partnerships include:

- Defining specific goals for the partnership. These might be related to a challenge that the organisation is facing, e.g. a lack of counselling skills.
- Identifying the people and organisations to work with to achieve the goal. An organisation can also make an assessment of its current partners, in terms of any joint activities that may achieve progress towards the goal, or the potential to work with current partners in achieving the goal.
- Deciding how to approach each partner in a way that is appropriate to the position and interests of the partner. In order to build strong, effective partnerships an organisation needs to know and understand its partner – what it does, its views and positions and areas of influence.
- Identifying champions, to get the partnership off the ground.
- Agreeing, with identified partner organisations, to shared governance.
- Defining the details of the collaborative relationship, and formalising these in a memorandum of understanding.

Mapping (or recording) a partnership's 'ups' and 'downs' can help identify the strengths and weaknesses in a relationship, and can be used in monitoring a partnership. A partnership review is an opportunity to build on successes and learn from mistakes.



Red Flags and Special Challenges

The challenges reflected below should not detract from the fundamental truth, which is that partnerships can and do benefit those involved to achieve their own or shared goals. Having stated that, organisations should be alert to possible pitfalls, which may include:

- That there is no guarantee that civil society organisations or government agencies that the company wishes to engage in partnership with, will be "willing" partners;
- That there is also no certainty that, if "willing", these partners will bring resources, knowledge, skills or leadership that would add value to what the company could achieve alone;
- That partnerships with NGOs may, in some instances, be tainted by prevailing negative images of NGOs as not able to get results;
- That NGOs, as community activists, may create problems by calling attention to difficult issues;
- That broaching or pursuing the issue of HIV/AIDS with suppliers, customers and contractors could be difficult and will need strong and sustained leadership;
- That HIV/AIDS can pose special challenges to the building of partnerships, such as personal attitudes and beliefs, and institutional practices, policies or beliefs; and
- That partners may not feel comfortable or competent in the HIV/AIDS field.



Tool: Guidelines for conducting a partner analysis

Instructions

When embarking on HIV/AIDS partnerships, it is useful to have a clear idea of who is out there, doing what. Follow this step-by-step process to conduct such a partner analysis.

Task 1: Identify (i) your organisation’s current partners and (ii) any potential future partners from:

- Within government – different ministries;
- Within government – different spheres/levels;
- Parastatals;
- Agencies (including other donors);
- Networks;
- Boards;
- Associations (professional and voluntary);
- Private sector (commerce and industry);
- Training institutions;
- Research institutions;
- NGOs and civil society structures; and
- The informal sector.

Task 2: Identify their (i) current and (ii) potential future areas of involvement – both those that are HIV/AIDS-related and those that are not. For example, who is, or can be involved in:

- Policy making;
- Advocacy;
- Planning;
- Co-ordination;
- Implementation;
- Technical input; and
- Other areas.

Task 3: Describe **who they work with, where and at what level** (coverage).

Task 4: Then describe **how they work together** and **how effectively**.

Task 5: Describe **how** those with the potential to become involved, but who are not as yet involved, should be **recruited**.

Task 6: Finally, from the list, identify those organisations whose involvement is key to the success of your organisation’s HIV/AIDS programme. These then become the prioritised organisations with whom to pursue collaborative relationships.



Questions to be asked about company HIV/AIDS partnerships

The following constitute reality checks for successful partnerships:




- Goals – what do we hope to accomplish and can a partnership help achieve our goal/s?
- Rewards – what are the tangible and intangible benefits we can expect from the partnership/s?
- Risks – are there any apparent or potential risks involved in the partnership/s?
- Success – how will we know if we are making progress?
- Capacity – does capacity exist to afford the partnership and give it a chance of success?
- Timing – is partnering the best option now, and if so why?
- Weightings – have we considered issues of control, direction and need for speed?



Score Card: HIV/AIDS partnerships

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Discussions to extend memorandum of understanding (MOU) with agency providing non-HIV/AIDS-related services (e.g. basic adult education courses for less literate employees) to include HIV/AIDS • Interested parties able to access information about company HIV/AIDS programme 		
 Good Response	<ul style="list-style-type: none"> • Audit of current partners conducted, to identify opportunities for collaborative relationships on HIV/AIDS issues 		
 Blue-chip Response	<ul style="list-style-type: none"> • MOU with public sector health services to extend wellness programme to infected dependents of employees 		

Costs

The costs associated with establishing and sustaining HIV/AIDS partnerships should always be assessed in terms of the cost benefits of the partnerships, and the possible cost of “going it alone”.



Case Study: HIV/AIDS partnerships - Sishen Iron Ore Mine

Sishen Iron Ore Mine is situated in the Northern Cape Province of South Africa. Sishen’s approach to addressing HIV/AIDS has taken seriously the need to engage not only employees, but also stakeholders – in the workplace and the surrounding community – who can have an impact on employees’ lives. Collaboration with these partners and stakeholders takes many forms, from responsiveness to requests for information and speakers, to support for district level strategic planning around HIV/AIDS and training of community peer educators.

Some key partnership roles and approaches that are part of Sishen’s HIV/AIDS response are described below.

1. Unions

Engagement in the promotion of a KAP survey and the Know Your Status (KYS) campaign. They are also part of the committee reviewing and approving the Kumba Resources-wide HIV/AIDS policy.

2. Departments of Health and Local Government

Involvement with them in the district HIV/AIDS committee; support for district-level strategic planning; training of service providers in peer education techniques; and engagement of local home-based care providers in the KYS and other awareness campaigns.

3. Medical aid plans and resources

Contract with medical aid provider for half-time nurse and social worker to provide HIV/AIDS services (including voluntary counselling and testing, condom distribution and STI treatment). Engagement of medical aid provider in implementation and follow-up of the KYS campaign.

4. Community groups and schools

The Sishen drama group and peer educators receive regular invitations to give lectures at community events. They have visited a number of local schools and churches, and participated in community day activities through HIV/AIDS exhibitions, videos and drama. They have performed a drama for farm workers on a large commercial farm.

Sishen has also engaged proactively in partnerships with local police and other community groups to raise awareness of and promote action on violence against women; has held an HIV/AIDS programme launch that raised awareness throughout the community; and, perhaps most importantly, they have trained a number of community members and home-based care providers as peer educators. These individuals are now part of the Sishen peer education team, and receive the same ongoing training and support as the Sishen team members.

5. Complementary health care providers

Sishen has contractual relationships with several local practitioners to provide various forms of complementary therapy.

Other partnerships are being explored, including the establishment of a herbal garden from which plants could be distributed to PLWHAs and their families through the home-based care network. Home-based care providers would be trained by qualified practitioners in the use of herbs for the treatment and control of a variety of infections.





Case Study: Taking workplace programmes to heart; how Konkola Copper Mines turned a pilot testing process into a lever for workplace action

Konkola Copper Mines was asked to do just one job: pilot test the draft of the **HIV/AIDS Guide for the mining sector**.

Instead, quietly, systematically, and with 100% commitment, KCM created a partnership in which not one, but 11 companies tested the draft **Guide**. In the process, Zambia's largest copper and cobalt mining company turned out more than two dozen new champions for workplace programmes across the continent, and a model showing how the private sector can work together for the common good.

Partnership as a model

The thought of this level of commitment would be daunting for many companies. But the Buyantanshi HIV/AIDS Partnership (which means progress driven by internal motivation and is also the name given to KCM's strategy to improve its business performance), was a natural progression, KCM says, as all the company's social responsibility activities take partnership as a model.

KCM has been consulting with its business partners since July 2000, to find out how best to contribute to sustainable development in Zambia. This intensive process – pulling in amongst others, national government, contractors, municipal councils, social development consultants and local non-governmental organisations – was part of the Social Management Plan KCM was required to develop for all its operations and sets the framework for all of the company's social responsibility activities.

It was on the basis of this framework that KCM approached its business partners to discuss piloting the implementation of the **Guide**. Its aim was to ensure that all business and organisations working with KCM have a uniform approach to HIV/AIDS in the workplace.

How the partnership to pilot the Guide worked

Some 23 contractors, suppliers and community partners, such as education and banking organisations, were invited to the initial meeting on 14 October 2003 to co-ordinate the pilot testing. Each company worked through the **Guide**, noting which elements they had in place and which they could review or implement, using the **Guide**. Even those who had comprehensive programmes in place, participated in one way or another.

From that point, the testing slotted into an organised process, in a given time frame, from February to September 2004.

"HIV was a natural progression. We felt that the only way that we could create sustainability was to involve the community, to share the responsibility and the burden and joy with the rest of the business community. That is how we approached our colleagues. The approach is all inclusive – national community, local programmes – everyone is a participant; everyone is a winner or loser."

"The piloting process was seen as an opportunity to learn: most partners already know the tempo and way KCM works and were very motivated at the opportunity to learn."



Memoranda of Understanding (MOU) were signed, to ensure the process was systematic, and expertise would be shared. The objectives of the MOU were to:

- Raise awareness and build capacity to effectively manage the risk of HIV/AIDS in the workplace and community;
- Promote action and sharing of best practices;
- Initiate, strengthen and review the response to the HIV/AIDS epidemic; and
- Pilot the **Guide** in the areas selected by the partners.

Companies that signed the MOU

Company	Nature of business
Konkola Copper Mines plc	Mining
P&H Minepro	Mining Equipment Supplier
District Education Board – Chingola	Education
Kagem Mining Ltd	Mining
Copperbelt Health Education Project	NGO – Health Education
J C Bousfield	Transport
Standard Chartered Bank	Banking
Barclays Bank	Banking
Alfred H Knight	Metallurgical and Technological Engineering Consultants
Nchanga North Hospital	Medical
Lusanga Technical Services	Mining Machinery Supply and Maintenance

Twelve elements of the **Guide** were piloted in total. These included monitoring the corporate response to HIV, PMTCT, legal compliance, voluntary counselling and testing, management of sexually transmitted infections, condom promotion and distribution, peer education, workplace policy, and co-ordination in the workplace.

“Technical Groups were a case of the strong helping and weak and the weak helping the strong. We had experience of how do deal with a workforce of 10 000, but what do you do when there are fewer than five people? “

All partners were required to focus on a number of specific issues, such as piloting activities, the value or benefits of the work done, constraints and future steps. Key performance indicators were set, and fortnightly report-back meetings scheduled. Technical Groups were created for each area of implementation so that expertise could be shared.

Creating champions for workplace HIV/AIDS programmes

More than 30 people attended the report-back meetings, some even flying in from South Africa. The knock-on effect was powerful. Senior executives of the companies involved developed more faith in both the concept and process of implementing the **Guide**, because it had the backing of a broad partnership. The individuals involved found themselves becoming respected champions of workplace interventions, with unique insights, experiences, and skills.

So successful was the process that the Buyantanshi HIV/AIDS Partnership has remained in place even after the pilot testing was completed.

“Its easy to have a good programme in the workplace but it is difficult to have an effective programme in the community.”

The original MOU provides for the group to continue working together. The Buyantanshi HIV/AIDS Partnership is now seen as an evolving, dynamic and organic process which can continue into the future and be a model, showing that the private sector can work together for the common good, in the workplace and the community. Its next goal is to reach out to the broader population – strengthening the community by sharing information and systems and broadening the partnership by recruiting new members.



Additional Information

UNAIDS and the Prince of Wales Business Leaders Forum published a document entitled *The business response to HIV/AIDS: innovation and partnership* (1990). The document includes the seven principles of partnerships, which are a useful additional tool for organisations developing their competency in the field of HIV/AIDS partnerships.

Generic information on partnerships is available on the Business Partners for Development website at www.bpd-naturalresources.org. For the mining sector, examples of tri-sector partnerships are given at each of the different project phases.

The agreement, signed by the NUM and the Chamber of Mines on behalf of their member mines in August 1993, defines the commitments of all parties to work together to find effective, sustainable and affordable solutions to the HIV/AIDS epidemic, in accordance with the documented strategy. The agreement is contained in the ILO education and training manual, entitled *Implementing the ILO code of practice on HIV/AIDS and the world of work* (2002), which is available on www.ilo.org.

Other useful references include:

- Gates Foundation; *Making health alliances successful*; and
- Harvard University Business School and Kennedy School; *HIV/AIDS and business: building sustainable partnerships*.

Footnotes



¹ At the CASM AGM and Learning Event held in Ghana in September 2003, participants attending the HIV/AIDS session identified a wide range of creative partnerships to enable them to mount comprehensive responses to the HIV/AIDS epidemic



Section Four

HIV/AIDS Networks

Section One

Section Two

Section Three

Section Four

Section Five

Appendices

Contributors



Briefing Note

What is an HIV/AIDS network¹?

An HIV/AIDS network consists of individuals and/or organisations willing to assist one another or collaborate to achieve common goals.

Networks are created out of a powerful sense of shared mission, shared vision, shared commitment and shared action. Networks are created by people who want to be connected, to communicate, plan and act in concert. A network is a process of rapidly disseminating information – lessons, innovations, techniques, ideas, news, requests, questions. A network gives its participants a strong sense of solidarity.

Why is it important for an organisation to participate in an HIV/AIDS network?

Organisations must recognise that, however good their workplace HIV/AIDS responses may be, they will be limited if there is no participation in broader community-wide and sector-wide HIV/AIDS activities. Participation in HIV/AIDS networks is a pre-requisite to this wider involvement.

Contractors may find participation in a local HIV/AIDS network challenging, particularly if their area of operation frequently changes. There are, however, obvious benefits – such as sharing information, resources and experiences – that membership of an HIV/AIDS network brings, and contractors should recognise these and participate whenever possible.

What are the characteristics of an HIV/AIDS network?

Most networks have some or all of the following characteristics:

- Member-ownership;
- Commitment to shared objectives and means of action;
- A jointly developed structure;
- Shared responsibility;
- Shared action;
- Reduced duplication and resource wastage;
- Communication, exchange and mutual learning; and
- Synergy (the effect of things done together is greater than the sum of individual activities).

In the process of creating these networks, we are learning that they are fragile entities, difficult to get established and to sustain. They require much commitment and patience from their members, particularly their founding members. But we are also learning that they form an essential part of the community response to the epidemic. Without them, people are often merely told what others think they should do. With them, we can strengthen the process of questioning, reflection and learning.

They are the places in which an individual in search of help can go, spaces in which communities can seek to understand how, wisely and humanely, they can respond.

Elizabeth Reid

The additional characteristics of an HIV/AIDS network include that it:

- Involves people living with HIV/AIDS;
- Maintains the trust of involved communities;
- Strengthens advocacy;
- Influences others (inside and outside the network);
- Broadens understanding of HIV/AIDS (by bringing together different constituencies); and
- Provides a sense of solidarity, and moral and psychological support.

Structure

Networks can sometimes be established within existing structures: at other times, new structures are required. Networks can be formal or informal in nature. Typically, most networks fall somewhere along a continuum between a loose, single-purpose network for information exchange and a highly formalised network conducting and/or co-ordinating activities. It is also important to note that network structures are not static, and tend to change over time. Factors that will influence the structure of a network are:

- What the network is trying to achieve;
- What resources (time, money and people) are available; and
- How the members want the network to be organised.

Membership

Most networks have both individual and organisational members. Individuals should ideally have a constituency that they represent. In the case of HIV/AIDS networks, in order for the network to be truly representative of and responsive to the needs of people living with HIV/AIDS, it is imperative to ensure the involvement of PLWHAs in a meaningful way. Membership should therefore consist of individuals and organisational representatives, PLWHA, local NGOs providing HIV/AIDS-related services, decision-makers from key sectors or people who can influence decision-makers, and technical experts.



Red Flags and Special Challenges

The nature of networks means that they are loose entities and this can limit their value, particularly if members are constantly changing, or dropping in or out of the network.



Tool: Checklist of HIV/AIDS network activities

Instructions

Although there are many different reasons why HIV/AIDS networks are formed and many different ways in which they operate, there are some basic activities that are common to most HIV/AIDS networks, such as building solidarity, enhancing collective capacity and uniting in common cause. Use the following checklist when deciding on the activities that your HIV/AIDS network will undertake.



- **Alliance building**
Networks can provide for relationships among partners.
- **Generating and sharing information**
Networks can provide a structure for members to establish and maintain essential communications with each other.
- **Advocacy**
Networks can co-ordinate advocacy action on HIV/AIDS-related matters identified by members.
- **Skills and capacity building**
Networks can provide both formal and informal opportunities for enhancing the HIV/AIDS skills of members.
- **Building solidarity**
Networks can assure members that their HIV/AIDS work is important, particularly when the political and social environment is not hospitable.
- **Creating opportunities for co-operation**
Networks can generate and/or support HIV/AIDS programmes which are complementary, collaborative and which reinforce one another.
- **Monitoring network indicators**
Networks can assess progress being made and identify problems needing to be addressed.

One of the activities that HIV/AIDS networks often undertake is to set up a database of organisations offering HIV/AIDS-related services. The need for such a database is consistently identified when groups gather around a common concern and recognise that they do not know each other, or what their respective organisations do.

The following are simple steps that can be followed in creating a database.




1. Set up a task team with responsibility for overseeing the creation of the database. Appoint a suitably qualified person (or persons) to take responsibility for leading the process of developing the database.
2. Define the areas of information to be collected and the questions. There are many model questionnaires available that can be used or adapted for this purpose.
3. Decide in what form the database will be – hard copy or electronic.
4. Identify mechanisms to disseminate the database questionnaire and then distribute.
5. Advertise the database process, with details of how to get the questionnaire.
6. Collect and collate all the information. It is preferable to use a suitable computer package for this purpose.
7. Check the information provided. This is usually done telephonically.
8. Layout and print the final product (if hard copy) or develop the web page (if electronic). Include the means to submit additional entries or amendments.
9. Disseminate copies to all the organisations listed in the database, and to any other stakeholders who could use it.
10. Advertise the database, including details of how to access it.
11. Agree on a process to maintain and update the database and establish this process.



Score Card: HIV/AIDS network

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> HIV/AIDS Co-ordinator attends meetings of the local HIV/AIDS network Database of AIDS Service Organisations (ASOs) created 		
 Good Response	<ul style="list-style-type: none"> Company is a driving force in the local HIV/AIDS network – represented by the members of the HIV/AIDS Committee Secretariat for the network provided by the company 		
 Blue-chip Response	<ul style="list-style-type: none"> Company successful in securing representation on the network of all major sectors in the area Strategic planning for the network facilitated by the company 		

Costs

The costs of participation in a local HIV/AIDS network are not likely to be significant, outside of the time of those involved, and unless the organisation chooses to provide certain services to the network (such as copying and posting minutes), that have cost implications.





Case Study: An HIV/AIDS network - Namakwa Sands

Namakwa Sands is a division of the Anglo American plc Group, with an operation in the Western Cape Province in South Africa. The company participates in the West Coast Employee Organisation HIV/AIDS Forum. The terms of reference of the forum are as follows:

1. To perform a needs analysis within the identified communities in order to identify projects, programmes and activities which will assist with addressing and managing the HIV/AIDS threat facing the communities, with an emphasis on the following:
 - The promotion of awareness, training and education regarding HIV/AIDS within the ranks of organised labour, as well as in the community;
 - The identification of projects to enhance existing employer/employee initiatives to address HIV/AIDS in the workplace and community;
 - The implementation of organised labour policies regarding HIV/AIDS in the region; and
 - The mustering of support and commitment of members and their families, and recruitment of volunteers to be trained as counsellors and helpers to assist with the initiatives.
2. To provide assistance and advice to the other HIV/AIDS forums.
3. To prioritise the identified projects, programmes and activities and do cost estimates.
4. To develop a five-year strategic and business plan, in accordance with the priorities, for submission to the West Coast HIV/AIDS Initiative Board, for consideration and inclusion in the main strategic and business plans.
5. To receive funds allocated by the Board, to implement the strategic plan and initiatives.
6. To effectively manage all the approved/agreed initiatives and provide feedback on progress to the Board.



Additional Information

There are many references that provide information and guidelines on networks, generally within the NGO/CBO sector. Useful information can be extracted from these and applied to HIV/AIDS networks as well.

The International Council of AIDS Service Organisations; *HIV/AIDS networking guide* (1997) provides guidance on setting up HIV/AIDS specific networks.

Footnotes



¹ With acknowledgements to the International Council of AIDS Service Organisations; *HIV/AIDS networking guide* (1997)

Section Four

Community Entry Strategies for HIV/AIDS Interventions



Briefing Note

What HIV/AIDS-related tools and skills are required for entry into communities?

Many of the tools and skills that are used in development work can be usefully adapted for use in HIV/AIDS community projects. Two such tools have been selected – a risk mapping tool and a community consultation tool.

Why do we need the tools?

Whilst, on the face of it, the tools may seem over-simplified, they (and others like them) constitute necessary entry processes for successful community-level HIV/AIDS interventions.

1. The purpose of the **risk mapping tool** is to depict HIV/AIDS related facts (such as groups at risk, hot spots for HIV transmission and AIDS-related services) in a way that can guide planning, action and monitoring. We need the risk mapping tool to assist in targeting HIV/AIDS activities appropriately.

Although everyone is vulnerable to HIV infection, some groups are more vulnerable, due to a host of factors such as age, gender, socio-economic status and so on. And, whilst interventions for an entire community or for the general public are important, there is much evidence to support targeting interventions (which are tailored for specific groups). This is both more effective as well as more cost effective. Identifying where these groups are, and understanding the situations that place them at risk, can be helpful in defining appropriate interventions.

2. The purpose of the **community consultation tool** is to structure the consultation process. We need the community consultation tool to facilitate engagement with communities around HIV/AIDS and to ensure that it takes cognisance of important community dynamics.

Many people have trouble talking about sensitive issues like HIV/AIDS. Discussion about HIV/AIDS is even more difficult when talking in a public forum, with people from different backgrounds (social and educational). Nevertheless, involving communities in HIV/AIDS prevention, and care and support activities is essential to an effective response to the epidemic. In addition, public discussion on HIV/AIDS fosters private discussion among partners, parents and children, and extended families.





These sorts of exercises can inform:

- Policy and strategy development;
- Advocacy efforts;
- Stakeholder and community mobilisation; and
- Intervention targeting and design.

Contractors, particularly when moving into a new location, should utilise such tools and skills in their engagement with local communities.



Red Flags and Special Challenges

The best-intentioned initiatives to establish HIV/AIDS projects in communities run very real risks of failing if certain principles are not observed. These include that:

- Many communities are experiencing HIV/AIDS, donor and/or project fatigue and disappointment regarding unfulfilled expectations. It is important to recognise this, and to take care not to aggravate the situation further;
- There are community “gatekeepers” whose permission and support must be sought and secured for any project – whether internally or externally initiated;
- All communities are unique, and a “one size fits all” approach is unlikely to succeed;
- Any project must be grounded in the concerns and priorities that community members identify, which may mean that dedicated/vertical HIV/AIDS projects have to take on some of these issues in order to survive;
- Community time frames must be respected, which means going at the pace set by the community; and
- The lead person should be carefully selected – language, race, gender and age are important, as is experience working at community level.



Tool: Risk mapping

Instructions

Follow these steps when conducting a risk mapping exercise.

1. Establish a small multidisciplinary mapping team. Identify representatives from different areas (who can provide local knowledge and information).
2. Obtain the largest scale map of the area, depicting significant physical features, roads, suburbs/populated areas and services.
3. Call a consultative meeting of the team and the local area representatives.
4. Agree on the purpose and process of mapping.
5. Conduct an exercise to arrive at a common understanding of vulnerability and risk within the local context. Capture these characteristics – both those that represent high risk as well as those that represent low risk – in a template, such as the one below.
6. Using different colours or symbols, depict on the map the location of identifiable risk groups (e.g. students, migrant workers) and risk situations (e.g. truck stops).
7. Now discuss interventions to reduce risk, facilitate access to services and record the discussions in the template under the heading of “possible mitigation actions”.
8. Agree on the process to take this information into the planning process and the means to check that the mapping information has been used.

Template for mapping risk areas and activities					
Risk		Characteristic	Present	Absent	Possible mitigation actions
High	Low				
		Location			
X		On major trading/transport route			
X		Near a port			
	X	Geographically isolated			
X		Located in very poor area			
X		Near a border			
		Demography			
X		Refugees			
	X	Extended family structures			
		Type of work and employment			
X		Mobile workers			
X		Seasonal workers			
?	?	Source of migrant workers			
		Operations			
X		Result in family dislocation			
?	?	Challenge traditional authorities			
		Social conditions			
X		Poor housing/informal settlements			
X		Poor access to water			
	X	Family housing			
X		Single sex hostels			
X		Poor access to health services			
		Facilities			
	X	Sports grounds			
	X	Recreation facilities			
	X	Youth-friendly health services			



Tool: Community consultation guide

Instructions

Use the list below to facilitate your community consultations about HIV/AIDS¹.

Preparing for the consultation

- Talk to community stakeholders (chiefs, church leaders, etc.) in advance to let them know that you want to discuss HIV/AIDS at the next formal consultation. Get their support and encourage them to bring up HIV/AIDS themselves during the consultation.
- Identify community “champions.” These are people who will help you include HIV/AIDS in community consultations and support interventions.
- Identify specific language or words that people in the community use to talk about HIV/AIDS to avoid confusion and misunderstandings. Use words you are comfortable with.
- Talk with a local NGO or CBO who works in the community for suggestions on the best way to start discussion and to identify major problems and concerns about HIV/AIDS in the community.
- Practice talking about HIV/AIDS with your colleagues or fellow employees and others to increase your comfort in discussing HIV/AIDS. Get advice from HIV/AIDS counsellors who specialise in helping people talk about HIV/AIDS.
- Do your homework. Gather information about the community and be sure about what you will be talking about, including anticipating what kinds of questions may be asked.
- Take someone with you who is knowledgeable about HIV/AIDS.

During the consultation

- Ask for permission to talk about HIV/AIDS if no one has brought it up. “It is very important that we talk about AIDS. This is a crisis for our area. Does everyone agree?”
- Some people will not want to face dealing with HIV/AIDS and may exhibit various forms of denial (e.g. nothing can stop the epidemic). Acknowledge that talking openly about HIV/AIDS can be difficult and embarrassing. Even confess your own discomfort (if it exists) but remind community participants that there is no other way to fight the epidemic.
- Ask about HIV/AIDS activities already underway and what seems to be working. This will help people identify unmet needs and problems.
- Ask anyone currently working in HIV/AIDS prevention or care to volunteer information and suggestions.
- Tell people about HIV/AIDS projects that are operating in other parts of the country to give them ideas about other approaches and opportunities.
- Reassure participants that supporting HIV/AIDS interventions will not take money from other activities.
- People often say, “We cannot talk openly about sexual issues. It is not part of our culture.” The reality is that there are very few cultures that embrace open discussion about sexuality either between partners or especially among parents and children. However losing young adults to a disease like HIV/AIDS, in the prime of their lives, is also not part of any culture. HIV is a crisis. In times of crisis, cultures must adapt.
- Remember that HIV/AIDS is not a moral or cultural issue. It is a public health and development crisis. Making judgements will not help prevention, care and support.



After the consultation




- Review the discussion. Think about problems that blocked discussion and how you can be better prepared for the next consultation.
- Get some feedback. Ask a community participant for his or her opinion on the consultation. What could you do better the next time?
- Give some feedback.
- Document the issues raised and the opportunities identified carefully.
- Be sure to follow-up on any tasks that are allocated to you.



Score Card: Community-level skills and tools

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Official with community credibility appointed as lead person for the company’s external HIV/AIDS response 		
 Good Response	<ul style="list-style-type: none"> • Wide range of community-level techniques employed in engaging with local communities • External HIV/AIDS response focuses on risk areas identified during risk mapping exercise 		
 Blue-chip Response	<ul style="list-style-type: none"> • Community “gatekeepers” endorse the company’s external HIV/AIDS response • Community consultation takes place at planning, implementation and monitoring stages of the company’s external HIV/AIDS response 		



Costs

Time may be the most significant investment when gaining access to communities. Otherwise, there may be some small expenses associated with the processes themselves.



Case Study: Advocacy checklist and report - Bambisanani Project

The Bambisanani Project operates in the Eastern Cape Province, in South Africa, in the area previously known as the Transkei. The project provides a range of services to community members, including home-based care. Many of the clients are ex-miners who have been repatriated back to their rural homes with terminal illnesses, primarily HIV/AIDS.

The following checklist was developed for use in the community mobilisation phase of the project.

Instructions: Complete this checklist in preparation for the meeting.**Part A:****What is the purpose of the meeting?**

For example: To give information about the project in order to lobby for support for the project

Audience analysis

Who is the target audience (Church leaders, local government, health staff etc.)?

Who are the influential people?

Who are your allies?

Who are your opponents?

Advocacy design

What is the key message?

What information/data/research do you need to get across your key message?

How will you deliver the message?

Have you practiced your presentation?

Yes

No

What action do you want the audience to take?

Have you briefed your allies?

Yes

No

Getting ready

What resources are needed for the meeting?

- Handouts
- Presentation aids

What arrangements need to be checked?

- Invitations and responses
- Venue (electricity, lighting, seating)
- Catering (where, what, when)
- Speakers (who, what, when)



Instructions: Complete this report following the meeting.

Part B:

Submitted by:..... Date.....

Meeting details Date
Time
Place

What were the key responses? 1.
2.
3.

What was the main outcome of the meeting?

Who made contact at the meeting? Name:
Contact details:
1.
2.
3.

What follow-up action is required? *1.
By whom? *2.
*3.

How successful was the meeting?
What can be done to improve the next meeting?

Very Moderately Unsuccessful

Action *1: Taken Pending Not taken
Comments:

Action *2: Taken Pending Not taken
Comments:

Action *3: Taken Pending Not taken
Comments:



Additional Information

The International HIV/AIDS Alliance has multiple publications that have been developed to assist with HIV/AIDS work at community level. These are listed on their website, at www.aidsalliance.org.



Footnotes



¹ With acknowledgements to the Ministry of Local Government (Botswana)



Section Four

Community Outreach Projects



Briefing Note

What is the mining sector's role in terms of broader, community-based responses to HIV/AIDS?

The mining sector, as a significant sector in most Southern African countries, can assume many important roles within the broader community-based response to HIV/AIDS. These include:

- Leadership;
- Governance;
- Policy and strategy development;
- Support – financial, material, human or in-kind;
- Responding to requests for specific needs (e.g. by NGOs); and
- Building relationships and partnering with others to make a difference.

Why is it important for organisations in the mining sector to be involved in outreach or external responses to HIV/AIDS?

Companies in the mining sector can act as catalysts for local economic development, which is often associated with addressing the factors that fuel the HIV/AIDS epidemic. There are HIV/AIDS-related opportunities associated with each stage of a mining project's life cycle. These opportunities range from employment, human resources, small businesses and infrastructure development to service delivery, the generation of revenue and post-closure local economic development.

Involvement in external outreach activities can be justified in many ways:

- It is a way to safeguard direct commercial interests, by protecting employees and their families;
- It can contribute to the protection of other stakeholders, by educating customers, contractors and suppliers;
- It is an opportunity to influence community-based programmes to deal with the HIV/AIDS epidemic in an holistic manner;
- It can represent a platform for proactively securing future skills pools and markets;

- It is an opportunity to strengthen and scale up small initiatives, to benefit more individuals, families and communities, some of whom may be employees and their families;
- It is an opportunity to reduce duplication, improve efficiency and leverage resources;
- It is an investment in the future and can create a positive image of the company; and
- Companies have a responsibility to society.

Contractors, like bigger companies, can benefit community projects by sharing their expertise and resources with these projects. At the same time, involvement in these projects can support and strengthen the contractor's HIV/AIDS response. For example, supporting a home-based care project can ensure that employees (and their families) have access to quality community-based care when or if this is required.

Global Business Coalition on HIV/AIDS - harnessing business expertise¹

The Global Business Coalition on HIV/AIDS identified the following corporate expertise that can benefit broader external HIV/AIDS interventions.

Corporate expertise	Benefit to HIV/AIDS response
Communications and marketing	Behaviour change programmes, particularly those targeting specific groups, like young people
Logistics expertise and distribution capacity	Ensuring materials, condoms and treatments are distributed promptly, and securely, on a sustainable basis, particularly to hard-to-reach areas, such as rural communities
Strategic and long-term planning	Identifying medium to long-term priorities in setting macro HIV/AIDS strategic plans
Business administration	More effective, less bureaucratic management of HIV/AIDS services
Rapid monitoring and evaluation	Ensuring programmes can respond quickly to changing environments and situations, and failing approaches can be adapted swiftly
Employee training and development	Maintaining performance of both paid staff and volunteers
Application and use of information technology	Improved networking and access to important HIV/AIDS-related information



What are the elements of successful outreach projects?

Successful outreach projects require the consideration of a multitude of issues, amongst which are the following:

1. Understand the context – the geography, the population profile, the leadership dynamics and the prevailing socio-economic conditions. Local people will have lots of information, but not always all the information required.
2. Look at and learn from existing models, but be prepared to change the model to fit the circumstances.
3. The project may be introducing a new idea – such as home-based care. Take time to explain this and to lobby support from Chiefs and other community leaders, health and social services, local government, and other significant role players and potential partners.
4. Always budget for some base-line research, to fill any gaps in the information that is available. But, never assume the right to research a community and be sure to feed back the results.
5. Decide in consultation on the goal or aim of the project, the guiding principles and focus, the beneficiaries, the expected outcomes, and the indicators. Review all the above from time to time.
6. Identify the means to collect data to monitor progress and measure impact, and institutionalise these processes. Be sure to build in ways to “hear the voices” of service providers and clients, and to respond.
7. And finally, be prepared to move at the pace set by the community, to do otherwise could spell early failure. Communities are concerned about HIV/AIDS, but they have multiple other priorities and needs as well, and they have their own, well-developed processes for doing things.
8. Recognise that sustainability will always be an issue that will require time and effort.



Red Flags and Special Challenges

The following questions should be asked to check the relevance of outreach activities:

- Does the project build on community consultation, ideas and existing action?
- Does the project strengthen the coping capacity of individual's families and communities?
- Does the project include an economic intervention to help affected families?
- Is there an active approach to destigmatising HIV/AIDS?
- Does the project contribute to information exchange and build partnerships with others in the sector, with NGOs and with government?
- Does the project contribute to local development priorities and plans?

Example of the parameters of a home-based care project

For patients/clients:	<ul style="list-style-type: none"> • Reduced suffering and improved quality of life • Appropriate treatment, care and support • Enhanced end-of-life care
For families:	<ul style="list-style-type: none"> • Improved capacity to cope and to care • Practical support • Bereavement support
For care givers:	<ul style="list-style-type: none"> • The capacity, resources and support to deliver quality care • Access to colleagues and community networks of support
For communities:	<ul style="list-style-type: none"> • Improved capacity to cope • An enhanced environment for care and reduced stigma • Skills development and job creation
For women:	<ul style="list-style-type: none"> • Skills development • Networking and support
For children/youth:	<ul style="list-style-type: none"> • Early identification of children in need • Enhanced HIV prevention • Access to holistic care and support • Access to income generating activities (IGAs)
For PLWHAs:	<ul style="list-style-type: none"> • Skills development • Access to networks of support
For health services:	<ul style="list-style-type: none"> • Reduced pressure on services • Effective referrals between different levels and different service providers • Cost savings
For welfare services:	<ul style="list-style-type: none"> • Improved utilisation of social services • Better access to grants • Enhanced ability to place orphaned children in alternative care
For the country:	<ul style="list-style-type: none"> • Lessons learned • Replicable models

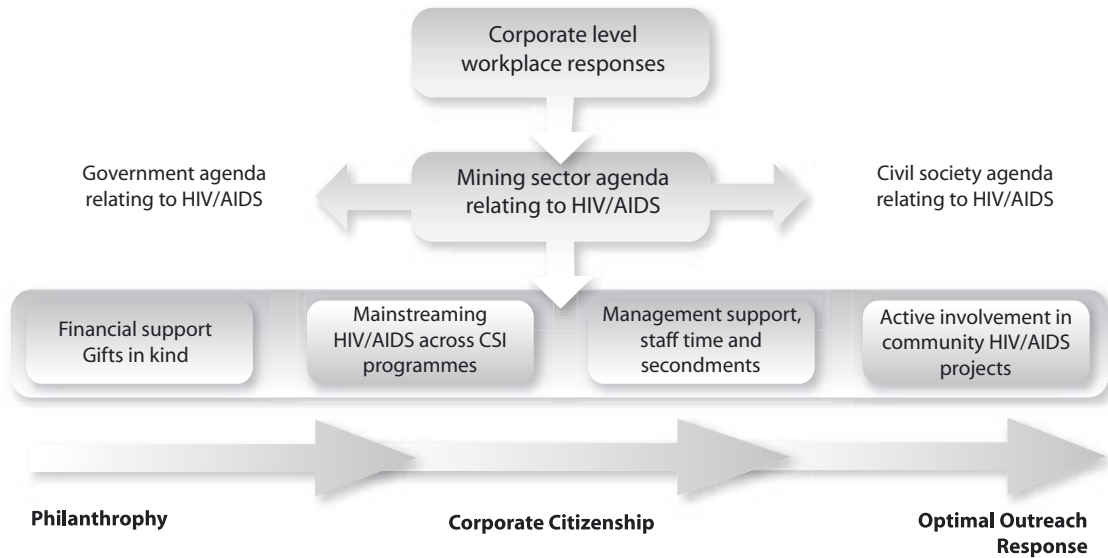


Tool: Model for moving to meaningful involvement in outreach activities

Instructions

Identify where your organisation fits in the following model and the areas where its involvement can be strengthened towards an optimal outreach response.

Model for moving towards an optimal outreach response



Score Card: Community outreach

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> Peer educators attend community HIV/AIDS events HIV/AIDS stand at company open day, to which employees’ families are invited 		
 Good Response	<ul style="list-style-type: none"> Company pays a local NGO a nominal amount per incapacitated employee who receives home-based care services Company takes HIV/AIDS outreach activities, e.g. drama to communities 		
 Blue-chip Response	<ul style="list-style-type: none"> Company initiates, co-funds and actively participates in a comprehensive HIV/AIDS prevention project in the community 		

Costs

Costs could be financial, material, human resource or in-kind, or a combination of these; and, whilst the benefits to the company may be difficult to quantify, efforts to do so should be made.



Case Study: The Powerbelt initiative - Anglo Coal, Ingwe Coal and Duiker Mining and others

In the Mpumalanga Province of South Africa, Anglo Coal, Ingwe Coal and Duiker Mining, as the major coal mining companies, joined together with Harmony Gold Mine and Ferrometals, Sasol, local government and the unions represented by COSATU, to address the HIV/AIDS epidemic in the area. The Council for Scientific and Industrial Research (CSIR) manages the project, with each mining company committed to ZAR 150 000 (approximately \$ 20 270) per annum seed capital.

The Powerbel model has the following components:

- The introduction of a comprehensive primary health care programme for treating STIs, ensuring that everyone in the area has equal access to treatment, and reducing the time between infection and treatment;
- Home-based care programmes for PLWHAs who are ill, and for those who are dying;
- Condom distribution programmes through formal channels, as well as through peer educators and commercial sex workers;
- Behaviour change education targeted at high risk groups in the community; and
- Socio-economic upliftment projects aimed at improving the basic living standards of local communities.



Case Study: Reaching out to rape survivors, how Kumba Resources extended its efforts to prevent HIV/AIDS in surrounding communities

A chink in the doorway

In July 2002 Kumba Resources had an effective workplace HIV/AIDS programme in place. But a single phone call from the local police station, revealed a chink in the South African iron ore company's many workplace and community interventions – and opened a door on how Kumba could further help prevent the spread of HIV/AIDS.

Rape was a crime regularly reported to the South African Police Services (SAPS) in Kathu, in the Northern Cape. These offices provide the only police service to the 6 000 residents of the town and the surrounding rural areas. Typically, once a statement had been taken and the legal process was underway, traumatised rape survivors were on their own.



The Industrial Welfare Assistant at Kumba Human Resources and a hands-on member of the HIV/AIDS management team, decided to investigate. “I went to the police station, and realised straight away that there was no help for rape survivors. Sometimes, because the police took clothes as evidence from the children, the kids even walked out of there naked,” she says.

Figuring out what steps to take

With phone calls, faxes, e-mails, letters and hand-delivered invitations everyone was called to a meeting to discuss the issue – HIV/AIDS peer educators, Kumba contractors, community workers, cultural organisations, the ANC Women’s League, unions and SAPS itself.

During the meeting, at Tshipi, Kumba’s training centre in Kathu, it was realised by everyone that rape puts survivors – be they women, men, or children – at risk of infection with HIV, and so cannot be separated from the issues and existing work around the epidemic.

The community needed to become more sympathetic and understanding towards rape survivors. Somehow everyone needed to take responsibility and become involved and supportive. The place to start, it was decided, was to hold marches to raise awareness in Kathu, and its surrounding towns of Deben, Dingleton and Sesheng.



The problem and responses were presented to the Management Team at Kumba. They agreed to back a second intervention: sponsoring a trauma therapist to train local volunteers in HIV/AIDS and rape, so that they could then act as a network of support for rape survivors.

Organising the new effort

The marches were first to be organised, with permission from both the mine and the local municipalities.

Then they ensured transport was available for all participants, as well as stocks of posters and pamphlets to distribute. On the day the community representatives were joined by school children, horse riders, the SAPS dog unit, anyone with a sports car and a local body builder, who stood on a pick-up truck carrying the slogan “Strong men are gentle”. The marches ended with speeches, denouncing abuse against women and children and explaining how rape spreads HIV/AIDS.

To set up the network of support a group of 15 youths, men and women were hand-picked from the many willing individuals already active in the Kathu community. The group underwent a two-day training course on supporting rape survivors, with Kumba covering the costs of the training, transport, venue and refreshments.

Kumba also integrated information about rape and HIV into its workplace programme, so that peer educators are well aware of the dangers of transmission, ways to prevent it, and the contact details of the network of support.

How the network operates

Ten rape survivors were assisted during 2002 and the Reaching out to Rape Survivors project is now well established in Kathu. Today, when a rape survivor from the Kathu municipal region reports to the Kathu SAPS she or he will be:

- Provided with a package of clothing, donated by the community, especially churches;



- Able to recover in a private room with a bathroom at the station, painted and renovated by Kumba;
- Encouraged to choose a trained volunteer counsellor from the list of 15 kept at the station;
- Allowed to rest while police phone the project co-ordinator, to call in the volunteer;
- Supported by the volunteer during the medico-legal examination;
- Helped by the volunteer to access antiretroviral treatment from the local hospital or clinic, if the rape is reported within 72 hours;
- Informed of his or her legal rights by the volunteer, and also motivated to continue with the court case;
- Supported during the legal process; and
- Referred to the trauma therapist for additional counselling if necessary.

This range of support services is also available to anyone who accesses the volunteer network directly through a Kumba peer educator rather than through the police.

Volunteers are themselves supported by quarterly meetings with the project co-ordinator and trauma therapist, as well as receiving annual refresher training and visits from outside trauma experts. The project co-ordinator and police consult monthly, to keep statistics and ensure that all elements are working smoothly.

Kumba continues to assist in numerous ways, by providing venues, transport and hearty refreshments for meetings and training, granting volunteer supporters time off to support survivors during court cases, and enabling the co-ordinator to attend further training on rape support.

How the word and the good work fanned out

Within months of Reaching out to Rape Survivors starting in Kathu, the Moffat Mission in Kuruman, 50kms away, asked for help in setting up a similar network to assist the many rape survivors the church encountered in local rural areas.

There are now at least sixty volunteer rape supporters in Kuruman, supported by monthly visits from the Kathu trauma therapist, and some 20 rape survivors have been helped over the past two years.

The Kuruman project has also proved a bridgehead for introducing the issue of HIV/AIDS prevention to the local community.

Rape red flags and special challenges

The Reaching out to Rape Survivors project has raised particular issues for workplace HIV/AIDS programmes, namely the need to:

- Include rape and HIV/AIDS as an issue in workplace programmes, to support survivors, to raise awareness of the danger of contracting HIV through rape, and – as in the case of Kuruman – as another channel through which to introduce information around general prevention to local communities; and
- Tackle substance abuse, which, in the Kumba experience, often decreases inhibitions and social controls and encourages actions like casual sex and rape, thus increasing the spread of HIV.

“We realised during the initial training that abuse was a common experience in Kuruman, but, because this community is not reached by the Kathu peer educators, people were not aware of HIV/AIDS or why they needed to take the medicines. By talking about rape, we could also start raising the broader subject of preventing HIV generally.”



Case Study: Home-based care for ex-mineworkers - TEBA and others

In April 2002, a groundbreaking initiative to provide home based care for mineworkers who are repatriated with chronic or terminal medical conditions was launched. Using the services of long-term partner, TEBA, and working with local structures and NGOs, this has become an important part of the mining industry’s response to the HIV/AIDS epidemic.

The Home-based Care Programme, as it has been named, was conceived to address a number of stark realities facing the industry.

The **first** reality is that many mineworkers have already died as a result of AIDS and many more have advanced HIV disease. Whether the prevalence is 20% or 40% – and both figures have been released by different mining companies at different times – is less important than the challenge that this presents to an industry that relies on the fitness and strength of its workforce.

The **second** reality is that the majority of mineworkers have their homes in rural areas – Lesotho, Swaziland, Mozambique, northern KwaZulu-Natal and the Eastern Cape. These are the areas to which they return when they are no longer able to work (due to ill health) and these areas are amongst the poorest and least resourced in the sub-continent.

And the **third** reality is that home-based care is an acceptable and, indeed a preferred option for people with terminal conditions.

Until the launch of this initiative, wellness programmes for infected mineworkers included the prevention and treatment of opportunistic infections but lacked the next step, namely rehabilitation at medical incapacity and separation. With more and more employees retired due to ill health, and returning to their rural homes, usually in areas with no NGO home-based care services, and often with not even the most basic resources from local hospitals and clinics. The burden on families was immense – and when the ex-mineworker died, the finalisation of benefits often presented yet a further obstacle for the bereaved family.

There were only two options for the mines, either to keep terminal mineworkers in mine hospitals – to eventually die there without their families, or to create a system that would encourage them to retire before the onset of terminal illness, to return home when they could still enjoy some quality of life and, when they do become terminal, to receive good quality care in their homes.

The choice was clear – from every perspective – moral, financial and pragmatic. Discussions begun in earnest; and a model was agreed that was based on a community-based project in the Eastern Cape called Bambisanani.

The Home-based Care Programme is implemented by TEBA Development, the mining industry’s development organisation. TEBA has offices in all the rural areas of Southern Africa. In phase one of the programme, TEBA appointed fieldworkers at each of its rural offices. These 40 fieldworkers are the frontline workers of a family support programme that includes home-based care, counselling and welfare support.





The fieldworkers establish exactly where all existing families of ill ex-mineworkers are, in the process creating a valuable database. Then, as new mineworkers are repatriated, the fieldworker visits the family, conducts an assessment and links the family with the Home-based Care Programme.

Building on TEBA's experience in rural areas, firm links have been established with communities, government and other service organisations to ensure appropriate referrals, when necessary, and access to services. In time it is hoped to spread the service beyond mineworker families, forming partnerships with other service providers to provide care to all in need in the community.

Mining companies receive regular reports on the progress of ill ex-mineworkers through quarterly reports. Ex-mineworkers and their families are assisted to access grants and other support that is available through public channels.

The cost of the programme is borne by the mining industry, through a per capita charge levied on employed miners from the areas where the programme operates.

The programme will be a learning experience for TEBA and for the mining industry. It is expected that many valuable lessons will emerge from the programme, not least how to form partnerships between business, communities and the government.

South Deep example

One of the HBC partner companies, South Deep, in 2003 began providing income generation support to the families of mine workers repatriated with HIV/AIDS. Linked to skills and entrepreneurial training, former mineworkers or their proxies have the opportunity to take a basic business course called Financial Life Skills. Following this training, participants can either choose a small business or a reskilling option to further develop their skills.

One hundred and ten families were assisted in 2003. At the same time Placer Dome South Africa (PDSA) initiated collaboration with TEBA and the rest of the mining industry aimed at having these services available to all mineworkers and their families.

Initiatives such as this could be extended in the form of apprenticeships for orphaned children from HIV/AIDS affected families.



Additional Information

Many examples of mining sector community outreach projects can be found in the MMSD report, available on www.iied.org/mmsd/rrep/s_afr.html.

For more information on the South Deep income generation initiative go to www.placerdome.com/sustainability/social/careproject.html

Footnotes



¹ From Plumley B, Bery P and Dadd C; *Beyond the workplace: business participation in the multisectoral response to HIV/AIDS*



Section Five

Measuring and Monitoring an HIV/AIDS Response

Section Five contains the final component of an organisational HIV/AIDS response, namely monitoring and evaluating, as well as recording and reporting on the response.

Our opportunity is historic. For when the history of AIDS and the global response is written, our most precious contribution may well be that at a time of plague we did not flee, we did not hide, we did not separate ourselves.

Jonathan Mann

Section Five

Monitoring, Evaluating, Recording and Reporting an Organisation's HIV/AIDS Response



Briefing Note

What is implied by monitoring, evaluating, and recording and reporting on an organisation's HIV/AIDS response?

Monitoring is the routine, daily assessment of on-going activities and progress.

Evaluation is the episodic assessment of overall achievements (which may be conducted internally or externally).

Monitoring looks at what is being done, whereas **evaluation** examines what has been achieved or what impact has been made.

An effective monitoring and evaluation strategy is nothing more or less than an open and critically reflective communication process that will serve to improve practice and strengthen partnerships.

Recording and reporting is the formal documentation of processes and events, and the release of information, which may be a statutory requirement, a requirement in order to meet certain set specifications, or an internal requirement (for shareholders or management).

Monitoring, evaluation, and recording and reporting are functions that all organisations are familiar with, and, as far as is practical, HIV/AIDS-related M&E, and recording and reporting should be integrated into these functions. This applies equally to large organisations and **contractors**, though the ways in which this will be done may vary.



Why should an organisation monitor, evaluate, and record and report on its HIV/AIDS response?

It is important to **monitor and evaluate** a project or programme in order to:

- See what has been achieved;
- Collect evidence of activities and results;
- Measure progress and programme effectiveness in reaching predefined objectives and targets;
- Improve monitoring and management;
- Identify strengths and weaknesses;
- Judge whether the cost was reasonable for what was achieved;
- Collect information to help run activities better; and
- Avoid repeating mistakes by sharing experiences.

It is important to **record and report** on a project or programme in order to:

- Document successes and failures;
- Develop a body of knowledge and of good practices; and
- Meet internal and external reporting requirements.

What are the components of an M&E strategy?

The following are important components of any M&E strategy:

1. Defining responsibilities

The responsibilities for M&E include:

- Planning and developing systems for M&E;
- Collecting and generating data from different sources;
- Verifying data;
- Analysing and interpreting data; and
- Reporting and dissemination.

2. Identifying indicators

Indicators are the cornerstone of M&E. An indicator is a measure of the progress made towards an objective. It can be quantitative or qualitative. It can be a process, outcome or impact indicator. It can also be a project target.

Indicators should be:

- Simple, clear and understandable as a measure of project effectiveness;
- Reliable – conclusions based on any indicator should be the same, regardless of who, when and under what circumstances the assessment is conducted;
- Replicable, allowing for comparative analysis and potential replication of the project; and
- Available – using data that is available.

In workplace HIV/AIDS programmes, consistent indicators are desirable to enable comparisons to be made and in order that trends can be identified.

So-called “core” indicators are those that are globally defined, such as:

- The percentage of respondents who report at least one non-regular sex partner in the last 12 months; and
- The percentage who say that they used a condom the last time they had sex with a non-regular partner.



If used across countries and across sectors, these allow for comparisons to be made. However, if core indicators are combined with local indicators, it is more possible to get a complete picture. The following table describes different types of indicators, and the different stages in a project's life that they can be used.

Types of indicators

Project stage	Indicator type	Sexual and reproductive health examples
Pre-intervention Participatory exploratory research Existing data review	Base-line	<ul style="list-style-type: none"> Existing attitudes and self-reported behaviours Existing service utilisation data STI/HIV prevalence
Training, participation Information distribution Service provision	Process	<ul style="list-style-type: none"> # of people trained # of materials distributed # of condoms distributed
Short-term, post activity	Intermediate	<ul style="list-style-type: none"> Changes in knowledge and attitudes Changes in social/peer norms
Medium-term, post activity	Outcome	<ul style="list-style-type: none"> Self-reported adoption of positive behaviours Increased service utilisation
Long-term, sustained	Long-term outcomes and impacts	<ul style="list-style-type: none"> Maintenance of positive self-reported behaviours Reduced HIV/STI incidence Changes to social/peer norms

The **NOSA HIV/AIDS management system**¹ lists multiple indicators related to:

- Commitment and HIV/AIDS management policy;
- Planning of HIV/AIDS management system;
- Implementation, operational controls and management of HIV/AIDS management system;
- HIV/AIDS management system evaluation, corrective and preventive action; and
- HIV/AIDS management review.

3. Developing an M&E framework

A commonly used M&E framework consists of a pathway of results, beginning with inputs, and progressing to outputs, outcomes and impacts.



M&E framework

Inputs	Outputs (quality, access, coverage, costs)	Outcomes (short and intermediate effects)	Impacts (long-term, major, measurable effects)
<ul style="list-style-type: none"> • Resources • Staff • Funds • Facilities • Equipment • Supplies • Training 	<ul style="list-style-type: none"> • Condom availability • Trained staff • Quality of services • Knowledge of HIV transmission 	<ul style="list-style-type: none"> • Behaviour change • Attitude change • Change in STI trends • Increase in social support 	<ul style="list-style-type: none"> • HIV trends • AIDS-related mortality • Social norms • Coping capacity in communities • Economic impact

Many companies use tailor-made roadmaps as a means to monitor and report on their HIV/AIDS responses.

4. Using and disseminating data

Once data has been collected, analysed and interpreted, it should be properly disseminated and used. The results of M&E activities should be communicated to all relevant stakeholders. Results should also be shared with those who collect the data, so that they may provide feedback on the results.

Dissemination can be done in many ways, such as through annual reports, at annual planning and evaluation meetings and in scientific publications.

What are the important features of recording and reporting?

In South Africa, the 2002 **King Report** on corporate governance for South Africa sought to ensure that the standards of governance in South Africa were current and competitive with international norms and best practice. In relation to HIV/AIDS, King 2, as it is known, the recommendation on HIV/AIDS is that the board of directors of an organisation should:

- Ensure that it understands the social and economic impact of HIV/AIDS on business activities;
- Adopt an appropriate strategy, plans and policies to address and manage the potential impact of the pandemic on business activities;
- Regularly monitor and measure performance using established indicators; and
- Report on all of these aspects to stakeholders on a regular basis.

The **Johannesburg Securities Exchange** (JSE) of South Africa is also promoting a more formalised approach towards reporting on HIV/AIDS. The JSE announced in 2002 that it was investigating the introduction of a listing requirement for all companies on the exchange to report on HIV/AIDS.

The **Global Reporting Initiative** (GRI) is a multi-stakeholder process and independent institution whose mission is to develop and disseminate globally applicable sustainability reporting guidelines. The guidelines are for voluntary use by organisations for reporting on the economic, environmental, and social dimensions of their activities, products, and services.

The GRI has recently developed guidelines for voluntary disclosure of HIV prevalence within, and impact on, companies². The GRI proposes using a comprehensive set of indicators for reporting on an organisational HIV/AIDS response, in the following categories:

- Good governance: policy formulation, strategic planning, effective risk management, stakeholder involvement;
- Measurement, monitoring and evaluation: prevalence and incidence of HIV/AIDS, actual and estimated costs and losses;
- Workplace conditions and HIV/AIDS management; and
- Depth/quality/sustainability of HIV/AIDS programmes.

There are indicators that can be used by companies with well-established HIV/AIDS programmes and for those companies (small or low-capacity organisations) reporting for the first time.

Basic-level GRI indicators for small or low capacity organisations

Indicator	Response
1. Does the organisation have an HIV/AIDS policy? (please attach copy)	Yes/No
2. Is there a strategic plan to manage the current and future impact of HIV/AIDS on the organisation?	Yes/No
3. Has the organisation involved stakeholders in the planning and implementation of the response to HIV/AIDS?	Yes/No
4. Has the organisation arrived at an HIV/AIDS prevalence rate for the workforce?	Yes/No
5. What is the organisation's estimated HIV/AIDS costs/losses for the current year in terms of:	
5.1 The cost of programmes in questions 6-9 below?	R.....
5.2 Other costs/losses arising from HIV/AIDS?	R.....
6. Does the organisation have HIV/AIDS awareness/education/training programmes for its workforce?	Yes/No
7. Does the organisation have a VCT programme for its workforce?	Yes/No
8. Does the organisation have HIV/AIDS prevention interventions such as behaviour change interventions, STI treatment assistance, and a distribution programme for:	
8.1 Behaviour change programme	Yes/No
8.2 STI treatment assistance	Yes/No
8.3 Condoms	Yes/No
8.4 Femidoms	Yes/No
9. Does the organisation have programmes to assist workforce members who are AIDS sick?	Yes/No
10. Does the organisation provide antiretrovirals to HIV positive employees, or those who are AIDS sick?	Yes/No



GRI's reporting principles (contained in Part B of their Guidelines) are an essential platform for all GRI reporting, including that on HIV/AIDS.

The principles, in brief, are as follows:

- **Completeness.** All information that is relevant to users for assessing the organisation's performance should be as complete as possible.
- **Inclusivity.** The reporting organisation should systematically engage its stakeholders to help focus and continually enhance the quality of reports.
- **Consistency.** The organisation should maintain consistency in the boundary, scope and content of reporting.
- **Accuracy.** A high degree of exactness and a low margin of error in reported information will enable users to make decisions with a high degree of confidence.
- **Clarity.** The reporting organisation should make information available in a way that is responsive to the maximum number of users while still maintaining a suitable level of detail.
- **Neutrality.** Reports should avoid bias in the selection and presentation of information, and should strive to provide a balanced account of the organisation's performance.
- **Timeliness.** Reports should provide information on a regular basis which meets user needs.
- **Auditability.** The reported data should be provided in a way that will enable internal auditors or external assurance providers to attest to its reliability.
- **Transparency.** Full disclosure of the processes, procedures and assumptions in the report preparation are essential for its credibility.
- **Sustainability context.** The reporting organisation should strive to place its performance in a broader context, where such context will add significant meaning to the reported information.



Red Flags and Special Challenges

Most programmes/projects collect far more data than they can use. M&E systems must be as simple as possible. The more complex an M&E system, the more likely it is to fail.

M&E must be built into the design of a programme.

The process of establishing and implementing M&E systems can itself improve programme performance and enhance sustainability. Combining financial and programme monitoring provides a basis for sound finance/programme cross-verification.

No matter how sound an M&E system may be, it will fail without widespread stakeholder "buy-in".

Effective training and support for those collecting M&E data is vital for the success of M&E systems.



Tool: Template for an M&E plan

Instructions

Use the following template as a basis for your M&E plan³.

Template for an M&E plan

Indicator	Agreed target	Progress towards target	Rating of progress
Impact level			
•			
•			
Outcome level			
•			
•			
Output level			
•			
•			
Input level			
•			
•			



Tool: Template for recording and reporting

Instructions

The NOSA HIV/AIDS Management System (AMS) provides a template for reporting on an organisational HIV/AIDS response. This can be adapted and used to reflect your organisation's HIV/AIDS priorities.

Template for reporting on HIV/AIDS

Number of ribbons	Effectiveness criteria				
	Behavioural change	Community outreach programme	Employee and family assistance programme	Post-exposure prophylaxis treatment	Screening and testing programme
5 Ribbons (Excellent)	100% in place	100% in place	100% in place	100% in place	100% in place
4 Ribbons	75% in place	75% in place	75% in place	75% in place	75% in place
3 Ribbons	50% in place	50% in place	50% in place	50% in place	50% in place
2 Ribbons	25% in place	25% in place	25% in place	25% in place	25% in place
1 Ribbon	Informal	Informal	Informal	Informal	Informal



NOSA certification is based on a scoring system in which points are allocated for:




- Risk assessment (10%);
- Systems (20%);
- Compliance (30%); and
- Effectiveness (40%).



Score card for M&E, and recording and reporting

Instructions

Review the actions in the score card, which are indicative of a **minimal** (1 red ribbon), **good** (3 red ribbons) and **“blue-chip”** (5 red ribbons) response. Assess your organisation’s level of competence and allocate it a red ribbon rating for this intervention. Then decide on future actions to improve your organisation’s rating.

Score Card	Description	Rating	Future Actions
 Minimal Response	<ul style="list-style-type: none"> • Company monitors the workplace HIV/AIDS programme • Company reports on its HIV/AIDS programme in the health section of its annual report 		
 Good Response	<ul style="list-style-type: none"> • Company monitors all aspects of its HIV/AIDS response • Company integrates HIV/AIDS reporting into all internal and external reporting requirements 		
 Blue-chip Response	<ul style="list-style-type: none"> • External evaluation of company’s HIV/AIDS response commissioned • Results shared at a broad stakeholder consultation • Company policy supports full disclosure of all HIV/AIDS-related data and impact 		

Costs

The cost of **M&E** relate to designing and then operating the M&E system. Different sources quote allocations for M&E from 2-3% to 5-6% of a total programme or project budget.

The AIDS Impact Model for Business, developed by the Futures Group⁴, can be used to conduct cost-benefit analyses.

Economic evaluations of HIV/AIDS interventions can provide important information. Horizons provides the following framework for understanding different forms of economic evaluation.

Different forms of economic evaluation

Type of analysis	Considers ...	Useful for ...
Cost analysis	Inputs only	Budgeting or planning for continuation or scaling up of a programme or services
Cost estimation – per service, or person served	Inputs and outputs	Assessing costs of providing outputs such as services, or for comparing revenues to costs
Cost effectiveness	Inputs, outputs and outcomes	Setting budget or resource allocation priorities, when options are available

Recording and reporting costs will include:

- The costs of documenting the HIV/AIDS response;
- Layout, printing and dissemination costs; and
- The costs of feedback processes (whatever form these may take).





The **Construction Industry Development Board** has developed the following specification for reporting on HIV/AIDS-related activities⁵:

- The contractor shall prepare and attach to his claims for payment a brief report which outlines how the actions taken by the contractor in the period for which payment is claimed satisfy the requirements and a schedule which lists the names, identity numbers, trade/occupation and name of employer of all construction workers exposed to the programme (see annex C).
- The employer’s representative shall certify the report and schedule described in 5.3.1 whenever a claim for payment is issued to the employer.

Note: In the event that the contractor fails to satisfy the requirements of this specification, the employer may apply any of the sanctions provided for in the contract. Sanctions may include the rejection of claims for payment as being incomplete or the withholding of completion certificates (interim or final).

Annex: C

Compliance report

Contract number:

Payment claim number:

Period covered by payment claim:

- Distribution of condoms (briefly describe where and how condoms are distributed)
- Posters / pamphlets (briefly describe where posters were placed/how pamphlets were distributed)
- Voluntary HIV/STI testing (briefly describe the actions taken/information provided to promote testing)
- Counselling, support and care (summarise information provided)
- HIV awareness programme (briefly describe action)
- Schedule of construction workers exposed to the HIV awareness programme

Name:

Identity number:

Trade/occupation:

Name of employer:

I hereby declare the above to be a true reflection of actions taken to ensure compliance with the specification

For the contractor:

Employer’s representative:

Name:

Name:

Signature:

Signature:

Date:

Date:



Case Study: Recording and reporting on an organisational HIV/AIDS response - Assmang

Assmang Ltd has a number of mining operations (iron ore and manganese) in the Northern Cape Province in South Africa. They have 450 employees and more than 450 contractors at their Beeshoek mine and 1 200 employees and around 400 contractors at their Black Rock mine.

Since 1999, they have kept records of all HIV/AIDS-related activities. The following is an extract from the AIDS Sequence Report for Beeshoek, which is presented regularly to management.

May 2003	E pap (which is fortified porridge) to all night shift workers, and installation of sleeping facility to night shift workers, as part of the wellness programme
12 June 2003	Installation of anonymous AIDS help line – 053 311 6446 at Assmang, for Assmang and communities
July 2003	Beeshoek domestic workers and gardeners workshops
From mid-July 2003	Weekly AIDS awareness workshops for: <ul style="list-style-type: none">• Cerecast company• Booysen Bore• Leave returnees, as part of induction
9 July 2003	Postmasburg feeding project to community AIDS patients Meeting with the Steering Committee
23 & 24 July 2003	EAP/Wellness course by Careways (Johannesburg)
8 August 2003	AIDS audit feedback from Head Office, at Black Rock Mine Northern Section of Assmang placed second in AVMIN Group Consultation with auditors and HO presidents
9 August 2003	AIDS audit feedback from Head Office, at Beeshoek Mine Beeshoek placed first in a group of 12 mines on AIDS interventions at the mine and in the community Company and community stakeholders attended the feedback Meeting also held with AIDS Committee, peer educators and unions Presentation done to stakeholders and directors, from the AVMIN Mine Group
12 August 2003	Rape and AIDS counselling meeting held at trauma centre (SAPD, Postmasburg) SAPD commitment emphasised



12 August 2003	AIDS feedback session held at AVMIN HO (Johannesburg) Gap analysis done on all HIV/AIDS interventions Brainstorming done with different mines
Morning session	Presentation to delegates on healthy living
Afternoon session	Workshop on compiling new score card for AIDS audit for AVMIN Mines
14 August 2003	Planning strategy to address gaps in the 2003 AIDS audit
25 August 2003	Finalised the HIV/AIDS campaign programme in Kuruman, for 1-5 September 2003
26 August 2003	Visit to person who has revealed his HIV status at home, but not publicly
10 September 2003	Training needs analysis questionnaire to all HIV/AIDS peer educators (mine and contractors)



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Additional Information

HIV/AIDS-related M&E information and guidelines are available from a number of sources:

- UNAIDS, at www.unaids.org;
- WHO, at www.who.int;
- MEASURE, at www.cpc.unc.edu/measure;
- FHI, at www.fhi.org;
- CDC, at www.cdc.gov; and
- USAID, at www.usaid.gov.

Family Health International (FHI); *Evaluating programs for HIV/AIDS prevention and care in developing countries: a handbook for program managers and decision makers* (2002), available on www.fhi.org/en/aids/impact/impactpdfs/evaluationhandbook.pdf

UNAIDS/MEASURE; *National AIDS Programmes: a guide to monitoring and evaluation* (2000), available on www.cpc.unc.edu/measure/guide/guide.html

The GRI *HIV/AIDS Resource Document* offers a practical reporting framework for:

- Organisations that want to report on their performance – including policies and practices – with respect to HIV/AIDS; and
- Stakeholders that require a reputable reporting benchmark to measure or compare organisations' HIV/AIDS performance.

The *HIV/AIDS Resource Document* can be found on www.globalreporting.org/guidelines/HIV/hivaids.asp. Although this document was developed in South Africa, GRI believes its content will be useful in any country affected by HIV/AIDS. Phase II of the project will see pilot testing of this resource in India, China and Brazil.

Footnotes



¹ Available on www.nosa.co.za

² As an expansion of the Core Social Performance Indicator (Labour practices and decent work), number LA8 (Description of policies or programmes for the workplace and beyond on HIV/AIDS)

³ Adapted from UNAIDS and World Bank; *Monitoring and evaluation operations manual for National AIDS Councils* (2002), available on www.unaids.org

⁴ See www.futuresgroup.com/aim

⁵ See www.cidb.org.za



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Appendix One:	Comparative country data
Appendix Two:	Fact sheet on the mining sector in Southern Africa
Appendix Three:	IFC Against AIDS corporate roadmap on HIV/AIDS
Appendix Four:	Resources, references and contacts
Appendix Five:	Glossary

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Appendix One: Comparative Country Data¹

Basic demographic data

Country	Area (Km ²)	Population	Population growth	Political system
Angola	1 246 700	10 366 031	2.15%	Unitary Republic
Botswana	582 000	1 700 000	0.47%	Parliamentary Republic
DRC	2 345 410	53 000 000	?	Transitional government
Lesotho	30 355	2 177 062	1.49%	Constitutional Monarchy with an elected Parliament
Malawi	118 484	10 180 000	2%	Constitutional Republic with Unicameral Parliament
Mozambique	801 590	17 200 000	1.3%	Unitary State
Namibia	825 418	1 800 000	1.38%	Multiparty democracy
South Africa	1 225 815	44 600 000	0.26%	Parliamentary democracy with President as Head of State
Swaziland	17 363	980 000	1.83%	Monarchy; the bi-cameral Libandla (Parliament) is an advisory body
Tanzania	945 087	36 232 074	2.61%	Republic with elected President and National Assembly
Zambia	752 614	10 290 000	2% ²	Constitutional Republic with Unicameral Parliament
Zimbabwe	390 580	11 365 366	0.15%	Parliamentary democracy



Key economic data

Country	GDP	Inflation	Foreign debt	Unemployment rate
Angola	\$ 10.1 billion	325%	\$ 10.8 billion	+50%
Botswana	\$ 2.37 billion	8.6%	\$ 698 million	40%
DRC	\$ 5.8 billion	358%	?	?
Lesotho	\$ 899 million	6.1%	\$ 700 million	?
Malawi	\$ 1.8 billion	29.5%	\$ 2.6 billion	?
Mozambique	\$ 3.8 billion	11.4%	\$ 1.4 billion	?
Namibia	\$ 5.5 billion	9.1%	\$ 180 million	30% to 40%
South Africa	\$ 125.9 billion	5.7%	\$ 24.8 billion	40% ³
Swaziland	\$ 1.28 billion	7.3%	\$ 258.4 million	?
Tanzania	\$ 7.7 billion	5.9%	\$ 7.5 billion	?
Zambia	\$ 3.5 billion	18.7%	\$ 6.5 billion	10.3%
Zimbabwe	\$ 28.2 billion	60%	\$ 4.1 billion	?

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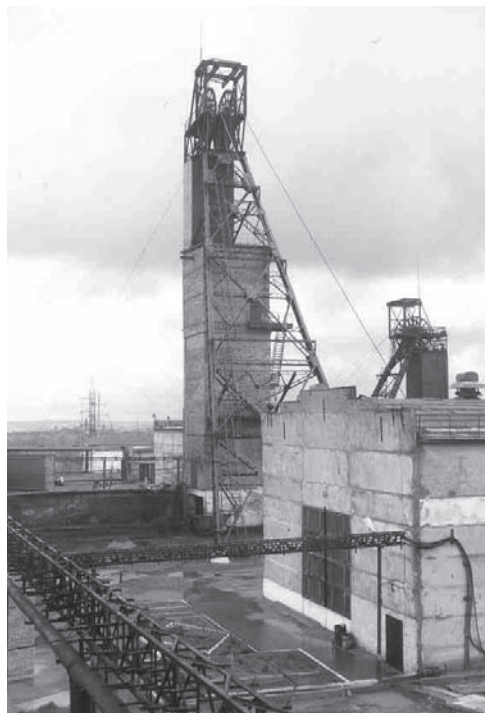
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Development data

Country	Infant mortality (per 1 000 live births)	Life expectancy (years)		Literacy	Human development index (out of 162 countries)
		Male	Female		
Angola	193.72	37.36	39.87	42%	146
Botswana	63.2	37.13		70%	114
DRC	?	47.2	51.1	M: 86.6% F: 67.7%	155 (of 173 countries)
Lesotho	82.77	47.97	49.74	M: 72% F: 93%	120
Malawi	121.12	36.61	37.55	58%	151
Mozambique	139.2	37.25	35.62	42.3%	157
Namibia	71.66	42.48	38.71	38%	111
South Africa	60.33	47.64	48.56	81.8%	94
Swaziland	109.19	37.86	39.4	M: 78% F: 75.6%	113
Tanzania	79.41	51.04	52.95	M: 79.4% F: 56.8%	140
Zambia	90.89	36 ⁴	37	M: 78% F: 69%	143
Zimbabwe	62.61	38.51	35.7	M: 90% F: 80%	117

Footnotes



¹ Data (2000-2004) from Canadian Department of Foreign Affairs and International Trade – see: <http://www.dfait-maeci.gc.ca>

² The 2000 Census Report quotes a 2.5% growth rate

³ Source: media reports from the Growth and Development Summit (June 2003)

⁴ The 2000 Census estimates male life expectancy at 54 years and female life expectancy at 57.2 years



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Appendix Two: Fact Sheet on the Mining Sector in Southern Africa

Included in the concept of a **mining community** are all stakeholders and organisations that interface with a mining operation. This would include those providing goods or services to mining companies, such as engineering supplies, safety equipment, medical supplies, geological studies, construction, transport, environmental management and impact mitigation services, research and development, recruitment, security, canteen and laundry, etc. In addition, stakeholders and partners, like government ministries, local government, NGOs, and training and research institutions are also members of a mining community.

Mining is a vital component of the national economies of numerous countries, particularly as a major foreign exchange earner. In classic development economies, it is the surplus generated from mining and agriculture and the related processes which stimulates economic growth and leads to the emergence of a modernised economy. Although led by the large companies, it is estimated that, in a number of Southern African countries, small scale mining contributes as much as 5% to the GDP, and in Zimbabwe and Tanzania, for example, small scale miners contribute up to 25% of the total gold production.

The exploitation of mineral resources has accelerated during the past century with the discovery of new ore bodies and the development of new mining and metallurgical technologies. These mineral resources hold the promise of exceptional long-term social and economic benefits for the region. Such potential benefits are recognised as a key component of the recently launched and widely supported New Partnership for Africa's Development (NEPAD).

In Southern Africa, over 60 minerals and metals are mined, including platinum, gold, diamonds, coal, asbestos, semi-precious stones, base metals, ferrous metals and industrial metals.

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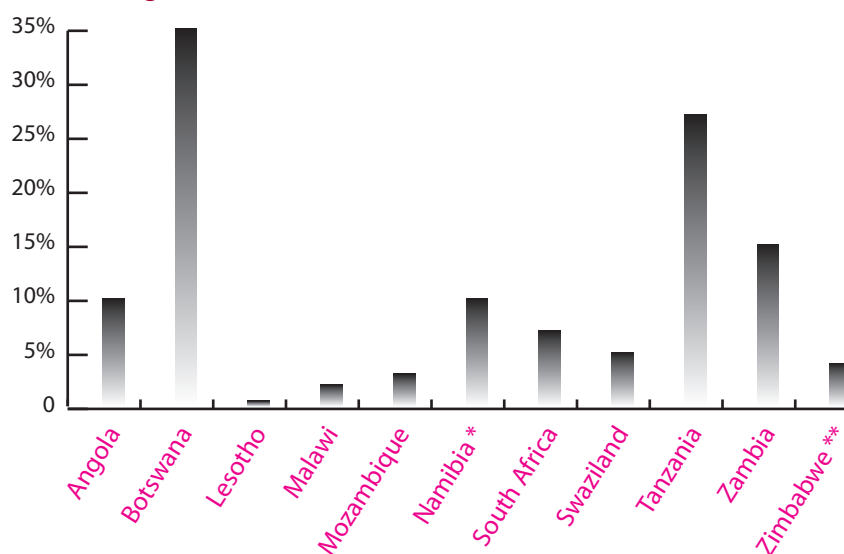
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Estimates of the mining and minerals sector's contribution to economies of continental SADC states in 1999 ^{1,2}

SADC Member	Mining and minerals sector's economic contribution
Angola	Official diamond exports of 2 132 937 carats valued at US\$ 296.24 million
Botswana	US\$ 2.0 billion diamond earnings out of a total of US\$ 2.7 billion exports
DRC	28% of GDP and 70% of exports
Lesotho	Artisanal diamond production to end-March 2000 – 1 053 carats valued at US\$ 85 000; US\$ 15 million is being invested in rehabilitating former De Beers operations
Malawi	<1% GDP comprising US\$ 1 million 95% of which was gemstones (informal gemstone exports are thought to exceed US\$ 2 million)
Mozambique	1.4% of exports and <0.25% of GDP; US\$ 1.34 billion Billiton Mozal aluminium smelter commissioned in 2001 with anticipated operating revenues of US\$ 400 million annually
Namibia	Mineral exports total 49% of total exports by value, to which diamonds contributed 68%
South Africa	33% of export revenue, and 6% of working population
Swaziland	2% of GDP with ex-mine revenues contributing US\$ 20 million to total export earnings of US\$ 825 million
Tanzania	2.1% of GDP and 14.5% of export earnings and a sectoral growth rate of 9.1%, with sectoral FDI of US\$ 720 million in the three years to end-2000
Zambia	Copper mining provided 85% of foreign exchange and 20% of GDP
Zimbabwe	6% of GDP, 7% of the labour force and 40% of foreign exchange earnings ³

Contribution of mining to GDP, selected countries (source: SADC 2001 in RTS MacFarlane)



* Some authorities consider mining's direct contribution to Namibia's GDP to be 15% (Schneider, pers. comm., 2001)

**Figures for Zimbabwe from Murangani (pers. comm., 2001). The contributions to GDP listed above exclude the significant indirect contribution arising from the activities of the sector. No data was available for the Democratic Republic of Congo.



Mining and migrancy are inextricably linked in Southern Africa, with large numbers of men migrating from their homes to work on the mines.

Employment of foreign migrants in the South African mining industry⁴

Country of origin	1984	1989	1994	1998
Lesotho	75 787	98 085	84 700	60 450
Botswana	18 599	15 229	10 837	7 752
Swaziland	12 152	16 555	14 829	10 336
Mozambique	42 294	44 015	44 044	51 913

Mines are located where the minerals are and historically this has often meant dependent communities in areas that are remote and inhospitable. However, the industry is changing and is focussing on using the mine's productive years to develop sustainable livelihoods in adjacent communities, encouraging local employment and devising ways to transport the workforce to and from the mine (e.g. bus in/bus out). There is an increasing awareness of mining company responsibilities in the area of community health and safety and this includes the indirect impacts that influx of people (e.g. seeking employment) into an area can have. Many companies take active steps to minimise these impacts, for example by having a policy of not offering employment at the mine itself, rather having remote recruiting centres. Remote recruiting does not feed into migrancy but rather helps organise migrancy, making it more predictable and, in the end, it is better for the migrant workers who are affected by these processes.



However, mines frequently do still operate as self-sufficient communities with housing, education, health care and sporting facilities provided. The health care or medical services range from first aid stations to fully equipped hospitals serving either the workers only or also the community surrounding the mine. In recent years, companies have elected to outsource many non-core functions, e.g., in 2003, 50% of the workers on site at Debswana mines were contractors.

Although mining has a historic reputation for being a dangerous occupation due to injuries and diseases, this does not have to be the case and modern occupational health and safety management and training can minimise such risks to low levels. Most countries have legislation which seeks to limit the risk of illness and injury by regulating the responsibilities of both employees and employers. Trade unions have also traditionally played a prominent role in the mining sector, particularly in encouraging legislative change in the areas of occupational health and safety.

Footnotes



¹ Quoted in Pharoah, R and Schönteich; *AIDS, security and governance in Southern Africa – exploring the impact*, ISS Paper 65 (January 2003)

² Source; MIGA: African Mining 2000 Symposium, London, Mining Journal Ltd. (2000)

³ http://www.sadcreview.com/country%20profiles%202001/zimbabwe_zimMining.htm

⁴ Quoted in Whiteside, A and Sunter, C; *AIDS, the challenge for South Africa* (2000)

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Appendix Three: The IFC's Corporate Roadmap on HIV/AIDS



Awareness, Education and Prevention

Program Item	Description	Status	Rating
HIV/AIDS Policy	The "public" policy statement endorsing the company's commitment with respect to HIV/AIDS for internal briefing and also provision to third parties.	In draft	1
		Formally adopted	2
		Communicated actively and reviewed	3
Tools for Awareness	Posters, signs, ribbons, news clips on notice boards, talks, video, live theatre, radio, television, competitions (e.g. posters), sponsored events, messages in pay packets, in-house magazine articles, "Health Question Box".	1-5 of these elements in place	1
		6-8 of these elements in place	2
		Maintained and updated	3
Training Modules	HIV/AIDS education is a component of the company's training, (e.g., recruitment process, new employees' induction programs, health education, safety briefings, module for managers).	Employees module	1
		Plus management training module	2
		Ongoing training exists	3
Targeting and addressing high risk and vulnerable groups	High risk (long-distance drivers, migrant workers) and vulnerable groups (women and youth), should be targeted for education and prevention programs.	Analysis to identify groups	1
		Programs for these groups in place	2
		>50% trained or analysis confirmed no high risk/vulnerable groups in company	3
Workplace discussion forum	A key step in the educational process is to engage in a dialogue and the opportunity for this should be established (with union involvement) in all workplaces.	Discussion leaders identified	1
		Discussion clearly scheduled	2
		Discussion sessions once a month	3
Peer educators	Informed dialogue is essential for properly developing an understanding of how HIV is spread and the impact it can have on people. Target ratio should be 1 educator : 50 employees.	Process for group formation	1
		Peer educators in training	2
		Ongoing peer education programs	3
People Living With HIV/AIDS (PLWA) involved	The involvement of People Living with Aids is a powerful way of strengthening the educational process, especially if they are representatives from the immediate community	PLWA involved in education as visitors	1
		PLWA in discussion sessions	2
		PLWA as peer group educators	3
Condoms distributed	Condom distribution (male and female) is an essential component of an education and prevention program. They should be free of charge (or a nominal cost) and readily available.	Available through clinics	1
		Through dispensers at a cost	2
		Through dispensers free of charge	3
Trained HIV/AIDS counselors	Trained counselors are a pre-requisite to ensure appropriate support available to those affected by HIV/AIDS and to implement Voluntary HIV Counseling and Testing (VCT). Counselors should be available in the company but visiting counselors can also supplement the company's staff.	At least one trained counselor available	1
		All clinical staff trained	2
		Ongoing training for counselors	3
Voluntary HIV Counseling and Testing (VCT)	Access to safe, confidential and convenient voluntary HIV testing and counseling integrated in the company's activities (e.g. communication efforts, medical examinations, disease prevention). The test is performed within the company's clinics or externally	VCT available	1
		VCT available and actively advocated	2
		VCT taken up by >50% employees and extended to the community	3
Prevention of vertical transmission (mother-to-child transmission)	Many children acquire HIV from their mothers before, during or after birth. The company can undertake or support such a program with VCT and anti-retroviral drugs for mother/child to invest in "the next generation".	Available to employees	1
		Available to employees and their partners	2
		80% pregnancies covered	3



Treatment and Care

Program Item	Description	Status	Rating
HIV and Occupational Health and Safety (OH&S)	The company has adopted and enforced a procedure for occupational blood or body fluids post-exposure to prevent accidental HIV transmission in the workplace.	In draft	1
		Formally adopted	2
		Implemented	3
Clinical staff training	Continuing professional training on HIV/AIDS and infectious diseases is ensured to the clinical and laboratory staff of the company.	Some staff members trained	1
		All clinic's staff attended one training	2
		Continuing training attended yearly	3
Nutritional program	Appropriate dietary supplements to support good general health and resistance to opportunistic infections will significantly delay the onset of AIDS.	Advice available on diet to support health	1
		Target program > affected employees	2
		Free supplements available	3
Opportunistic infections, TB, STDs	The impact of a decline in the immune system with the onset of AIDS can be prevented or mitigated by prophylactic and/or medication for other infections and quick response when they occur.	Treatment protocol in draft	1
		Treatment available for some infections	2
		Treatment and prophylactics available	3
Anti-retroviral (ARV) treatment	The company considers implementing therapy with medical staff or by partnering with others possessing experience in this treatment so highly-active anti-retroviral therapy (HAART) becomes part of the medical coverage of HIV+ employees and possibly dependants.	Feasibility study	1
		Available to some employees as a pilot	2
		Available to all employees	3
Home-based care	Terminally ill patients with AIDS require specific care. This could include hospice or home-based care developed with the support of appropriate third parties.	Home-based care under development	1
		Access for >20% of terminally ill patients	2
		Access for >50% of terminally ill patients	3

Monitoring and Leveraging the Program

Monitoring effectiveness and results	Indicators/items are used for monitoring, incentives, accountability and evaluation. Qualitative information includes general awareness of HIV/AIDS evaluated through questionnaires or Knowledge, Attitudes, Practices and Behavior (KAPB) Studies. Quantitative information includes productivity measures, absenteeism averted, condom use, requests for VCT or counseling.	Evaluation method identified	1
		Qualitative data used to measure effectiveness of the program	2
		Quantitative data and qualitative information used to measure effectiveness and make adjustments	3
Advocacy with customers, suppliers and other business partners	Business partners should be encouraged to have their own programs and to ensure they have assessed and dealt with relevant risk. For key suppliers, the latter could involve a system for supplier compliance certification.	Program information provided	1
		Formal advocacy/educational meetings	2
		Accreditation scheme for key suppliers	3
Commemorate World AIDS Day December 1st	World AIDS Day is a unique opportunity every year, to go beyond the workplace and to highlight the profile and reach of the company's program.	Day commemorated	1
		Activities open to employees' families & community	2
		Activities open to suppliers/service providers	3

The Road Map contains a list of possible interventions that can be put into place in the private sector. The "status" and "rating" columns provide companies with a means to set targets and evaluate their progress.

Source: Extracted from IFC Against AIDS, Good Practice Note and HIV/AIDS in the workplace, available in its full text on: www.ifc.org/ifcagainstaids

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Appendix Four: Resources, References and Contacts

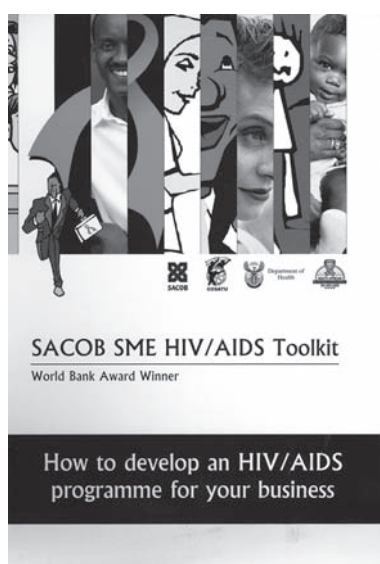
The following are suggested readings and resources for further information to assist organisations in mining communities in Southern Africa to develop comprehensive HIV/AIDS responses.

Codes

- International Labour Organisation; *Code of practice on HIV/AIDS and the world of work* (2001), available on www.ilo.org.
- SADC *Code of good practice on HIV/AIDS and employment* (1997), available on www.hri.ca/partners/alp.
- South African Department of Labour; *Code of good practice on key aspects of HIV/AIDS and employment* (2000), available on www.labour.gov.za.
- South African Department of Labour; *HIV/AIDS Technical Assistance Guidelines* (2003), available on www.labour.gov.za.

Toolkits

- Harvard University, in co-operation with the World Economic Forum (WEF), UNAIDS and the ILO, is developing a set of tools to build capacity for combating HIV/AIDS in developing countries. The tools include inventories of good management principles and practices, and model curricula for executive training.
- The ICFTU (International Confederation of Free Trade Unions), in collaboration with the ILO's Bureau for Workers Activities, ILO/AIDS and other partners are developing a "tool box" on HIV/AIDS for young workers.
- UNAIDS has developed a toolkit entitled *Methods and approaches for local responses to HIV/AIDS: Techniques* (undated).
- KIT is a project of the Royal Tropical Institute in the Netherlands, see www.kit.nl. Kit manages a "local responses to HIV/AIDS" information exchange forum funded by UNAIDS. This project provides a database of practices, techniques and training manuals in the form of tools (available in English, French and Portuguese).
- UNDP has designed tools to facilitate the mainstreaming HIV/AIDS into governance institutions.
- WHO and the International HIV/AIDS Alliance have developed a toolkit for programme managers entitled *A public health approach for scaling up ARV treatment*.





- The Synergy APDIME Toolkit is a user-oriented, electronic one-stop-shop of HIV/AIDS programming resources. The toolkit contains 5 modules of the programming cycle – Assessment, Planning, Design, Implementation and Monitoring and Evaluation – go to www.synergyaids.com.
- The LSHTM HIVTools Research Group has a website from which tools on costing and mathematical models for estimating the impact of different HIV prevention interventions can be downloaded, see www.hivtools.lshtm.ac.uk/.
- The Barnabas Trust in Port Elizabeth, South Africa, developed a community level toolkit; *The New Toolbox – a handbook for community-based organisations* (2002), which is available from barntrust@mweb.co.za.
- SMARTwork (Strategically managing AIDS responses together) released their *Workplace Guide for managers and labor leaders: HIV/AIDS policies and programs* in 2004, available on www.smartwork.org.
- Family Health International (FHI); *Workplace HIV/AIDS programme; an action guide for managers*, available on www.fhi.org/en/aids.
- SABCOHA, the South African Business Coalition on HIV/AIDS launched an HIV/AIDS Toolkit in 2004.
- Similarly, SACOB (the South African Chamber of Business) launched their SME HIV/AIDS Toolkit in 2004.

References

Governance

- UNDP, UN-Habitat; *HIV/AIDS and local governance in sub-Saharan Africa – occasional paper 1* (June 2002).
- CADRE; *The economic impact of HIV/AIDS on South Africa and its implications for governance* (2000).

Modelling

- Actuarial Society of South Africa (ASSA): Their AIDS model is available at www.assa.org.za/aidsmodel.asp.
- *AIDS Impact Model for Business*; AIM-B, available on www.futuresgroup.com/aim is an economic and demographic model designed to help managers analyse how HIV/AIDS is affecting their businesses and project how it will affect them in the future.
- *COALS for Business*, also available from the Future Group, enables organisations to effectively allocate resources to HIV/AIDS programmes implemented in the workplace. The model assesses whether an organisation's current HIV/AIDS strategies are realising their full potential and if they can be adapted to improve results.

Workplace and HIV/AIDS

- South African Department of Public Service and Administration; *Managing HIV/AIDS in the workplace* (2002), available on www.dpsa.gov.za.
- FHI; *Workplace HIV/AIDS programme; an action guide for managers*, available on www.fhi.org/en/aids.
- FHI; search for information on HIV/AIDS education on www.fhi.org.
- Loewenson R, ed. *Best practices: company actions on HIV/AIDS in Southern Africa*: Organisation of African Trade Union Unity (OATUU) Health Safety and Environment Programme (1999).
- ILO; *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual* (2002), available on www.ilo.org.
- IFC's Good Practice Note on HIV/AIDS in the workplace and other resources to assist in establishing an HIV/AIDS workplace programme.



Economics

- The Joint Center for Political and Economic Studies has a literature review on the economic impact of HIV/AIDS on South Africa, available on www.jointcenter.org/international/hiv-aids/1_lit-review.htm.
- A paper on the economic impact of HIV/AIDS in Southern Africa is available on the Brookings website at www.brookings.edu (#9; September 2001).
- Haacker M; *The economic consequences of HIV/AIDS in Southern Africa* (2002). This IMF working paper provides some tools for analysing the economic consequences of HIV/AIDS, in particular, the fiscal implications and the effect on economic growth.

Epidemiology

- UNAIDS; *Epidemiological Fact Sheets* (which provide country-specific HIV/AIDS statistics), available on www.unaids.org/hivaidsinfo/statistics/fact_sheets/index_en.htm.

Employee benefits

- Stevens M (Centre for Health Policy); *AIDS and the workplace with a specific focus on employee benefits: Issues and responses*, (2001).

Legal issues

- The AIDS Law Project (based in South Africa) has developed a number of workplace resources with a focus on legal and ethical issues; go to www.law.wits.ac.za/cals/alp.

Mainstreaming HIV/AIDS

- Health Economics and HIV/AIDS Research Division (HEARD) has numerous publications and AIDS Briefs for sectors and professions, available on www.und.ac.za/und/heard.

Gender

- UNIFEM, in collaboration with UNAIDS, has a comprehensive gender and HIV/AIDS website, www.GenderandAIDS.org, for researchers, policy-makers and practitioners.
- A draft SADC code entitled; *Urgent measures needed to promote the equality of women and the reduction of women's risk of HIV infection*, aims to focus attention on HIV/AIDS and gender. For more on the code go to www.alp.org.za/view.php?file=/resctr/other/20040405_ARASA.xml

PLWHA

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- UNAIDS; *The faces, voices and skills behind the GIPA workplace model in South Africa* (2002), available on www.unaids.org.
- POLICY Project; *Guidelines to establish and maintain support groups for people living with and/or affected by HIV and AIDS* (2003), available on www.policyproject.com.

Care and support

- Catholic AIDS Action in Namibia published a manual entitled; *Caring for ourselves in order to care for others*. Contact info@caa.org.na.



Contacts

- The Global Health Council publishes a *Global Health Directory* every year. The 2003-2004 version contains information on the contacts, mission statements, regions/countries served, target groups and service focuses of over 440 organisations. To order, contact membership@globalhealth.org.
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Websites

- www.ifc.org/ifcagainstaids; This IFC project aims to assist companies with information, tools and guidance to develop their responses to the HIV/AIDS epidemic.
- www.weforum.org; The World Economic Forum's Global Health Initiative is designed to foster greater private sector involvement in the global response to HIV/AIDS (TB and malaria). The website has resources and best practices to help companies in developing their responses.
- www.unglobalcompact.org/Portal/; The Global Compact brings companies together with UN agencies, labour and civil society in support of human rights, labour standards and the environment. The Global Compact, the ILO and UNAIDS have joined forces to mobilise businesses, encourage increased action on HIV/AIDS in the workplace and combat stigmatisation.
- www.icftu.org; The ICFTU believes that trade unions are uniquely placed to address the HIV/AIDS epidemic, as the workplace is a major entry point for information, prevention and rights campaigns.
- www.businessfightsaids.org/; The Global Business Coalition on HIV/AIDS brings together a growing number of international businesses dedicated to combating the HIV/AIDS epidemic. The website contains resources and information for employers on ways to address HIV/AIDS in the workplace.
- www.iaen.org; The International AIDS Economic Network (IAEN) provides data, tools and analysis on the economics of HIV/AIDS prevention and treatment in developing countries, to help developing countries devise cost-effective responses to the global epidemic.



- www.who.int/hiv/pub/en/; The World Health Organisation has numerous publications on HIV/AIDS, in particular health-related ones.
- www.redribbon.co.za; This is a website supported by Metropolitan Life. It is the primary link to the official website of SABCOHA (the South African Business Coalition on HIV/AIDS).

Resources

BCC materials

- All National AIDS Programmes develop and distribute small media materials, like posters and pamphlets. Some of these may be suitable for use within a workplace context.

Condoms

- In some countries Ministries of Health procure and distribute free male condoms, and may agree to provide supplies to companies for workplace distribution;
- Condoms are available commercially from a range of suppliers. Names and contact details of local suppliers can usually be obtained from the Ministry of Health;
- Population Services International (PSI), known as the Society for Family Health (SFH) in some countries, provide socially marketed condoms (which are subsidised and therefore cheaper than commercial brands).

PSI operates in the following countries in the SADC region: Angola, Botswana, Malawi, Mozambique, Namibia, South Africa, Tanzania and Zimbabwe. For more information visit www.psi.org.



Appendices

Appendix Five: Glossary

Absenteeism management	The process of collecting and analysing information relating to absenteeism and taking appropriate action on the basis of such information. The aim is to identify serious illness in employees as early as possible, so that the correct medical intervention can be implemented. The most successful absenteeism management programmes rest on two pillars: daily analysis of sick leave information and interpretation and recommendations by medical practitioners.
Acquired immune deficiency syndrome (AIDS)	The last and most severe stage of the clinical spectrum of HIV-related disease.
Affected persons	Persons whose lives are changed in any way by HIV/AIDS due to infection and/or the broader impact of the epidemic.
Antibodies	Substances produced by cells in the body's immune system in response to foreign substances that have entered the body.
Antiretroviral drugs	Substances used to kill or inhibit the multiplication of retroviruses such as HIV.
Asymptomatic	Infected by a disease agent but exhibiting no medical symptoms.
Audit	A systematic examination to determine whether activities and related results conform to planned arrangements, and whether these arrangements are implemented effectively and are suitable for achieving the organisation's policy and objectives.
Base-line data	Data about characteristics, figures of people/places, collected before a programme/project starts, and which can be collected again in the same manner during, or at the end of, a programme/project to see what changes have occurred.
Casual contact	Day-to-day social contact.
Collective bargaining	Collective bargaining is a process in terms of which employers and employee collectives seek to reconcile their conflicting goals through a process of mutual accommodation.
Confidentiality	The right of every person, employee or job applicant to have their medical information, including HIV status, kept private.



Contact tracing	Refers to the method of finding and counselling the sexual partner(s) of a person who has been diagnosed as having a sexually transmitted infection.
Cost-effectiveness	Cost-effectiveness is a measure of the comparative efficiency of discrete strategies and methods for achieving the same objective.
Discrimination	Discrimination is an action based on a pre-existing stigma. In the case of PLWHA, it may result from the worker's actual HIV status, his/her perceived HIV status, or even his/her sexual orientation.
Enzyme-linked immunosorbent assay (ELISA)	A laboratory test to determine the presence or absence of antibodies to HIV in the blood. A positive ELISA result is generally confirmed by a second test, e.g. a Western blot test.
Employee benefits	Any benefit granted to an employee or his/her family by an employer in respect of the period of employment of the employee, over and above salary. The term is usually used in the sense of retirement and life insurance benefits.
Employer	A person or organisation employing workers under a written or verbal contract of employment which establishes the rights and duties of both parties, in accordance with national law and practice. Governments, public authorities, private enterprises and individuals may be employers.
Epidemic	A disease, usually infectious, that spreads quickly through a population.
Epidemiology	The study of the distribution and determinants of disease in human populations.
Evaluation	An assessment, and analysis of, the design, implementation and results of an on-going, or completed, project.
False negative HIV antibody test	A negative test result that suggests a person is not HIV infected when, in fact, he or she is infected.
False positive HIV antibody test	A positive test result that suggests a person is HIV infected when, in fact, he or she is not infected.
Gender	Differences in social roles and relations between men and women.
Going to scale	Replication of a pilot project throughout, for example, a geographical area, or a project made larger in extent.
Hazardous biological agents	Any micro-organism which may cause infection or otherwise create a hazard to human health.
High-risk behaviour	Activities that put an individual at greater risk of developing or transmitting a particular disease. High-risk activities associated with HIV/AIDS include unprotected sexual intercourse and sharing of needles and syringes.
HIV-1	The retrovirus that is the principal worldwide cause of AIDS.
HIV-2	A retrovirus closely related to HIV-1 that also causes AIDS in humans, found principally in West Africa.

HIV/AIDS management system	The part of the overall management system that facilitates the management of the HIV/AIDS risks associated with the business of the organisation. This includes the organisational structure, planning activities, responsibilities, practices, procedures, processes and resources for developing, implementing, achieving, reviewing and maintaining the organisation's HIV/AIDS policy.
HIV-negative	Denotes the absence of HIV or HIV antibodies upon HIV testing
HIV-positive	Refers to the presence of HIV infection as documented by the presence of HIV or HIV antibodies in the sample being tested.
HIV testing	Refers to any laboratory procedure – such as blood or saliva testing – done on an individual to determine the presence or absence of HIV infection.
HIV transmission	The transfer of HIV from one infected person to an uninfected individual, most commonly through sexual intercourse, blood transfusion, sharing of intravenous needles and during pregnancy, childbirth or breast-feeding.
Human immunodeficiency virus (HIV)	A virus that weakens the body's immune system, ultimately causing AIDS.
Ill-health retirement	A member retiring prior to normal retirement age due to reasons of ill health.
Immune system	A complex system of cells and cell substances that protects the body from infection and disease.
Incidence of HIV	The number of new cases of HIV in a given time period, often expressed as a percentage of the susceptible population.
Incubation period	The period of time between entry of the infecting pathogen into the body and the first symptoms of the disease.
Informal sector	Very small scale units producing and distributing goods and services, and consisting largely of independent, self-employed producers, which operate with very little capital, technology and skills, and which generally provide low and irregular income and highly unstable employment.
Informed consent	Refers to the voluntary agreement of a person to undergo or be subjected to a procedure based on full information, whether such permission is written, or expressed indirectly.
Inherent requirements	The inherent requirements of a job are an essential characteristic, quality or capacity that is required in order to fulfil the duties of a job.
Key performance indicators (KPIs)	Statements that describe the dimensions of performance which are considered key when assessments and reviews are undertaken.



Medical confidentiality	Refers to the relationship of trust and confidence created or existing between a patient or a person with HIV and his attending physician, consulting medical specialist, nurse, medical technologist and all other health workers or personnel involved in any counselling, testing or professional care of the former; it also applies to any person who, in any official capacity, has acquired or may have acquired such confidential information.
Medical scheme	A legal entity established with the purpose of undertaking liability in return for a premium or contribution in order to assist with the defraying the medical expenses of its members.
Medical testing	The process of gathering information, usually from duly qualified medical practitioners or from the applicant for membership or employment, concerning the health status of the individual.
Monitoring	The regular collection and analysis of information then used to guide a project – either to continue on its course, or to change direction.
Occupational disease	A disease contracted as a result of or during the course of an employee’s employment.
Occupational exposure	An incident or accident in the working environment involving blood or body fluids, and which may expose a person to the risk of HIV infection.
Occupational health and safety	The conditions and factors that affect the well-being of employees, temporary workers, contractor personnel, visitors and any other persons in the workplace.
Occupational health services (OHS)	A term used in accordance with the description given in the Occupational Health Services Convention, 1985 (No. 161), namely health services which have an essentially preventative function and which are responsible for advising the employer, as well as workers and their representatives, on the requirements for establishing and maintaining a safe and healthy working environment and work methods to facilitate optimal physical and mental health in relation to work. The OHS also provide advice on the adaptation of work to the capabilities of workers in the light of their physical and mental health.
Occupational injury	An injury caused as a result of an accident arising out of and in the course of an employee’s employment.
Openness	A climate in which HIV and AIDS is freely discussed and acknowledged, and people living with HIV/AIDS feel enabled to disclose their HIV status.
Opportunistic infection	An infection with a micro-organism that does not ordinarily cause disease, but that becomes pathogenic in a person whose immune system is impaired, as by HIV infection. OIs common in persons diagnosed with HIV/AIDS include pneumocystis carinii pneumonia (PCP), Kaposi’s sarcoma, cryptosporidiosis, histoplasmosis, other parasitic, viral, and fungal infections, and some types of cancers.

Organisation	The organisation, company, operation, firm, enterprise, institution, association or any part thereof, whether incorporated or not, public or private, that has its own functions and administration. For organisations with more than one operating unit, a single operating unit may be defined as an organisation.
Palliative care	Care that promotes the quality of life for people living with HIV/AIDS and other terminal conditions, by the provision of holistic care, good pain and symptom management, spiritual, physical and psychosocial care for clients and care for the families into the bereavement period.
Pandemic	An epidemic occurring simultaneously in many countries.
Post-exposure prophylaxis	Anti-retroviral therapy taken immediately after an exposure to HIV (such as a needle-stick injury) to reduce the risk of HIV transmission.
Post-test counselling	Refers to the process of providing risk-reduction information and emotional support to a person who submitted to HIV testing at the time that the test result is released.
Pre-test counselling	Refers to the process of providing an individual with information on the biomedical aspects of HIV/AIDS and emotional support for any psychological implications of undergoing HIV testing and the test result itself before he/she is subject to the test.
Prevalence of HIV	The number of people with HIV at a point in time, often expressed as a percentage of the total population.
Prophylaxis for OIs	Treatments that will prevent the development of conditions associated with HIV disease such as TB and PCP.
Reasonable accommodation	Any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS to have access to or participate or advance in employment.
Retirement fund	A legal entity established with the purpose of providing retirement benefits to its members. Contributions are collected from members and invested to secure retirement benefits at a member's normal retirement age. Other benefits such as death in service, disability and spouses' pensions are often also provided through a retirement fund.
Screening	Measures whether direct (HIV testing), indirect (assessment of risk-taking behaviour) or asking questions about tests already taken or about medication, designed to establish HIV status.
Sentinel surveillance	Surveillance conducted through "watchpost" sites that provide access to populations that are of particular interest or representative of a larger population.
Seroconversion	The point at which the immune system produces antibodies and at which time the HIV antibody test can register an HIV infection.
Serological testing	Testing of a sample of blood serum.
Seronegative	Showing negative results in a serological test.



Seropositive	Showing positive results in a serological test. A person who is seropositive for HIV antibodies is considered HIV infected.
Seroprevalence	The proportion of a given population with a particular marker in the blood, such as antibody to HIV, at a specific time.
Serosurvey	Systematic testing of sera from a group of persons to determine the frequency of a particular marker, such as antibody to HIV, in that population.
Sexually transmitted infection (STI)	An STI refers to any disease – such as syphilis, chancroid, chlamydia, gonorrhoea – that may be acquired or passed on through sexual contact.
Source person	Person whose blood may have been exposed to another person, in an occupational accident.
Stigma	The holding of derogatory social attitudes or cognitive beliefs, the expression of negative effect, or display of hostile or discriminatory behaviour towards members of a group, on account of their membership of that group.
Surveillance	A method of determining HIV prevalence rates in a population.
Symptomatic	With symptoms.
Tripartite	The term used to describe equal participation and representation of governments, employers and workers in a sector.
Unfair discrimination	Unfair discrimination is when a policy or practice differentiates between people on an arbitrary ground, in a way which adversely impacts on the person's dignity, and in a way which is not reasonable or justifiable in terms of the laws of the land.
Universal precautions	A simple standard of infection control practice to be used to minimise the risk of blood-borne pathogens.
Virus	Infectious agent (microbe) responsible for numerous diseases in all living beings. They are extremely small particles, and in contrast with bacteria, can only survive and multiply within a living cell at the expense of that cell.
Voluntary HIV testing	HIV testing done on an individual who, after having undergone pre-test counselling, willingly submits himself/herself to such a test.
Vulnerable groups	Vulnerable groups refer to groups of person who, by reason of socio-economic disempowerment and the existing cultural context, are vulnerable. In the working environment, working situations that make workers more susceptible to the risk of infection may cause vulnerability.
Vulnerable groups (occupational)	Persons in employment or service who become exposed to or come into contact with infected body fluids through, for example, cuts or accidental “needlestick” injuries such as health care and community workers, e.g. doctors, dentists, nurses, first-aiders, emergency services personnel. Usually education in universal precautions is provided.

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Appendices

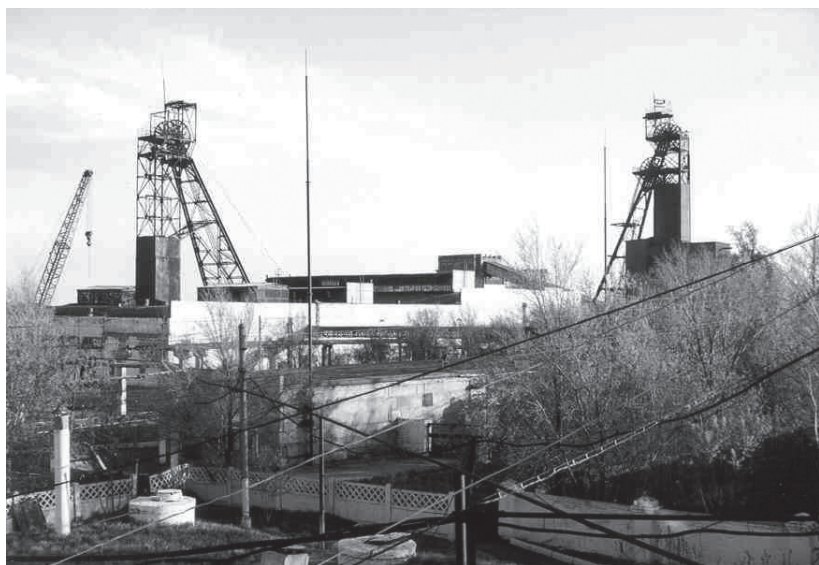
Contributors

Window period The period of time, usually lasting from two weeks to six months during which an infected individual will test negative upon testing for HIV antibodies, but can transmit the infection.

Workers' representative In accordance with the Workers' Representatives Convention, 1971 (No. 135), these persons are recognised as workers' representative by national law or practice whether they are:

- (a) trade union representatives, namely, representatives designated or elected by trade unions or by members of such unions; or
- (b) elected representatives, namely, representatives who are freely elected by the workers of the undertaking in accordance with provisions of national laws or regulations or of collective agreements and whose functions do not include activities which are recognised as the exclusive prerogative of trade unions in the country concerned.

An alternate glossary, which includes a number of medical terms, is available on the IFC Against AIDS website, at: www.ifc.org/ifcext/aids.nsf/Content/Glossary.





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