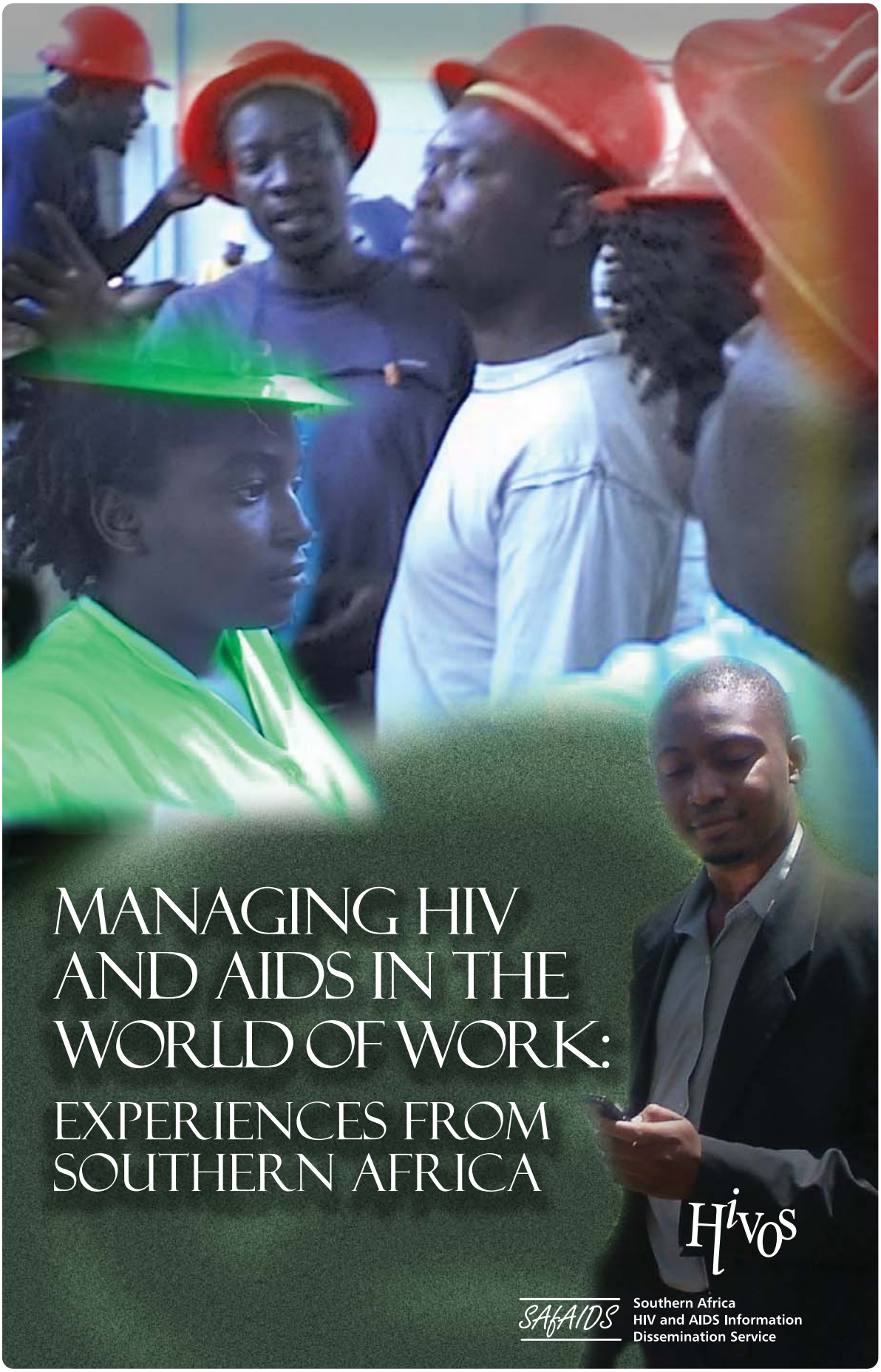

MANAGING HIV AND AIDS IN THE WORLD OF WORK:

EXPERIENCES FROM SOUTHERN AFRICA

Hivos

SAfAIDS Southern Africa HIV and AIDS Information Dissemination Service

MANAGING HIV AND AIDS IN THE WORLD OF WORK:

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HIVOS

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Managing HIV And AIDS In The World Of Work: Experiences from southern Africa

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ACRONYMS

AIDS	–	Acquired Immune Deficiency Syndrome
ARV	–	Anti-retroviral (Drugs)
BONELA	–	Botswana Network on Ethics Law and HIV and AIDS
HIV	–	Human Immunodeficiency Virus
HIVOS	–	International Humanist Institute for Cooperation With Developing Countries
ILO	–	International Labour Organisation
PLHIV	–	People Living with HIV and AIDS
SADC	–	Southern Africa Development Community
SAfAIDS	–	Southern Africa HIV and AIDS Information Dissemination Service
UNAIDS	–	Joint United Nations Programme on HIV and AIDS
US PEPFAR	–	United States President's Emergency Plan For AIDS Relief
VCT	–	Voluntary Counselling and Testing

FOREWORD

An estimated 63% (24,7 million) of all those living with HIV worldwide are in sub-Saharan Africa (UNAIDS 2006). The region continues to bear the brunt of the global epidemic. In 2006 alone, 40% of all new infections occurred among young people aged between 15 and 24 years. Nearly one third of the population in the sub-region is living with HIV and AIDS and its debilitating effects. The majority of those infected are men and women in the productive age groups. The ILO estimates that over two thirds of those living with HIV go to work (ILO Global estimates, 2004). Therefore, tackling the impact of HIV and AIDS on productivity of the workforce and enterprise efficiency in all sectors of economic activity and development should be a major concern.

In most of the affected countries in the sub-region, HIV and AIDS is worsening the economic situation of impoverished households. The informal economy that has long been able to absorb most of the growing labour force has become especially vulnerable. Gender-based inequalities have also become more pronounced, putting the burden of care on women. The region also suffers from limited funding, inadequate health services and personnel to cater for the ever-increasing numbers of those infected and affected. The challenge for national policies is therefore to address human capital issues and develop means to sustain the supply and quality of public goods and services.

The responses to the epidemic have therefore been manifold. Countries have introduced enlightened legislation and revised or made new HIV and AIDS specific laws to facilitate mitigation of the impact of the epidemic and for protection of the rights of persons living with or affected by HIV and AIDS. International and regional bodies in consultation with the social partners have also come up with Codes of practice that define the key principles, as in the ILO Code of practice on HIV and AIDS and the world of work, and the SADC Code on HIV and AIDS and employment. At the sector and enterprise levels, consultative processes among workers and employers and their organisations and other key stakeholders have also resulted in comprehensive workplace policies and programmes.

Despite all these efforts, new infections continue to occur and the impact of the epidemic continues to cause untoward pain and suffering across sectors and at family and individual levels. More still needs to be done.

In 2004, SAfAIDS in conjunction with HIVOS successfully hosted a regional symposium on HIV and AIDS in the world of work in Namibia. The main purpose of the symposium was to share experiences and knowledge in responding to HIV and AIDS in the world of work. As an outcome of the 2004 symposium, it was proposed that practices and experiences of businesses, government departments, non governmental organisations (NGOs) and development agencies be documented.

Over the past two years, SAfAIDS in collaboration with key stakeholders and partners within the sub region has been documenting some of the selected good practices that were shared at the symposium. This book covers such experiences and good practices on diverse topics

including employment rights, an overview of policies and legislation within southern Africa and the experiences of a range of businesses and organisations that have successfully implemented workplace policies and programme responses to HIV and AIDS. It also includes the contributions from private health insurance schemes that offer affordable solutions to problems related to access to prevention, treatment, care and support services, including antiretroviral therapy (ARVs). The book covers practical topics such as principles of good practice in workplace HIV and AIDS programming, peer education programmes, human resources planning, as well as the all important monitoring and evaluation of the programmes.

It is my belief that this book will prove an important resource in expanding HIV and AIDS programming in the world of work. The challenges of HIV and AIDS in southern Africa remain huge but with a robust response and interventions by various stakeholders and partners, the long term impact can be mitigated.

Tayo Fashoyin
Director,
ILO Sub-Regional Office for Southern Africa

Section 1.

Introduction To Mainstreaming HIV and AIDS

INTRODUCTION

In a Kenyan village, a 14 year old boy was beaten to death last year. His crime: being an HIV positive orphan. This happened in 2006, twenty years into the epidemic and yet denial, discrimination and lack of basic knowledge around HIV and AIDS still persist. Where have we failed?

A recent secondary school contest in Zimbabwe revealed that pupils hardly touched on the root causes of AIDS and didn't dare to refer to condoms as a means of protection. Years of campaigns, peer education and TV spots have apparently not created an environment where youth feel free to talk openly about sex, let alone safe sex.

A research carried out in 2003 by the Community Development Resources Association (CDRA) about the invisible impact of HIV and AIDS on the NGO workplace, revealed dramatic cases of staff that fell sick with all the symptoms of AIDS. However, instead of disclosing their status and accessing treatment, they succumbed to denial and died a slow death. The NGOs not only lost valuable staff, but had to deal with the emotional burden on the remaining staff as well. Could these deaths have been avoided if the NGOs had effective workplace policies in place?

Collective Responsibility

HIV affects all of us and it is our collective responsibility as governments, the private sector, donors, NGOs and faith-based organisations, to join hands in the fight against the pandemic. Many donors, including Hivos, have committed themselves to support the implementation of workplace policies as one of several strategies. We have offered training and technical support for partners on HIV awareness and policy development in Zimbabwe, Mozambique, Malawi and Zambia. After the initial training, several partners indicated that they lacked the capacity to develop a workplace policy.

Hivos then engaged SAfAIDS to provide technical support. SAfAIDS' involvement started with a survey in Zimbabwe, indicating that the vast majority (88,5%) felt the impact of HIV such as staff turnover, extended sick leave, time off to care for sick relatives or to attend funerals and requests for loans. Still, 11,5% of the Hivos partners were convinced that HIV didn't affect them at the workplace. The next step in the involvement of SAfAIDS was assistance to motivated partners to design an effective workplace policy. An intensive partnership between Hivos and SAfAIDS was born, leading to the publication of this book.

Lack of funds is often mentioned as the main constraint in developing a workplace policy. Instead, many NGO's and smaller companies prefer to have an 'informal' policy that deals with individual staff members on a case-to-case basis. That might seem to be cost effective, but how do you set your limits? If you have a 'suspected' case, how do you deal with it? Suppose you agree to provide ARVs to a sick staff member, will you also provide for her spouse and children if need be? Will you contribute to funerals and provide extra leave days if staff members have to care for sick family members? Read the article about the CDRA research to understand the negative consequences of an 'informal' workplace policy.

Bear in mind that a workplace policy isn't all about money. Training, awareness raising, a visit to a test centre or free provision of condoms, are low cost activities, that will assist staff to deal with HIV.

Hivos' Experience

Speaking from our own experience as Hivos, we are convinced of the benefits of a workplace policy. Since 2002, when the workplace policy was drafted, staff have participated in training sessions varying from the basics on HIV and AIDS, to personal attitudes, treatment literacy, healthy living and a collective visit to a Voluntary Counseling and Testing Centre (VCT). Further, there are provisions for extra leave days, funeral benefits and health insurance that covers ARVs.

The immediate impact is that HIV and AIDS are more openly discussed at work. Staff members have become experts in their circles of family and friends. This is a positive multiplier effect of the workplace policy and training. Another positive result is that team building is enhanced through the training sessions. Hivos staff, and many of our partners, were trained by Peter Busse, whom we fondly remember. Peter, who passed away in January 2006 was HIV positive himself and had developed a breakthrough methodology that made even the most tight lipped staff member talk enthusiastically about positions and safe sex!

The Importance Of Health Insurance

Workplace policies are certainly not a panacea for HIV. No matter how open and enabling your workplace is, due to stigma, an employee can still decide not to go for a test, not to seek treatment or consult traditional healers only. Even if they know their status after testing, they have the right not to disclose. This should not prevent them from accessing health care and treatment. Affordable health care for all staff, including cover for chronic diseases, should be provided by any employer who values the wellness of their staff. In most countries, treatment in public hospitals is free (though sometimes difficult to access) and most insurance companies offer health care packages that include ARVs. Read more about the affordable health care now on offer in Namibia, thanks to tireless negotiations between PharmAccess, the business sector and insurance companies. Zimbabwe also offers a comprehensive cover for the private sector to consider through Cimas Medical Aid Society.

It is interesting to note that the corporate sector is well ahead of the NGO sector. Several companies acknowledged years ago that the cost to replace human resources is higher than investing in a workplace policy and health insurance to keep staff healthy. They formed business coalitions against AIDS and liaised with health service providers. Read the articles from the Global Business Coalition, sugar estate Hippo Valley and the Swaziland Business Coalition.

The most difficult sector to reach is the transport sector and the truck drivers. You can read more about chokepoints and hotspots in the respective article. A key intervention in this area is obviously the empowering of sex workers, so that they can insist on condom use.

Though US PEPFAR funding excludes any activity related to sex workers in the region, Hivos fully supports NGO's that acknowledge the difficult, abusive and risky conditions of sex workers and help them to empower.

Finally, the aim of this publication is to motivate, to encourage organisations and companies to talk openly about AIDS, to acknowledge its existence and treat it like any other chronic disease. If you haven't developed a workplace policy yet, or if you have that unfinished draft somewhere in your drawer, then read this book as it will give you inspiration and motivation on how to respond to the challenges of HIV on your shop floor. We hope that the experiences shared in this book will convince you that in the end, your organisation will benefit.

Corina Straatsma

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CHAPTER 1

Why Mainstream HIV And AIDS In The World Of Work?

by Ngoni Chibukire

There is plenty of evidence that the epidemic is already impacting negatively on the Gross Domestic Product (GDP) of African countries and on the bottom line of private sector business. According to a World Health Organization (WHO) report, a 20% adult HIV infection rate translates into an annual reduction of 1% of GDP. The World Economic Forum on Global Health (2005) suggests that after two decades, HIV affected economies will be 20-40% smaller than they would have been in the absence of HIV.

According to the 2006 study done by the Ministry of Small and Medium Enterprises (SME) Development in Zimbabwe, a single SME lost an average of 3,6 days in a month because of workers attending funerals. About 75 percent of the 2,000 entities interviewed indicated that employees had taken leave to attend funerals and due to illness in the last 12 months. The study suggested that the average cost of time lost to each SME as a result of funerals, illness and absenteeism was estimated at Z$3,8 billion over the last 12 months. Yet if you asked the owner of any SME if she could afford to spend even a quarter of this figure on a workplace HIV programme, she would probably think you were making a joke.

Although there are many NGOs working with the private sector in the region, the response from this sector remains disappointing. Evidence has shown that South Africa is the only country that has made significant progress in providing any meaningful workplace response to the epidemic, but even here, this is mostly limited to large employers. It is assumed that

this is because they have the financial resources to support such programmes. Large employers generally provide their employees with comprehensive medical insurance schemes that include treatment of chronic diseases, including HIV related illnesses. By contrast, SMEs tend to perceive HIV programmes as a significant cost item and are not in a position to include them as budget line in their annual budgets, assuming they have such a thing. Yet as we have seen above, the actual overhead cost of not having workplace programmes is enormous.

Given the severe impact of the epidemic in the region, it makes business sense for all workplaces - large, medium and small - to mainstream HIV in their day-to-day activities. This will help reduce or mitigate the impact of HIV amongst the most productive segment of the population. The multimillion dollar questions around this concept of mainstreaming are:

- How is HIV mainstreaming done?
- How is it financed?
- Is it sustainable?
- Who should be involved?

Mainstreaming is not a new concept as such but its application in the area of HIV is fairly recent. People have talked about 'gender mainstreaming', mainstreaming natural resources in sustainable national growth and development programmes', 'mainstreaming business practices within a globalised economy' and so on. The mainstreaming of HIV can be done at global, regional, national or micro (enterprise) level. For most organisations, the entry point in mainstreaming HIV is through the development of an HIV workplace policy, but this is not the end of it. The policy should be implemented effectively and in a timely fashion in order to make a mark.

Simply defined, HIV mainstreaming is the integration of HIV into organisational operational strategy, work plans and day-to-day activities, in other words, bringing HIV issues and responses to the centre of the organisational agenda. This means taking the HIV epidemic as both an endogenous and an exogenous factor that negatively affects the production process or service delivery of an organisation or company.

In order to assess the impact the epidemic is having on the business, companies should first conduct a situational analysis. This will provide information on how the organisation is being affected by the disease, how the operations of the organisation may be aggravating the situation and what can be done to mitigate such impacts.

Mainstreaming has two domains; the internal domain, in this case the workplace, where staff risks and vulnerabilities to HIV infection are addressed; and the external domain, where the organisation is involved in HIV interventions outside the company gate, i.e. with local communities or national programmes. In supporting organisations in this process, SAfAIDS applies a 3-2-1 approach to mainstreaming HIV and AIDS. This approach is explained in Figure 1.

Three questions need to be asked when considering mainstreaming HIV into all aspects of lives and work:

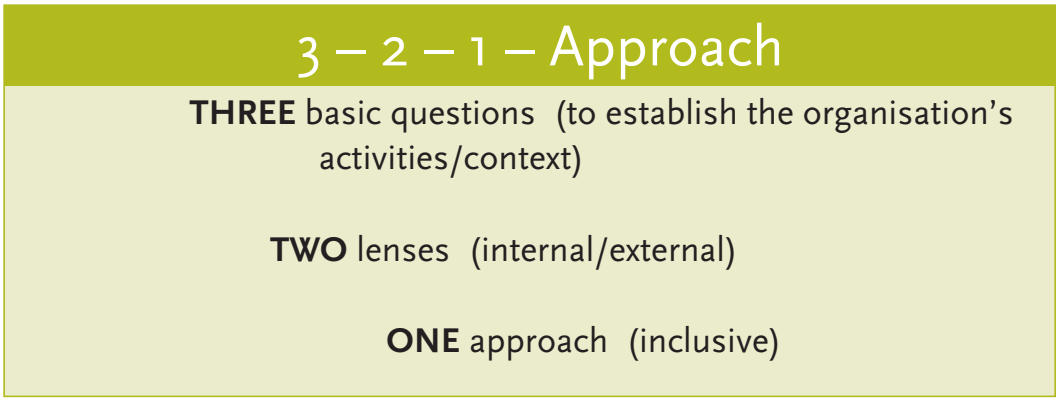
1. How does HIV and AIDS affect your organisation?
2. How does HIV and AIDS affect your work (projects and programmes)?
3. How do the efforts of your organisation affect the HIV epidemic?

Two domains are involved in mainstreaming HIV. Here, issues include:

- Internal integration (developing HIV workplace policies and programmes for staff)
- External integration (incorporating HIV issues into the core activities of the organisation)

One approach to mainstreaming HIV requires active participation and consultation among key stakeholders to create the spirit of ownership, commitment and sustainability that leads to impact. In developing policies and programmes it is important to involve all layers of employment from shop floor to top management level. Polices and programmes should not be imposed on employees; rather everyone should be involved in and committed to the process. This will ensure successful implementation of the policies.

Figure 1



How To Internally Mainstream HIV At Organisational Level

The entry point to mainstreaming HIV is the development of effective HIV personnel policies and programmes. This can be done at government department, ministerial, sector or enterprise levels. The process of policy development is the same wherever it is done - what differs is the organisational culture and ethics.

The main thrust of a workplace policy that addresses HIV is to encourage the prevention of further HIV infection among the workforce, to reduce stigma and discrimination and

to promote and preserve the human rights of people living with HIV. However, a comprehensive programme will do much more; it will prolong the working lives of HIV positive employees (by giving them access to treatment and encouraging positive living), leading to reduced staff turnover, training costs and absenteeism, as well as improved service delivery and productivity.

Developing an HIV workplace policy should not be a linear process. The stages involved depend on a number of factors such as organisational culture, number of employees and the knowledge and attitudes of employees with regard to HIV related issues. These will be revealed through the baseline assessment. Usually policy precedes workplace prevention but there is no harm in establishing HIV prevention, treatment, care and support programmes before developing policy. However, with the current increased emphasis on access to treatment, it is crucial for organisations to have their policy clearly established in black and white. Table 1 shows the key elements of a workplace policy development.

Table 1

Key Component	Key Programme Activities
Situational assessment	• Definition of survey questionnaire and collection of data • Data analysis to reveal the impact of HIV on the organisation and assess possible interventions
Prevention programme	• Condom promotion & distribution • STI diagnosis & management • IEC materials • VCT promotion • Management of opportunistic infections such as tuberculosis. • Integrate TB programme in all workplace health programmes.
Treatment, care and support programme	• Encourage employees to be on medical aid scheme. • Provision of ARVs • Home based care programme • Nutritional support • Psychosocial support
Non-discrimination	• No unfair dismissal based on HIV status • Equal access to employment benefits and training • Establish clear grievance handling procedures.
Disclosure and confidentiality	• Encourage voluntary disclosure. • Guaranteeing confidentiality of all private information

In order to ensure that the policy is properly developed, implemented, monitored, evaluated and regularly reviewed, it is important to establish a focal point person or to set up an HIV committee. This committee should represent the interests of all levels of employment and include a senior person who can facilitate decision-making processes.

After finalisation and adoption of the policy, it is important for the committee to develop an agreed, concrete action plan that will ensure and enhance effective implementation, monitoring and evaluation of the programmes. An effective monitoring and evaluation system is an open and reflective communication process that will serve to improve practice and strengthen both the programme and the sense of ownership.

Programmes require both financial and human resources for them to yield the intended positive results. Companies can demonstrate commitment by effectively budgeting for HIV and AIDS in the world of work and also by allowing employees time to participate in such activities. Other elements such as education and awareness raising are not as expensive as most organisations or companies think and assistance is available to the creative employer from various sources, as can be seen in some of the examples in this book. The only major cost item will be the provision of medical insurance cover that provides ARVs. Besides budgeting, companies can also fundraise through other activities such as dinner dances and through submitting proposals to donors like the Global Fund.

Challenges In Implementing HIV And AIDS Workplace Programmes

Cost

There are numerous challenges that organisations or companies can encounter in programme implementation. Top on the list, with the exception of a few blue chip listed conglomerates, is lack of financial resources to procure antiretroviral drugs for employees who need them. This is where the existing health insurance and medical aid schemes that cater for ARV treatment become vitally important. Since employees are often reluctant to commit to paying for medical aid cover themselves, it may be a worthwhile investment for the employer to take on the full cost of providing medical aid cover. This may mean the difference between extending a productive employee's healthy working life, or contributing indirectly through sickness and leave benefits, staff training, funeral expenses and pension payments.

While continuity and sustainability of treatment programmes is a cause for concern, the situation is dynamic and treatment possibilities and access are improving all the time. A linked concern is the post-employment phase where an employee has been fired, or has willingly resigned or reached retirement age. Some companies automatically stop providing treatment or medical aid cover and this may affect employee take-up of such benefits. This is an important consideration in the implementation of workplace programmes.

Time

Most employers find it difficult to allow time to conduct HIV activities at the workplace, mainly because of production concerns. It is important for top management to show their commitment to the programme and allow employees to run workplace programmes on HIV within stipulated times. Prevention is much better than cure. It must be recognised that such activities are critical in order to minimise the long-term impact of HIV at the organisational level.

Stigma and Discrimination

A major concern among employees is fear of victimisation and subsequent loss of jobs or employment due to their HIV status. This does sometimes happen and there have been several cases within the region, some of which have been successfully prosecuted in the courts. Chapter 2 gives examples of successful cases brought against employers in Botswana, while Chapter 3 gives an overview of the legislative situation in the region. The work situation should create a conducive environment free of stigma and discrimination, which encourages openness. Employers should make it clear that all employees have equal access to employment benefits and to training and promotion opportunities. Where an individual is unable to continue in a particular job because of illness, the employer should seek to find appropriate alternative employment where possible. Being HIV positive does not mean that one cannot be productive, and effective ARV treatment can help return a previously unproductive employee to being a full member of the workforce.

Establishing workplace prevention & awareness often costs less than employers think. According to a study carried out in South Africa in 2000, it was actually more expensive for a company to financially support an employee to do an MBA programme than to conduct an HIV awareness session for all employees.

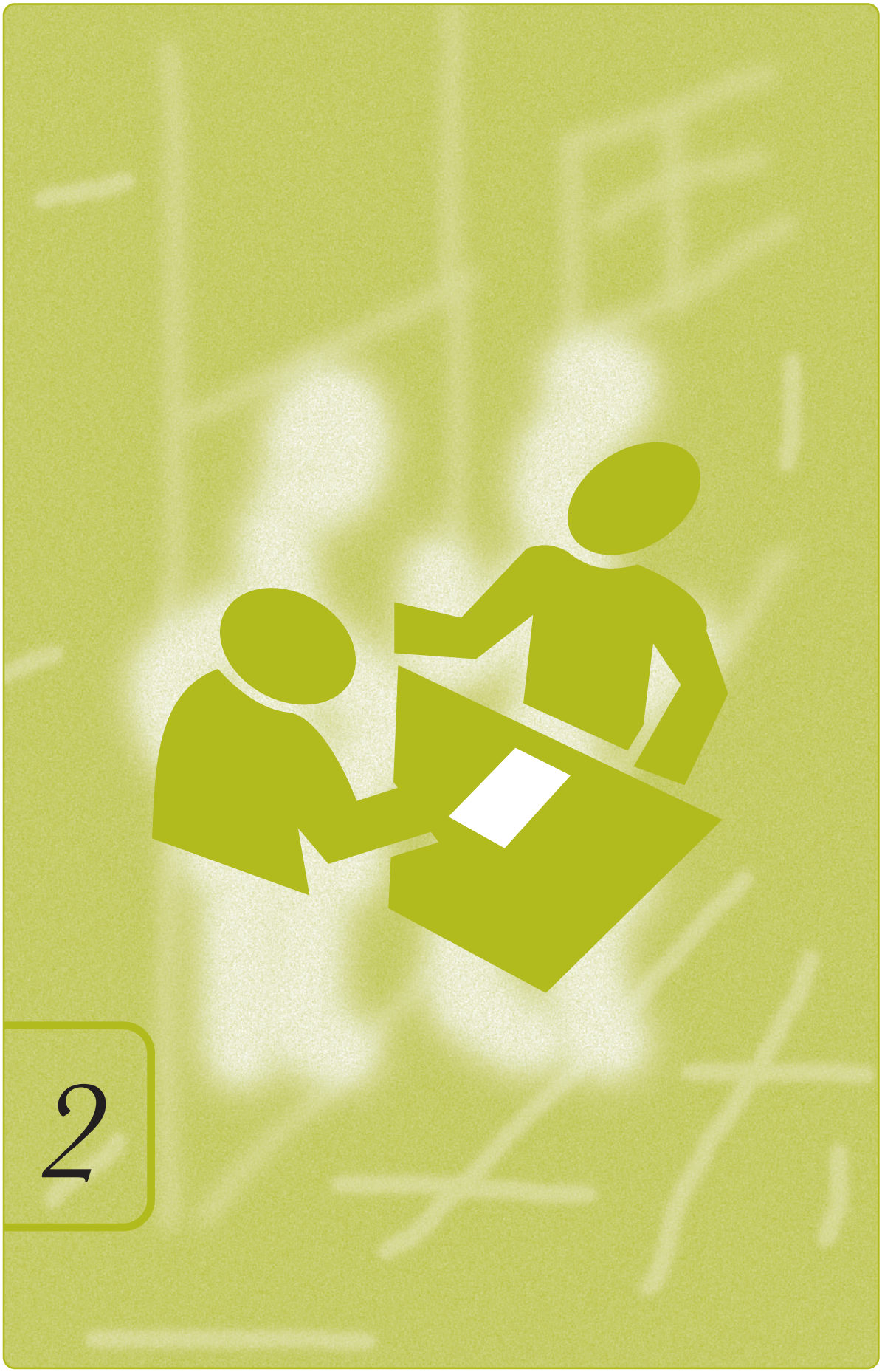
Dealing effectively with HIV demands that everyone begins to think outside the boxes of production versus costs, work versus leisure and to develop a wider, more inclusive understanding of the employer/employee relationship.

Lack of An all Encompassing Workplace Health Programme

In as much as organisations think that they have comprehensive HIV and AIDS programmes in the world of work, sometimes these programmes are very limited in nature because they attempt to deal with HIV in isolation to the exclusion of other employee health concerns. Tuberculosis (TB) is a serious health condition in southern Africa, and those infected with HIV are much more likely to develop active TB if exposed. It is therefore critical for organisations to integrate TB and other communicable diseases into their HIV and AIDS programmes so that the programmes are holistic in nature. HIV and AIDS should be treated like any other life threatening illnesse and many organisations are slowly shifting from discussing HIV issues alone to wellness programmes that focus on the individual in totality.

Section 2.

HIV And AIDS In The Regional Work Context



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CHAPTER 2

HIV And AIDS And Employment Rights

by Christine Stegling

Introduction

In recent years the HIV and AIDS landscape has developed rapidly. With the advent of antiretroviral treatment programmes in many parts of the developing world, policy issues with regard to care and treatment have focused on equitable access to quality treatment. The availability of treatment has also resulted in a change in understanding of HIV at the workplace. We no longer think about how to care for people who have become too ill to work but instead are focusing our attention on how to create an accommodative legal environment that ensures the continuous and meaningful participation of people infected with HIV in the labour force.

The starting point of any discussion on HIV and the world of work needs to be the understanding that for many people infected with HIV the most severe experience of discrimination is at the workplace. This experience of discrimination violates people's right to work and ultimately disenables them from looking after themselves and their families if discrimination results in dismissal or non-employment due to HIV infection. These realities cannot be over-emphasised since they negate the attempts by governments, such as the government of Botswana, to enable people to continue contributing to national productivity.

The following article is a discussion of employment rights with regard to HIV and AIDS in the context of Botswana. The discussion highlights existing legal provisions that in some form or other exist in the various countries in the region, points out gaps and finally makes

reference to some of the litigation that has been undertaken with regard to discrimination at the workplace in Botswana.

What Employment Rights?

Most countries in the region have no specific legislation on HIV and employment and Botswana is no exception. The notable lack of legislation however should not be understood to mean that people living with HIV are not protected from discrimination at the workplace. The recognition and protection of key human rights principles applies to the workplace as it does to all other areas of life. The key human rights to consider at the work place are:

- the right to privacy
- the right to be free from discrimination
- the right to liberty and security of the person
- the right be free from inhumane and degrading treatment
- the right to health
- the right to work under equitable and satisfactory conditions and to receive equal pay for equal work

Of particular interest to this discussion are the right to be free from discrimination and the right to confidentiality. The right to non-discrimination ensures that HIV positive workers receive the same opportunities and treatment as non-infected workers with respect to hiring, promotion, training, benefits, workplace conditions, retirement and termination of employment. The right to non-discrimination and the right to confidentiality are inextricably linked and are the rights that are most often violated at the workplace. Public campaigns and prevention programmes often encourage employees to disclose their HIV positive status to their employers, arguing that such openness will enable employers to accommodate the infected worker's needs. This is theoretically true but such openness is based on the assumption that strict confidentiality applies at the workplace with regard to employees' medical records. If confidentiality is not protected, such openness leads in many cases to discrimination. Furthermore, arguments can be made that nobody can realistically expect workers to be open about their HIV status in the absence of clear legislation ensuring non-discrimination at the workplace as much as in all other spheres of life.

In Botswana, existing legislation does protect employees with chronic illnesses, even in the absence of specific HIV related legislation. For example, the Bill of Rights in the Constitution of Botswana, the Employment Act, the Trade Disputes Act and the Public Health Act do provide legal guidance regarding employment issues and can be applied to protect the rights of HIV infected employees. In addition to these legislative provisions, Botswana's labour court, the Industrial Court, is a court of equity which allows the court to consider fairness beyond the limitations of the law. To assess fairness, the court may, for example, consider domestic or international guidelines such as conventions of the International Labour Organisation (ILO).

The core principle of the ILO to consider in this context is that of reasonable accommodation for employees who have chronic illnesses. Reasonable accommodation is defined as 'any modification or adjustment to a job or to a workplace that is reasonably practicable and will enable a person living with HIV and AIDS to have access to, or participate or advance in employment'. Such reasonable accommodation is based on a mutual agreement between

the employer and the employee to accommodate the employee's legitimate leave requirements and reduced capacity to continue working due to illness. Such an arrangement will have to balance the employee's right to work with the employer's right to do business. Once more, reasonable accommodation remains important in the era of increased access to antiretroviral treatment since employees may require time off to go for medical check-ups and to collect their medication. Again, the employer can only reasonably accommodate the employee's needs if they are aware of such needs which often requires the employee to disclose their medical condition.

HIV In The Courts In Botswana

Pre- and Post Employment HIV Testing

In 2003, Botswana saw HIV-related litigation at the Industrial Court for the first time. Two claims were brought to the court against the same employer, the Botswana Building Society, and both were based on the institutional policy of the employer to carry out pre-employment HIV testing. The cases received much public attention and ignited a heated public debate about the lack of legislation in the employment sector. While activists and legal experts had warned for some time that the lack of legislation to protect HIV infected employees and potential employees was worrisome, most people, including government departments, only fully appreciated the urgent need to legislate after these issues had been discussed at the courts. It is therefore important to examine the two cases in some detail.

The applicant in the first case brought a complaint to the Industrial Court regarding unfair dismissal. The applicant had been offered a position as a security guard by the Botswana Building Society. As a requirement for employment, he was asked to undergo a medical examination which he passed before entering into employment. Three weeks after starting his job, the applicant received a letter by his employer, requesting him to undergo an HIV test in addition to the medical exam that he had already passed. When the applicant returned to the doctor who had administered the initial medical exam, she refused to test him because she doubted the voluntary nature of his request. The applicant instead undertook the HIV test at a different doctor who did not inform him of the results but sent them directly to the employer. Subsequently, the applicant was served with a termination letter which also included his HIV positive test results.

The court found that the dismissal had been procedurally and substantively unfair, mainly because the request for the HIV test was made almost three weeks after the employee had started work and after he had already passed a medical exam. The request amounted to '*compulsory post-employment HIV testing*' which was in breach of the employment contract. The court also found that the dismissal based on the applicant's HIV status did not constitute an acceptable reason for dismissal under the Laws of Botswana. The court awarded a compensation of six months wages but the defendant challenged the part of the ruling that identified the HIV test to be a post-employment requirement at the Court of Appeal.

The higher court agreed with the employer and ruled that the testing requirement and the subsequent dismissal based on the HIV positive status of the employee were not substantively unfair. Remarking on the fact that the lower court had made reference to the National Policy on HIV/AIDS, the Court of Appeal noted that the policy '*had never been translated into law and had no statutory authority. While it had strong moral persuasive force, [BBS] was not bound to follow it and had the right to make its own decisions regarding recruitment and its requirements in respect thereof*'. In the

initial Industrial Court judgment, the judge emphasised the urgent need for government to translate its supportive and protective policies regarding HIV and employment into legislation in order for the discrimination of people living with HIV and AIDS to be eliminated.

This Court of Appeal judgment has never been challenged and since no new legislation has been introduced, it is legal to decide as an employer that one of your requirements for employment may be a negative HIV test. For human rights activists and people who are often mediating and, in fact, legally representing people living with the virus, this situation is unacceptable.

Human Rights in the Workplace

- the right to privacy
- the right to be free from discrimination
- the right to liberty and security of the person
- the right be free from inhumane and degrading treatment
- the right to health
- the right to work under equitable and satisfactory conditions and to receive equal pay for equal work

The second case against the same employer centred around the very same issues. In this instance, a woman had been employed as a security guard. Six months into her employment, she was requested by the Botswana Building Society to undergo an HIV test. She responded to this request by indicating that she was under no obligation to share her HIV test results with her employer. Shortly after her refusal to test, she was dismissed. The Industrial Court found that the dismissal was procedurally and substantially unfair, mainly because the applicant was dismissed during her probation period. Furthermore, the judge noted that *'the instruction to undergo an HIV test was irrational and unreasonable to the extent that such a test could not be said to have been related to the inherent requirements of the job. The applicant was (…) entitled to disobey the order and/or instruction'*.

The judge went a step further and examined whether and how the constitutional rights of the applicant had been infringed upon or been violated. He asserted that the applicant's right not to be subjected to inhumane and degrading treatment had been violated since the request to undertake an HIV test was made in a compulsory manner and was not based on a voluntary choice accompanied by informed consent.

The judge further found that the behaviour of the employer had violated the applicant's right to autonomy which is protected by the right to liberty. The application of the constitution to the context of HIV and AIDS marks a new legal understanding of the situation. The judge noted the responsibility of the judiciary in as far as:

> *'(…) a proper application of the Constitution can serve as a potent source of a sober critique of the existing arrangements and/or practices that serve, often unwittingly, to promote stigma and prejudice about HIV and AIDS at the workplace. (…) In the context of the reality of HIV and AIDS afflicting our society, rampant ignorance of the syndrome, the consequent problems of stigma and prejudice, it is imperative for the courts to interpret the constitutional provisions purposefully, as far as the language permits, and in a manner consistent with the contemporary norms, aspirations, expectations and the sensitivities of the people of Botswana as expressed in the Constitution (…)'*.

This judgment was not challenged by the applicant at the Court of Appeal and therefore the higher court has not considered the constitutional issues. While the judge's interpretation of the constitution notes the inherent protections for people living with HIV, other judges are not required to follow his interpretations of the constitution without a binding pronouncement from the Court of Appeal.

Absenteeism

While testing is one of the most hotly debated issues when it comes to HIV at the workplace, absenteeism is equally disputed. In 2004, the Botswana Network on Ethics, Law and HIV and AIDS took another workplace related case to the Industrial Court. This time the employer dismissed the applicant due to poor attendance. The applicant had been absent from work for almost 200 days over a period of five years. Once he had used up all his paid leave and sick leave, he requested unpaid sick leave which he was granted. At the beginning of 2004, the employer suggested that the applicant see a private medical doctor to assess the applicant's fitness to work. The day after that suggestion was made, the applicant disclosed his HIV positive status to the employer and after his disclosure the employer dismissed the applicant for poor attendance over a period of three years.

The court ruled that the dismissal had been substantially unfair. The judgment noted that the employer had shown the highest level of compassion and had tolerated the applicant's absenteeism for a long period of time until the day the employee had disclosed the reason for his absenteeism being his HIV positive status. Since the applicant had not received a warning, his dismissal was also procedurally unfair. The court awarded compensation of six months wages and made an unambiguous statement that dismissal solely on the basis of the HIV positive status of the employee without having established the capacity to work lacks rational foundation and is unfair.

While these were the only HIV related cases that have been heard at the courts, BONELA hears many more cases of discrimination each year. A majority of cases that come to the legal clinic are workplace-related and most of them are resolved through mediation.

Fighting Stigma And Discrimination In Botswana

BONELA recognised the need for appropriate legislation on HIV and employment as early as 2002 when a first workshop was organised on the subject. Participants at this initial event ranged from representatives of labour organisations, to government and employer organisations. Following from these first discussions, BONELA partnered with the Botswana Federation of Trade Unions and organised a three day workshop which was assisted by the International Labour Organisation and aimed at developing a policy document that would later inform legislation on HIV and employment. The policy framework addressed nine key principles:

Policy framework for legislation on HIV and employment

1. Employment protection and job security of infected and affected workers;
2. Prohibition of testing for HIV and AIDS for purposes of recruitment, promotion or other benefits;
    - Confidentiality of personal information including medical information;
    - Non-discrimination of HIV infected workers;
    - Protection of vulnerable groups;

- Care and support for HIV infected workers;
- Gender equality and empowerment;
- Prevention of HIV at the workplace; and
- Provision of education and awareness programmes.

Participants developed key strategies to implement these principles and utilised existing government policies and international labour policy documents to reference the document. While participation covered all key stakeholders, BONELA realised that greater buy-in was needed from the business community and therefore organised two breakfast meetings for employers at which they critiqued the document and contributed their ideas. In order to ensure that workers from rural areas would also have an input into the policy document, another workshop was held in Ghanzi (700km from the capital, Gaborone) to discuss HIV and employment with union members and non-unionised farm workers. The document was finally endorsed by the Ethics, Law and Human Rights Sector of the National AIDS Council and has provided the background for the National Policy on HIV/AIDS and Employment that is currently discussed by government. The Ministry of Labour and Home Affairs was charged in 2005 to produce such a policy in order to inform legislation. BONELA, as one of the interested parties, has been involved in this process of policy formulation and it is hoped that legislation will be drafted in the near future.

Policy framework for legislation on HIV and employment

1. Employment protection and job security of infected and affected workers;
2. Prohibition of testing for HIV and AIDS for purposes of recruitment, promotion or other benefits;
   - Confidentiality of personal information including medical information;
   - Non-discrimination of HIV infected workers;
   - Protection of vulnerable groups;
   - Care and support for HIV infected workers;
   - Gender equality and empowerment;
   - Prevention of HIV at the workplace; and
   - Provision of education and awareness programmes.

BONELA continues to lobby government to enact non-discriminatory legislation that will protect workers at their workplaces and will ultimately lead to more openness and less stigma at the place where most people spend the majority of their time; the workplace. The legal clinic continues to assist clients who have experienced discrimination, using existing legislation which is undeniably limited.

While litigation is an important tool to bring about legislative changes, advocacy remains imperative to create public debate around critical issues with regard to HIV and AIDS. During the time of the two BBS cases, BONELA and other civil society organisations issued press statements and publicly voiced their concerns about the company policy with regard to pre-employment testing. BBS reacted in a defensive manner initially but bowed to the public pressure created by 'naming and shaming' them and eventually paid the settlement in the second case without challenging the judgment at the higher court as they had done with the first case.

Conclusion

While Botswana undeniably has gone a long way in addressing HIV and AIDS, there has been a definite lack in the provision of a non-discriminatory legislative framework. Government has emphasised the 'normalisation' of HIV, treating it just as any other infection, but this approach will only be successful if people believe that their dignity and livelihood will be protected. In June 2006, governments from all over the world gathered in New York to renew their commitment to respond to HIV and AIDS. One of the fundamental principles agreed at the first United Nations General Assembly Special Session on HIV and AIDS was the application of a human rights approach in response to HIV. In the 2001 Declaration of Commitment, member states agreed that

> *'by 2003, [they would] enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment (…) while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic'.*

Almost every policy in the public and private sector makes reference to 'fighting stigma and discrimination' but such policies have never enjoyed legal back-up and, in fact, as the cases discussed above illustrate, the lack of adequate legislation has led to open discrimination of people living with HIV and AIDS. It is unacceptable that it is legal for employers to screen prospective employees for HIV and to deny work opportunities to those that are found to be HIV positive. Such practices undermine the public's trust in government programmes that are promoting the 'normalisation' of HIV and treatment programmes that are aiming at making HIV a manageable infection, such as the antiretroviral treatment programme. It is high time that all the countries in the SADC region enact appropriate legislation that prevents HIV infected workers from being denied entry to the workforce, or dismissal from it.

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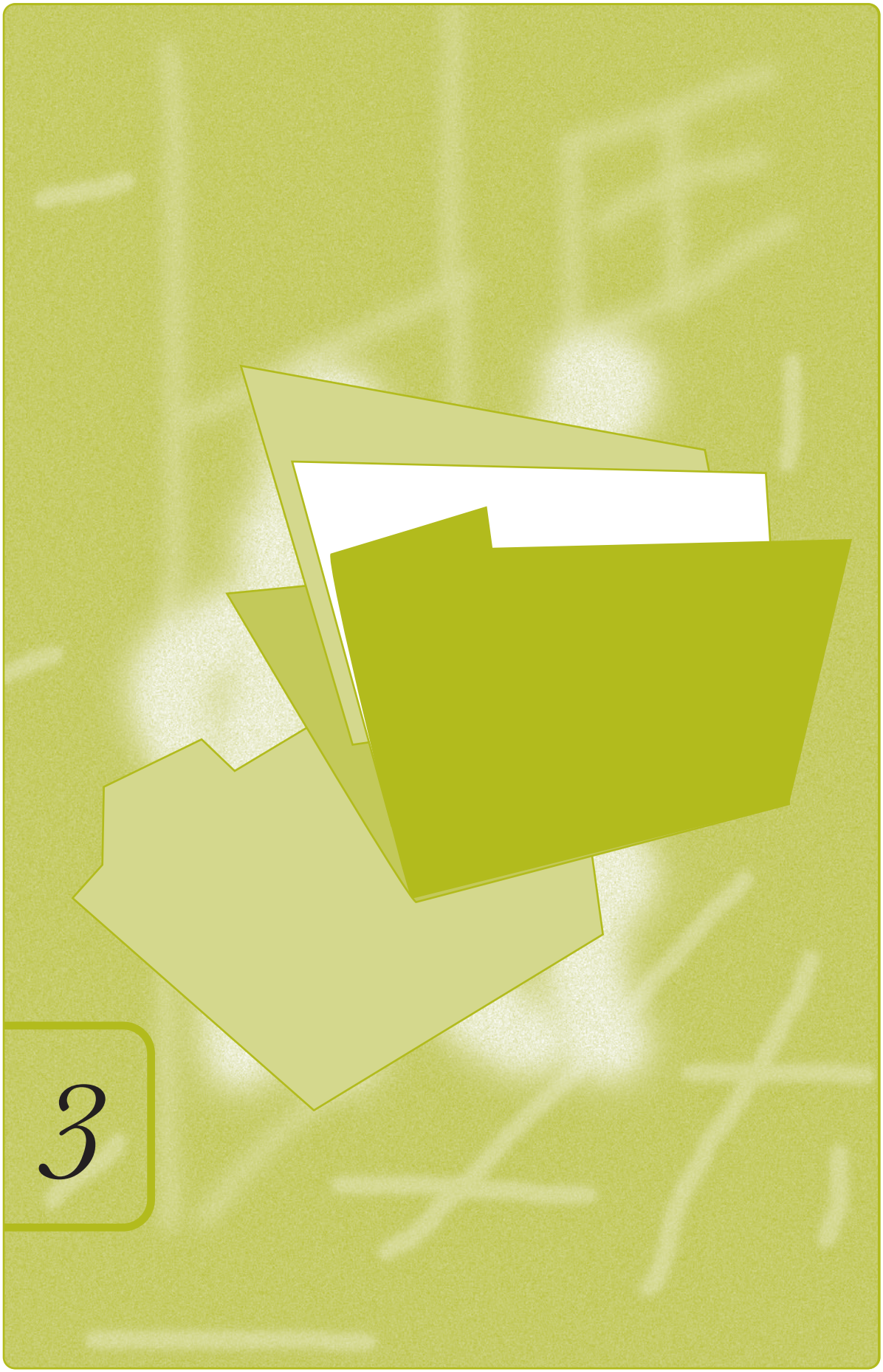

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CHAPTER 3

HIV AND AIDS Policies And Legislations In The World Of Work: The Southern Africa Context

by Evelyn Serima and Cecile Balima

Introduction

The importance of a legislative framework for establishing and defending basic principles concerning HIV and AIDS was recognised in June 2001, when 189 Member States at the Special Session of the United Nations General Assembly on HIV and AIDS (UNGASS) adopted, without reservations, the Declaration of Commitment on HIV and AIDS. The Declaration contains the commitment of leaders of Governments and States to take action on HIV and AIDS in a number of areas.

Paragraphs 58 and 69 of the Declaration aim at implementing legislation to eradicate HIV and AIDS discrimination and to ensure the enjoyment of Human Rights and fundamental freedoms by people with HIV and AIDS, as well as other vulnerable groups affected by the epidemic.

Among others things, the UN Declaration of Commitment, in its paragraph 69, urged member states *"… by 2003 to develop national legal and policy frameworks that protect, in the workplace, the rights and dignity of persons living with and affected by HIV and AIDS, and those at greater risk of HIV and AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV and AIDS and the workplace".*

One of the best ways to begin the response to the human rights implications of HIV and AIDS is to enact laws and legal provisions and develop policies at national and enterprise level that protect the rights of those infected and affected; this is particularly true if

stakeholders want to reduce women's particular vulnerability to HIV. Studies have also been published on the regulatory frameworks that can prevent further spread of infection and protect decent working conditions for persons living with HIV and AIDS. Of course once the relevant laws have been drafted, government and civil society then need to ensure that the laws are enacted in a meaningful way that impacts positively on the lives of individuals.

Since southern Africa exhibits some of the highest global HIV prevalences, it is reasonable to expect the governments of these countries to have engaged in a serious and determined manner to transform or strengthen their legal systems' response to the epidemic. While all heavily infected countries in SADC have adopted multi-sectoral national HIV and AIDS **policies** (some have gone further and developed sector-wide policies, e.g. transport) many are yet to adopt **legislation** on HIV and AIDS, and particularly, legislation on HIV and AIDS in the workplace.

This chapter gives examples of the legal and policy responses of some of the countries in the southern Africa sub-region. It also highlights key regional and international instruments and conventions that facilitate the rights-based approach in response to HIV and AIDS.

Policies on HIV and AIDS

Policies are the foundation of meaningful and sustained responses to the HIV and AIDS pandemic as they provide an operating framework for action, help plan resources, structure commitment, and give direction for action to service providers. Policies therefore inform existing laws and spell out the ethical and legal implications of HIV and AIDS for those infected and affected. They also include principles of human rights.

Policies provide the key pillars for the country's strategies and position on specific issues and approaches, such as co-ordination, resources, public awareness, issues of discrimination, blood safety, prevention, care and support. Often there are specific policies regarding specific groups or issues, such as on orphans and vulnerable children, or national policies and guidelines, such as those on rape, that are supported by Criminal Law measures to protect the survivors.

Status Of National Policies On HIV And AIDS In The Region

All SADC countries have to date adopted national policies on HIV and AIDS. Such policies have been developed against the backdrop of the devastating impacts of the pandemic in the sub-region. The aim of developing national policies and labour codes is to create a conducive environment for action and the prevention of further HIV infection. Sector-wide and enterprise-level policies have been developed to promote action specifically for the world of work to protect those workers infected and affected by HIV and AIDS.

Characteristics Of National Policies

A review of the policies in the sub-region reveals similar characteristics in their development processes, purpose and content. The development process is invariably participatory and consultative. The policies emphasise a multi-sectoral approach to the epidemic. Thus, with government leadership, they advocate for the inclusion of civil society, the private sector, donors, people living with HIV and AIDS (PLHIV) and other partners such as researchers

and academics. All focus on the human rights approach to addressing stigma and discrimination and emphasise the need for confidentiality and informed consent on testing and counselling for HIV.

The policies generally are aimed at:

1. Motivating for and sustaining political commitment;
2. Expanding the national response to the HIV and AIDS pandemic with a focus on prevention, treatment, care and support, mitigation of the impact of AIDS, and more recently, treatment access;
3. Improving co-ordination and the constitution of National Co-ordinating Councils or Commissions;
4. Ensuring public education;
5. Empowering women and children and other vulnerable groups;
6. Safeguarding human rights;
7. Promoting related research and
8. Motivating for a multi-sectoral approach in responding to the pandemic.

Below are some examples of national policies in the sub-region.

Botswana

The Botswana AIDS policy emphasises a multi-sectoral and human rights approach to addressing issues of stigma and discrimination against PLHIV. Key elements of the policy include prevention, care and support, and policy advocacy at all levels. The policy also spells out legal issues including those relating to confidentiality, informed consent and testing for HIV.

The policy on 'Orphans and Vulnerable Children' facilitates the provision of resources and access to free education for children orphaned by AIDS. The Public Service Code of Conduct lays out the rights and obligations of public service management and employees with regard to HIV and AIDS.

Lesotho

The Lesotho national policy on HIV and AIDS spells out the major pillars for the expanded national response; political commitment, a multi-sectoral approach, the need for co-ordination, information, education and communication, and comprehensive care and support. The policy provides for, among other issues, specific guidelines on HIV counselling and testing, human rights and non-discrimination, research and surveillance.

Mozambique

The key issues for policy implementation for Mozambique are provided in the AIDS Law, Act 5 of 2002. The Act clearly articulates the general principles that protect employees against unfair discrimination on the basis of HIV status. The law prohibits pre-employment and mandatory testing, protects employees' rights to confidentiality, equality of opportunity, a safe environment and employment.

South Africa

The national policy in South Africa has been revised a number of times to improve upon and expand the national response to the growing crisis. The policy focuses on prevention

of spread and the promotion of safer sexual behaviour, promotion of human rights and non-discrimination, provision of treatment care and support, research, monitoring and evaluation. Various legal instruments support the policy principles and the strategic plan provides the guidelines for implementation. The country has also developed a national strategic framework to protect children infected and affected by HIV and AIDS and a national policy and guidelines on rape and survivors of sexual offences.

Swaziland
The main objectives of the National General Policy on HIV and AIDS and guidelines are to maintain a sustained political commitment at all levels, support an expanded national response and maintain a strong co-ordination structure. It also stresses the need for access to information, education and communications materials, and for the protection and empowerment of women and other vulnerable groups.

Zimbabwe
The Zimbabwe national policy guides the individual on actions required to address the epidemic and provides guidelines based on values, and on human rights. The guiding principles relate to prevention, and management of sexually transmitted infections, safe blood transfusion, condom promotion, testing for HIV and counselling, treatment, care and support. The policy addresses the human rights issues relating to mandatory testing, confidentiality and partner notification, sexual health and gender violence.

Legislation On HIV And AIDS

Current Legal Frameworks Supporting Workplace Programming

A variety of legal initiatives can be used to respond to HIV and AIDS in the world of work, including; AIDS-specific laws; labour legislation, anti-discrimination and human rights legislation; disability laws and insurance laws. Countries with laws on HIV and AIDS benefit from having comprehensive, uniform and enforceable provisions. The ILO recognised that laws concerning the world of work provide an ideal channel for the fight against the spread of the virus and against the damaging myths surrounding the disease.

In recent years, several countries have adopted or revised legislation specifically to cover HIV and AIDS and employment issues. In others, especially countries with common law systems, courts have used human rights provisions in existing legislation (such as the Constitution) to confer protection to PLHIV and to those around them whose lives are changed by HIV and AIDS.

Specific HIV and AIDS laws

These allow for a comprehensive and co-ordinated approach as most of the provisions covering AIDS issues are included in a single document, it is easier to understand the protection provided. In general, HIV and AIDS laws can be more detailed and include definition of fundamental issues, so they are not left to the interpretation of the courts.

Labour legislation

This is widely used to both regulate employer-employee relationships and establish the framework for workers and employers to define their relations through collective patterns of interaction such as collective bargaining. Legislation serves to recall and guarantee

fundamental principles and rights at work, where much discrimination occurs. An increasing number of countries, especially in Africa and in the Caribbean, include provisions prohibiting discrimination and mandatory HIV testing for the purposes of employment, in their labour legislation. Others adopt legislation or Codes of conduct that specifically address HIV and AIDS and employment issues; collective agreements are also used to protect the rights of workers and to support the adoption of workplace policy on HIV and AIDS. Mozambique, South Africa and Zimbabwe are examples of countries that have developed HIV and AIDS specific legislation.

Anti-discrimination and human rights legislation

This has the specific objective of ensuring the protection of fundamental rights and freedoms. Complaints under these laws are often filed before specialised courts that are well versed in discrimination and rights-based issues. Anti-discrimination and human rights legislation does not aim primarily to punish the perpetrator of a prohibited act but rather to educate and provide remedies that fully repair the prejudices caused by the violation of a right. In addition to compensation and reinstatement in employment, innovative remedies such as workplace education on non-discrimination can be obtained.

Disability laws

The Disability laws aim to protect persons with a disability against discrimination to ensure equal treatment and as much as possible, to integrate persons with a disability into society. These laws often contain detailed provisions on the obligation of employers to make reasonable accommodation (adapting hours, tasks and working space), to help persons with disabilities to remain in work as long as possible. They can be very useful in providing protection for persons who are suffering from HIV-related illness but are still able to work. The extent of the protection will of course depend on the definition of disability given in the law, and its interpretation by the courts.

The exclusion of PLHIV from **life and health insurance schemes**, by either non-eligibility or exclusion from benefit, is a common practice worldwide. Indirect exclusion by charging unaffordable insurance premiums is similarly practised. Many PLHIV and their households find themselves without cover when they need it most. Numerous governments are struggling to come up with policies that can both reduce exclusion and ensure a viable and sustainable insurance industry.

All these legal instruments show that different regulatory frameworks can be used to eliminate workplace discrimination related to HIV and AIDS and ensure workplace prevention as well as social protection. The use of one type of instrument does not preclude the use of others. On the contrary, different provisions covering HIV and AIDS issues can be incorporated into labour, disability, anti-discrimination and human rights legislation. This multifaceted approach ensures that every issue is covered under a relevant instrument. Each country has to choose the regulatory framework that properly reflects considerations agreed at the national or regional level after consultation with social partners and other relevant stakeholders.

Particularly worrying are the **rights and status of women** as they become more affected in an environment of widespread inequalities including political, social and human security factors. In Africa, women represent 55% of all people with HIV and AIDS. Indeed, it is

women and girls who are increasingly bearing the brunt of the HIV and AIDS epidemic, not only because of their physiology, but above all because of the lack of power and decision making on issues relating to their sexuality, reinforced by their social and economic inequality. Therefore, the ability to address the HIV epidemic is inextricably linked to the ability to address gender inequality at all levels. One has to move beyond questions of health to address critical questions of poverty, development and human rights, and their interconnectedness with HIV and AIDS.

In addition, it is important to note that *dual legal systems* operate within many SADC countries. As a consequence of colonial rule in Africa, certain states provide for the recognition of various legal systems. Within these systems, customary and religious laws on the one hand, and the 'received' laws, based on the law of the former colonial state (English common law or Roman Dutch Law) on the other hand, co-exist in certain fields, including family and succession law.

Numerous customary laws and practices make women particularly vulnerable to human rights violations and therefore also to HIV infection. For example the practice of mandatory wife inheritance by a brother if a woman's spouse dies; 'cleansing' of virgins on reaching puberty through forced sex with a disguised male; customary courts treating adultery as a female crime only, or assigning greater penalties to the woman etc. compound women's vulnerability to HIV infection and serve as powerful driving forces of the epidemic. While in many instances, customary laws or practices are discriminatory or contrary to the principles of human rights, their value and weight for African communities explain why in an attempt to maintain order and deliver justice, countries are trying to strike an uneasy balance between these different kinds of law.

Both human rights and the law can play an important role in reducing women's vulnerability to the epidemic, if gender and gender equality concerns are incorporated into the laws, policies and programmes that address HIV and AIDS (prevention, protection, treatment and care). Also by addressing the status of women and girls more generally, as well as issues of masculinity in different cultural and national settings.

Some Selected Country Responses

Botswana
As in other countries in the sub-region, the Botswana law does not specifically address HIV and AIDS in the workplace, however some sections of its Penal Code criminalise sex work. It also moots greater punishment for HIV positive rapists. Employment case law in Botswana is discussed in chapter 2.

Botswana is currently working on their Labour Relations Act.

Mozambique
Mozambique (Act No.5 of 2002) prohibits discrimination against employees "with regards to promotion of rights, withholding benefits, all forms of exclusion, issues of testing and confidentiality and employment protection. It requires that employers provide AIDS education and pay for treatment. The law is comprehensive, but lack of capacity limits its enforcement.

Namibia
Namibia's National Code on HIV/AIDS and Employment and its accompanying guidelines protects against victimisation and stigmatisation. It adopts a ban on testing though there is no provision for enforcement.

South Africa
South Africa has extensive legislation on HIV and AIDS in the workplace. The Employment Equity Act (no 55 of 1998) prohibits discrimination on the basis of one's sero status and mandatory employment-related testing. The Promotion of Equity and Prevention of Unfair Discrimination Act (No. 4 of 2000) gives greater effect to the Employment Equity Act on prohibition of unfair discrimination on grounds of disability.

The Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993) provides for compensation of employees infected in the course of employment and the Medical Schemes Act (No. 131 of 1998) ensures inclusion of persons irrespective of inability to pay for contributions.

Zimbabwe
In Zimbabwe, the Statutory Instrument 202 of 1998 prohibits pre employment testing and unfair dismissal on the grounds of one's HIV status, protects confidentiality, and directs employers to provide workplace education. The Labour Relations Amendment Act (2002) prohibits discrimination based on a person's HIV status. The legislation makes it unlawful to disclose information on one's status without their consent. The act states that *"No employer shall require any employee and it shall not be compulsory for any employee to disclose in respect of any matter whatsoever in connection with his employment his HIV status."*

Figure 1

Legislation concerning HIV and AIDS in the workplace should, as a minimum, cover the following areas:

- Clear delineation of the purpose of the text and appropriate definitions;
- Basic right to non-discrimination at work;
- Ban on dismissal based on HIV and AIDS until medically unfit to carry out adapted work;
- Prohibition of non-consensual pre- and post-employment testing;
- Medical confidentiality;
- Prevention and containment of transmission risks;
- Workplace accommodation, in particular working time flexibility;
- Training and re-insertion options;
- Benefits, including early retirement options, medical and funeral coverage;
- Scope for negotiation on those issues;
- Grievance and disciplinary procedures;
- Implementation / enforcement bodies and links to existing labour inspection systems;
- Assistance for compliance and penalties for violation.

Regional and International Codes and Relevant Conventions

The SADC Code of Conduct on HIV and AIDS and Employment

The SADC Code was developed in consultation with member States and the assistance of the World Health Organization and the International Labour Organization (ILO). The Code serves as a blue print for national laws and policies in the sub-region and is based on the fundamental human rights principles and guidelines, a compassionate attitude and prudent business practices. It sets out policy components to be addressed by government, employers', and workers' organisations including education and awareness programmes, workplace testing, and confidentiality. It is however weak on the gender dimensions of HIV and AIDS.

The ILO Code of Practice on HIV and AIDS and the World of Work

The ILO Code was developed through consultations involving representatives of governments, employers and workers in all regions. Finalised by a tripartite meeting of experts and adopted by the ILO Governing Body in June 2001, it was launched the same month at the United Nations General Assembly, 26th Session, held in New York on HIV and AIDS. The Code takes a rights-based approach to HIV and AIDS, i.e. it establishes both the rights and responsibilities of the tripartite partners (Government, Employers and Workers and their organisations), and fundamental principles for policies and practical guidelines for workplace programmes.

The Code sets out fundamental principles for policy development and practical guidelines from which concrete responses to HIV and AIDS can be developed at enterprise, community and national levels (Box 2). It promotes a comprehensive approach to workplace programmes, including:

- the protection of workers' *rights*, including employment protection, gender equality, entitlement to benefits and non-discrimination;
- *prevention* through education, gender-awareness programmes and practical support for behavioural change;
- *care and support*, including reasonable accommodation, access to benefits, confidential voluntary testing and counselling and treatment, in settings where local health care systems are inadequate.

To complement and guide the application of the Code, the ILO has produced an education and training manual: '*Implementing the ILO Code of Practice on HIV and AIDS and the World of Work*'. Together the Code and the Manual are being used to develop skills and institutional capacity for the benefit of ILO constituents in all regions. The ILO Code of Practice on HIV and AIDS and the World of Work has become an invaluable tool to guide constituents in developing workplace policies and programmes.

Figure 2

Key Principles of ILO Code of Practice on HIV and AIDS and the World of Work

1. **Recognition of HIV AND AIDS as a workplace issue**
   HIV and AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.

2. **Non-discrimination**
   There should be no discrimination or stigmatisation of workers on the basis of real or perceived HIV status.

3. **Gender equality**
   More equal gender relations and the empowerment of women is vital to successfully prevent the spread of HIV infection and to enable women to cope with HIV and AIDS.

4. **Healthy work environment**
   The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

5. **Social dialogue**
   A successful HIV and AIDS policy and programme requires co-operation and trust between employers, workers, and governments.

6. **Screening for purposes of employment**
   HIV and AIDS screening should not be required of job applicants or persons in employment, and testing for HIV should not be carried out at the workplace except as specified in this code.

7. **Confidentiality**
   Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with existing policies and the ILO code of practice.

8. **Continuing the employment relationship**
   HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

9. **Prevention**
   The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behaviours.

10. **Care and support**
    Solidarity, care and support should guide the response to AIDS at the workplace. All workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

Relevant International Labour Standards

Currently, there is no international Labour Convention or Recommendation that specifically addresses the issue of HIV and AIDS in the workplace. There are however, a large number of instruments that cover both protection against discrimination and prevention against infection that can be and have been, used in this field. Figure 3 highlights relevant conventions that can be used to respond to HIV and AIDS and guide policy development and labour courts actions.

Figure 3.

Some Relevant International Labour Instruments in Responding to HIV and AIDS

- Discrimination (Employment and Occupation) Convention, 1958 (**No.111**)*****
- Termination of Employment Convention,1982 (**No.158**)
- Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (**No.159**)
- Right to Organize and Collective Bargaining Convention, 1949 (**No.98**)*****
- Collective Bargaining Convention, 1981 (**No.154**)
- Occupational Safety and Health Convention, 1981, (**No.155**)
- Occupational Health Services Convention, 1985 (**No.161**) and its recommendation (**No.171**)
- Employment Injury Benefits Convention, 1964 (**No.121**)
- Social Security (Minimum Standards) Convention, 1958 (**No.102**)
- Nursing Personnel Convention, 1977 (**No.149**).
- Migration for Employment Convention (Revised), 1949 (**No. 97**) and Migrant Workers
- (Supplementary Provisions) Convention , 1975 (**No.143**)
- Part Time Work Convention, 1994 (**No.175**)

*** Indicates one of the eight ILO Core Conventions.**

Of principal interest is the key ILO instrument on the right to equality at work, which is *the Discrimination (Employment and Occupation) Convention, 1958 (No.111)*. It prohibits not only discrimination in access to training, to jobs, promotion processes, security of tenure, remuneration, conditions of work (including leave, rest periods, occupational safety and health measures and social security benefits) but promotes proactive measures designed to protect those infected and affected requiring special protection. It lists seven grounds of prohibited discrimination. These seven grounds are: race, colour, sex, religion, political opinion, social origin and national extraction and permits, in its article 1(1) (b), ratifying States to add, after consulting representative workers' and employers' organisations, additional grounds. The ILO Committee of Experts on application of Conventions and Recommendations has recommended an additional protocol to Convention No.111 to include, among other grounds: 'disability', which in turn would cover HIV and AIDS.

The Termination of Employment Convention, 1982, (No.158) sets out the international position concerning possible dismissals. Article 4 specifies that termination can take place only when there is a valid reason connected with the capacity or conduct of the worker, or based on the operational requirements of the undertaking, establishment or service. Article 6 makes it clear that temporary absence from work because of sickness or injury (whether occupational or not) is not a valid reason for dismissal. Both provisions are relevant to workers with HIV infection and AIDS.

The Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983, (No.159) promotes equality of opportunity and treatment of persons with disabilities and promotes special protective measures, such as workplace accommodation and transfers in order to enable persons with disabilities to continue to earn a living. The accompanying Recommendation (No.168) suggests measures on community-based care and highlights strategies for workers with disabilities in rural areas.

International Labour Standards dealing with negotiation and collective bargaining are also tools that can be used to address HIV and AIDS in collective bargaining agreements and labour relations pacts.

Read together in the context of HIV and AIDS at work, the above clusters of international labour standards offer policy guidance, not only on the content of the legislative texts but also by extrapolation, on the structure of the law.

Institutional challenges in enforcing HIV and AIDS legislation

While legislative instruments and national policies have been developed to guide actions to protect those infected and affected by HIV and AIDS, major challenges remain.

The major challenges in responding to the issues of human rights protection and discrimination relate to the weak and often limited capacity of government to respond and enforce the provisions of legislative instruments or fulfil human rights. In many instances human and financial resources have created major bottlenecks to action, as labour officers are often inadequate and the courts not adequately equipped to implement and enforce the provisions of the regulations and policies.

Furthermore, some countries do not have adequate legal provisions to meet the demands of those seeking recourse in the legal system and where laws exist, sanctions for non compliance often do not present adequate deterrence. Coverage for certain groups such as in the informal economy is often limited by lack of information, thus excluding those who are already vulnerable.

The process of litigation can also be long drawn and prohibitive and is complicated by stigma and fears of being revealed. This becomes a deterrent for those that could seek the protection of the law. A major bottleneck in this respect is the lack of awareness of the general public, particularly women, of their rights and awareness on what action to take when their rights are being violated. In general, the courts are also challenged by the need to balance and apply flexibility to their actions without jeopardising the human rights of the individual.

Having recognised, in the UNGASS Declaration of Commitments, the relationship between the protection of human rights and the reduction of vulnerability (and therefore levels of AIDS discrimination), political leaders should, together with community leaders, identify aspects of customary law operating in their countries, that could advance the spread of HIV and AIDS and should positively influence and transform these aspects to take into consideration the new challenges brought by the AIDS epidemic and globalisation. Without strong leadership commitment at all levels, the impact of HIV and AIDS will continue relentlessly to burden us all.

4

CHAPTER 4

Transport Chokepoints And Hotpoints For HIV Transmission In Southern Africa

by Titus Gwemende

Transport is central to development. In fact, without the movement of goods and people, countries stagnate and economic growth decreases. It is essential to national economies, to allow both internal and external movement of goods and services. It also plays a crucial role in many other sectors - without adequate transport infrastructure and provision, the productive sectors would be unable to move goods to markets or obtain raw materials, tourism would cease; normal and cultural life would be crippled as well.

The strategic nature of this sector inevitably calls for greater investment and attention. Regrettably, the dynamics of the sector have also rendered it vulnerable to the HIV pandemic. Indeed the transport sector has become one of the main vectors of the spread of the virus. Workers in the transport sector face a disproportionate risk of contracting and transmitting HIV, compared to workers in most other areas of employment. Many of them travel frequently throughout the region, spending long periods of time away from their families. They develop their own culture and form social and economic bonds with those with whom they interact on their routes.

Common Risks In The Region

As earlier alluded to, many involved in the sector are mobile and spend time away from their homes. In fact, long distance truck drivers, maritime, rail and air workers spend the

majority of their working lives away from home. Research in South Africa revealed that 71% of long distance truck drivers had spent 15 or fewer days at home in the six months prior to the study[1]. It is recognised that mobility may lead to increased opportunities for sexual activity with new partners. In southern Africa transport drivers travel from the South African port of Durban to the mines of southern Democratic Republic of Congo, spending weeks on the road, and often having to spend days waiting to go through border formalities. Road service operators are particularly at risk. A survey of 168 bus and truck drivers in Cameroon in 1993 found that they spent, on average, 14 days away from home on each trip. Some 62% had sex during the trip and 25% had sex every night they were away. In Tanzania on the Dar-es-Salaam highway HIV prevalence was 28% for truckers and 56% for their female partners, in 1991.One trucking company lost a staggering 39 out of 144 drivers in 3 years (27%) due to AIDS deaths.[2]

Truck drivers frequently give rides to cross border women traders traveling to sell their goods in exchange for sexual favours. These are usually low income women augmenting their desperately meager incomes through cross border trading. Two hundred and fifty thousand visas are issued to Zimbabwean women annually to shop in South Africa. Use of transactional sex reduces their transport and accommodation costs significantly. The comparative wealth of many drivers in comparison with the poverty of roadside sex workers makes it difficult for the sex workers to negotiate for safer sex lest they lose such a 'rich catch'.

Many transport workers engage in risky behaviour even when they have a general knowledge of the disease. Studies have shown that truck drivers face many potentially life threatening risks on a daily basis, making the danger of HIV and AIDS more remote and therefore seemingly less important. Some truck drivers have 'road wives' and some rail workers have 'rail wives' with whom they stay when traveling certain routes. Stressful working conditions, long absences from home, limited recreational opportunities and restricted social conditions contribute to this risk taking.

Operators and workers in road transport experience the longest and most serious border delays. While rail transport is deeply hampered by inefficiencies and infrastructure problems, border delays are usually much shorter than those experienced by road. The delays may lead a worker to corruptly find their way through in shorter time either through payment of bribes or through transactional sex. Such delays also mean that workers have to look for accommodation. They either sleep in their uncomfortable vehicles or make use of cheap accommodation nearby, which often means a truck-stop brothel.

Operators have less time to learn about HIV and AIDS, since most of the time transport workers are on the road. Long, lonely journeys may push a driver to look for 'female company.' Most truckers' wives are in the rural areas thus making it difficult for them to meet their spouses, even when 'at home'.

Hotspots in road transport include internal trading centres as well as border posts, while hotspots in rail include sidings which in many cases are not at border posts, where trains lie by and railway employees stay overnight,. The hotspots for airline employees are locations away from home in which they stay for most of a day or longer.

Selected Hotspots

Malawi

The most serious hotspots identified in Malawi include the internal trading centres, where drivers gather to drink and frequently mix with sex workers. These hotspots include; Lunzu in the south near Blantyre; Balaka in the centre; and Mzuzu in the north; Mwanza in the south, which is the busiest crossing; and Songwe at the northern Tanzanian border, which is the next busiest border crossing; followed more distantly by Mangochi/Mandima at the eastern Mozambique border; Mchinji at the Zambian border and Milange at the south-eastern border with Mozambique.

Mozambique

In road transport in Mozambique, the following hotspots were identified; the Komatipoort border post with South Africa; the Machipanda border with Zimbabwe and the Milange border with Malawi.

South Africa

In road transport in South Africa, the hotspots identified were; Beitbridge, which is widely recognised as the most serious hotspot, with drivers staying at the border for lengthy periods that may last up to seven days; other border posts such as Komatiapoort on the Mozambique border; and Lobatse on the Botswana border, and internal stop-over points Harrismith, Ventersburg, Beaufort West, and Port Elizabeth.

As for Zimbabwe, the hotspots are; Beitbridge, which is an important, high volume, crowded and slow border crossing with South Africa; the Chirundu border which has a high volume traffic and some long delays (though the longest delays are on the Zambian side; Ngundu which is an important transit point about 190 kilometres from Beitbridge where drivers frequently stop overnight, and then the Hwange coal depot where trucks sit for long periods. The spread of sexually transmitted infections has become a substantial problem in the area.

Recommendations

Dealing with HIV and AIDS in the transport sector is as complex as it is important. It is essential to consider that transport (including storage and communication), accounts for significant proportions of Gross Domestic Product (GDP) (5,34% in 1994) in low- and middle-income countries (6,78% in 1994) according to the World Bank[3].

Thus there needs to be a saturation of hotspots with HIV prevention messages and materials. Also needed are;

- Serious efforts to reduce time at border posts through integrated border and corridor management within especially the southern Africa region, to modernise, simplify and harmonise border crossing procedures.
- Peer educator programmes on HIV and AIDS at all hotspots.
- Free condoms at key hotspots.
- Trucking companies must invest in non-discriminatory HIV Workplace policy programmes for employees.
- Provision of rest stops for transport workers. South Africa has established rest stops whose benefits are seciurity, meal and rest facilities for drivers. Alternative entertainment opportunities must be provided at rest areas.

- Drivers should be discouraged from use of alchohol and narcotics.
- Co-operation of transport sector initiatives with other HIV prevention initiatives. For example, drivers might carry anti-HIV messages on their vehicles.
- Education materials at border points where there are inevitably long queues and delays, will also reach migrant populations,. Airlines might put information leaflets in seat pockets.
- Employment conditions for workers should provide for the movement of their families where practicable, and where it is not practicable, frequent leave should be encouraged.
- Governments should encourage the employment of local labour and require building and maintenance contract documents to include these issues.
- Establish clear definitions of the functions of government offices dealing with transport, building their capacity, and co-ordinating and streamlining their work so that information flows are integrated, with simple, clear and known rules so that exchanges of information are fast, efficient and effective.
- Incentivising whistle blowing. A lot of unprotected sex takes place between travellers and customs officials in return for speedy processing of documents. Incentives for whistle blowing will help keep unscrupulous officials at bay.
- Health care centres in the vicinity of hotspots, which encourage those infected to eat the right food, reduce consumption of alchohol and narcotics and to access treatment.
- Trucking companies must invest in HIV prevention, treatment and care efforts for their employees.
- Build more low cost overnight accommodation for stranded people trying to cross the borders.
- Partner with drivers to play either DVDs or Videos containing messages on HIV and AIDS whilst driving so that passengers are also informed.
- Empowerment and education of sex workers in these areas so that unsafe sex is not an option.

In a nutshell, the vulnerability of the transport sector to HIV and AIDS is clear. A multi-faceted approach, which involves improving the systems in place at various border posts to speed up border crossings, is critical. At the same time, a lot of resources need to be put into awareness campaigns which specifically target the transport sector and the communities they usually visit. Policies also need to be enacted to allow for spousal company where practicable, or frequent leave opportunities between trips to allow couples time together, which may reduce the use of sex workers.

1 AIDS Brief for Sectoral Planners And Managers, USAID Bureau for Africa, 2000
2 Makumbe R, Labour Mobility and HIV Infection: The case of the Transport Sector: A Regional Persepective, SAPES Trust, 2002.
3 Information primary from ILO AIDS Programme on HIV and AIDS and the World of Work, Geneva, December 2005

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CHAPTER 5

Role Of The Private Sector In Managing The Epidemic

by Global Business Coalition on HIV and AIDS

While some may think that it has been slow to come, it is at last being acknowledged that the burden of addressing HIV is too large to be managed by a single sector. The private sector has risen to the challenge and revolutionised the way in which HIV and AIDS is discussed, addressed and prevented. There has been a rapid growth in the adoption and implementation of workplace HIV and AIDS programmes over the last few years as businesses begin to acknowledge the risk that HIV and AIDS poses to their companies and put in place interventions to mitigate this risk. Programmes are becoming more and more comprehensive as the understanding of the disease increases and it is becoming clear that the programmes are beginning to positively impact on employees and their families.

It is generally accepted that the 'footprint' that a company follows when addressing HIV and AIDS follows the pattern of addressing HIV in terms of employees first, then their spouses/significant partners, followed by contractors/suppliers and finally addressing HIV in the community. This makes logical sense since, for example, a company cannot focus on addressing HIV and AIDS in the businesses of those who contract to the company, without having a programme in place to look after its own employees.

The Global Business Coalition on HIV and AIDS (GBC) was created by UN Secretary General Kofi Annan who called on Ambassador Richard Holbrooke to lead the global business response to AIDS in 2001. At that time the disease was already wreaking havoc in sub-Saharan Africa. The epidemic continues to spread into developing countries like Brazil, Russia, India and China and the corporate sector has to build a solid response. The GBC is the pre-eminent organisation mobilising the business sector in the response to HIV and AIDS. More than 200 leading international companies are members of the GBC and are committed to harnessing the power of business to overcome the HIV and AIDS epidemic. The GBC's goal is to increase the range and quality of business sector AIDS programmes, both in the workplace and in the broader community. The GBC identifies new opportunities for businesses, supports the development of HIV strategies by individual companies and encourages governments, the international community and the non-governmental sector to partner with the business sector.

The GBC has offices in New York, Geneva, Beijing, Paris, and Johannesburg. The Africa office's prime objective is to mobilise the private sector in sub-Saharan Africa to address HIV and AIDS in the workplace and recognises that the most sustainable manner in which this goal can be accomplished is by way of the national business coalitions (NBCs) in each country. As the 1990's unfolded, National Business Coalitions (NBCs) were originated in a number of countries around the world, and particularly in Africa, motivated by the varying prevalence rates which dictated a highly tailored response moulded by regional context. The NBCs have a vital role to play in the various countries as it is imperative to ensure that business is effectively mobilised to address the HIV and AIDS epidemic at country level. In addition, all interventions should be in convergence with that country's national HIV and AIDS strategy. The NBCs are in a position to fulfil this purpose, as they are familiar with the requirements of the national HIV framework, they know who the relevant stakeholders are in each country, and they are in a unique position to share best practice and provide a united front for the private sector.

The primary function of NBCs is to offer a value-added service to their members. A value-added service can be described as "facilitating information sharing; permitting economies of scale in the development of workplace HIV and AIDS products and services; and creating a strong unified front for public policy debate and advocacy. They may serve as service and product providers, offering constituents help with impact analyses, development of education, testing and treatment programmes; training of peer educators; and design and implementation of other workplace and even community interventions. National business coalitions against HIV and AIDS serve as important focal points for engaging with other stakeholders, particularly the national governmental HIV programme."

NBC's face a number of challenges, some of which are :

1) Funding: membership funding cannot sustain the operational requirements of an NBC unless a critical mass of members is obtained. Projects cannot be embarked on either unless excess funding is at hand.
2) Addressing unrealistic expectations such as:
    - Companies sometimes believe that their membership subscription fee should include the implementation of a workplace programme for that company. The role of the NBC is not to implement programmes, but to provide the necessary tools to empower the company to implement the programme.

- Members of NBCs expect the NBCs to address HIV and AIDS in SMEs and communities with little resources and capacity.

3) Operational shortcomings: dissemination of information is a key function of NBCs and fax or e-mail are the cheapest and most expedient ways of communication. However, some NBCs (and their members) don't enjoy the necessary infrastructure, which makes communication with members extremely difficult.
4) Lack of participation by members: it has been proven time and again that an involved member is a committed member. NBCs should convene committees to address topical issues and members should support these initiatives. It is also desirable that members attend the various workshops and information sessions that NBCs convene.

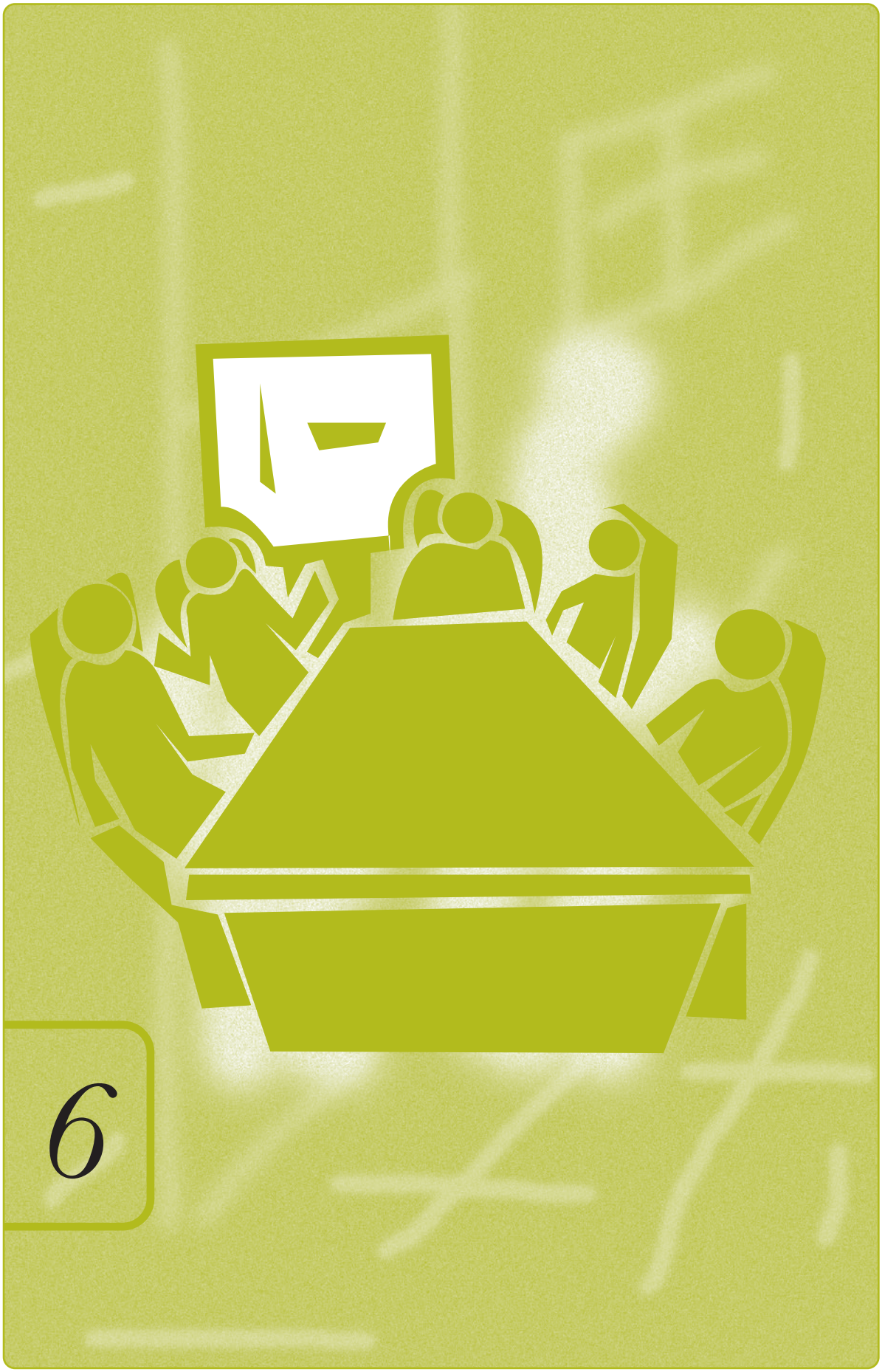
Identifying a need, the World Bank published a guideline on how to build Business Coalitions against HIV and AIDS which can be downloaded at http://siteresources.worldbank.org/INTAFRREGTOPHIVAIDS/Resources/Business_Coalitions_Guidelines-Jan-05-en.pdf. This guideline is highly recommended as it contains useful information on how to manage an effective NBC.

The GBC believes that business can respond to the HIV and AIDS epidemic in four main ways:

i) Implementing testing and care programmes and policies for employees and immediate communities. In many countries, company programmes will be the only source of accurate HIV information available to employees;
ii) Bringing business's core strengths of innovation and efficiency to improve the reach and effectiveness of AIDS programmes. Businesses' marketing, communication distribution and logistics skills are already strengthening the impact of many AIDS programmes around the world;
iii) Leveraging their products and services in unique ways to benefit the fight against HIV and AIDS;
iv) Leadership and advocacy by business leaders, lobbying for greater action and partnerships with governments and civil society.

The GBC website www.businessfightsaids.org is the only global website dedicated to providing the latest information on HIV that is relevant to businesses. In addition to promoting member company programmes, the GBC researches and collates information from the HIV field relevant to business. The private sector has a clear role to play in fighting HIV and AIDS: no sector can single-handedly manage the epidemic, nor can any company excuse itself from this responsibility.

HIV and AIDS Business Coalitions: Guidelines for Building Business Coalitions against HIV and AIDS: 2004. www.worldbank.org/afr/aids



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CHAPTER 6

Business Coalitions: Bringing Our Members On Board - The Experience Of Swaziland Business Coalition Against HIV/AIDS

by Swaziland Business Coalition against HIV/AIDS

Introduction

The Business Coalition against HIV/AIDS (BCHA) of Swaziland is an umbrella body for the co-ordination of HIV and AIDS workplace programmes in the private sector. It is a collaborative partnership of business leaders, labour unions, HIV and AIDS structures and workers. It was initiated by the Federation of Swaziland Employers and Chamber of Commerce (FSE & CC) in the year 2001, in response to the emergence of HIV and AIDS which was seen as a threat to business. There was limited activity until 2003, when a full time co-ordinator was employed and the constituency of BCHA was reviewed. The review involved:

- Re-examining the Coalition's constituency to include labour and government as well as non governmental organisations (NGOs) and people living with HIV and AIDS (PLHIV).

- Ensuring that labour and government are represented in the two main committees that govern as well as direct BCHA, that is, the steering committee and the technical committee respectively.
- Ensuring that there are resources for the private sector response and that such a response is well co-ordinated. This means that BCHA being the umbrella organisation, will not implement activities, but will facilitate action through private sector partners and/or NGOs.
- Strengthening the advocacy role of BCHA for both employers and employees as an organisation that encourages partnership between the employer and employee.
- Strengthening the co-ordination role of BCHA as well as its visibility.

Programme Implementation Strategies

BCHA facilitates HIV responses for both unionised and non-unionised companies and enables leverage of their resources to more effectively combat HIV. BCHA implements directly or indirectly through partnerships with NGOs, individuals or organisations. The objectives of BCHA include but are not limited to:

What do Business Coalitions do?

- Advise the private sector companies and unions.
- Promote HIV prevention in the private sector.
- Facilitate establishment of care and support strategies in the private sector.
- Facilitate impact mitigation strategies in the private sector.
- Ensure greater involvement of PLHIV within the workplace.

The various activities facilitated by BCHA ensure involvement of all stakeholders. These include:

Facilitating Information Sharing

- Peer trainings in which peers are trained to educate and counsel their peers. BCHA also set standards for such trainings in the event that an NGO or other organisation wishes to train for a workplace. BCHA advocates for peer educators to be used in the implementation of workplace programmes as recommended by ILO (International Labour Organization).
- Generic information, education and communication (IEC) material is developed and distributed to the stakeholders.
- Networking among private sector companies on issues of HIV and AIDS is facilitated. BCHA actively encourages the development of focal points for engaging with other stakeholders.

Facilitating Service Delivery

- BCHA serves as both service and product provider, offering constituencies help with impact analysis, development of education, testing and treatment programmes, including training of peer educators
- In partnership with NGOs, BCHA offers services to the private sector, currently for free. A mobile Voluntary Counselling and Testing (VCT)

Centre has been secured through the Global Fund. This vehicle offers comprehensive VCT services on site for employees and employers.

Developing Workplace HIV and AIDS documentation

- BCHA provides guidelines on the formulation of workplace HIV and AIDS policies, services and programmes.

Advocacy and representation

- BCHA creates a strong, unified front for public policy debate and advocacy. It has advocated, lobbied and represented the private sector both in policy development and in the development of laws and policies around HIV and AIDS.
- Designs and implements workplace as well as community projects.
- Represents business in issues and events for HIV and AIDS.

Advising the private sector

- Provides first recourse for advice, information on policy development and materials on HIV and AIDS for employers and employees in the private sector.
- Mobilises the business community to initiate and implement HIV and AIDS workplace programmes.
- Facilitates HIV and AIDS response activities and implementation by labour unions and employers.

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- Ensure greater involvement of people living with PLHIV within the workplace.

Role Of The Private Sector In Managing The Epidemic

The majority of private sector companies are concerned about how to protect their workforce from HIV infection and how to deal with those that are already infected. The response to HIV and AIDS by the private sector depends on the following key factors:

1. The HIV prevalence rate in the country, in the community and most of all in the company.
2. The level of knowledge and awareness by the management of the real and potential impacts of the pandemic.

Private sector organisations are the ideal environment to be involved in multi-sectoral action because they have:

a. An existing and effective organisational framework.
b. A clearly defined target group.

c. Ability to provide leadership to mobilise workers on a number of issues of concern to them.

In Swaziland therefore, the private sector has five main roles or initiatives that can be taken in response to HIV and AIDS:

1. Developing an HIV and AIDS policy for the company.
2. Providing HIV prevention education in the workplace.
3. Providing care and support in the workplace
4. Implementing fair employment practices and
5. Community involvement. This is part of their social responsibility.

As part of their social responsibility, private sector organisations put aside 1% of their profits for social support. Some of these funds are directed to caring for the employees as well as contributing to the welfare of the community including orphan care, home-based care and other support services. For a workplace response to be effective it should be:

- implemented during company time
- inclusive of top-level management
- offered in small group meetings
- mandatory for all staff
- structured to allow time for discussion and questions
- reinforced periodically by regular follow up meetings and
- monitored to assess employee knowledge through pre- and post programme surveys.

Challenges In Working With The Private Sector

Coalition member companies have substantial financial resources, well-established business and political networks and strong incentives to combat the disease. Through partnerships these attributes can be combined with existing knowledge and expertise on HIV and AIDS interventions in the public sector, allowing heightened outreach and impact. Acting through a business coalition also reduces the potential public relations challenges that a single company might face when tackling a sensitive and politicised topic like HIV and AIDS alone (UNAIDS 2004). However there are challenges, which include:

Delivery versus Funding

The private sector in Swaziland has been very slow to respond to the epidemic. This is a challenge to the BCHA and in convincing business to respond it addresses four areas:

- Why HIV and AIDS is a business issue
- What problems HIV and AIDS poses for the business.
- What is the impact of HIV and AIDS on the workplace
- What are the benefits of a workplace programme.

Companies that have put in place workplace programmes early are reaping the benefits, as death rates and absenteeism are more controlled than in companies where there is a limited or no response.

Companies are aware of the existence of the BCHA, but because of our being located within the Federation of Swaziland Employers (FSE) and Chamber of Commerce(CC), there is a tendency for some companies to believe that it is only open to FSE and CC members. There is a need to market BCHA as a non-aligned private sector organisation, whose services can be used by all.

Initiatives companies can take in response in HIV

1. Develop an HIV and AIDS policy for the company.
2. Provide HIV prevention education in the workplace.
3. Provide care and support in the workplace
4. Implement fair employment practices and
5. Community involvement. This is part of their social responsibility.

Relationships in the workplace

The relationship between the employer and the employee has always been problematic. However HIV and AIDS has opened an opportunity for the employer and employee to sit around one table and in unity agree on principles of caring. The employer has a unique opportunity to consult and work with employees to develop comprehensive workplace policies and implement them. Similarly, the employee organisations have a unique responsibility to protect the employees from discrimination and ensure that their rights are respected.

Drivers of the Epidemic

Workplace programmes have an added benefit, as they allow interrogation of the factors that drive HIV and AIDS in an environment that is uniquely effective in influencing behaviour change, because of peer pressure. Factors that are addressed in the workplace environment that have been proven to drive HIV and AIDS include:

- Cultural beliefs and practices that have a negative impact.
- Multiple concurrent sexual partners.
- Secrecy and denial of HIV infection.
- Lack of seriousness in dealing with the epidemic.
- Migration
- Poverty
- Decline in moral values.

Economic status

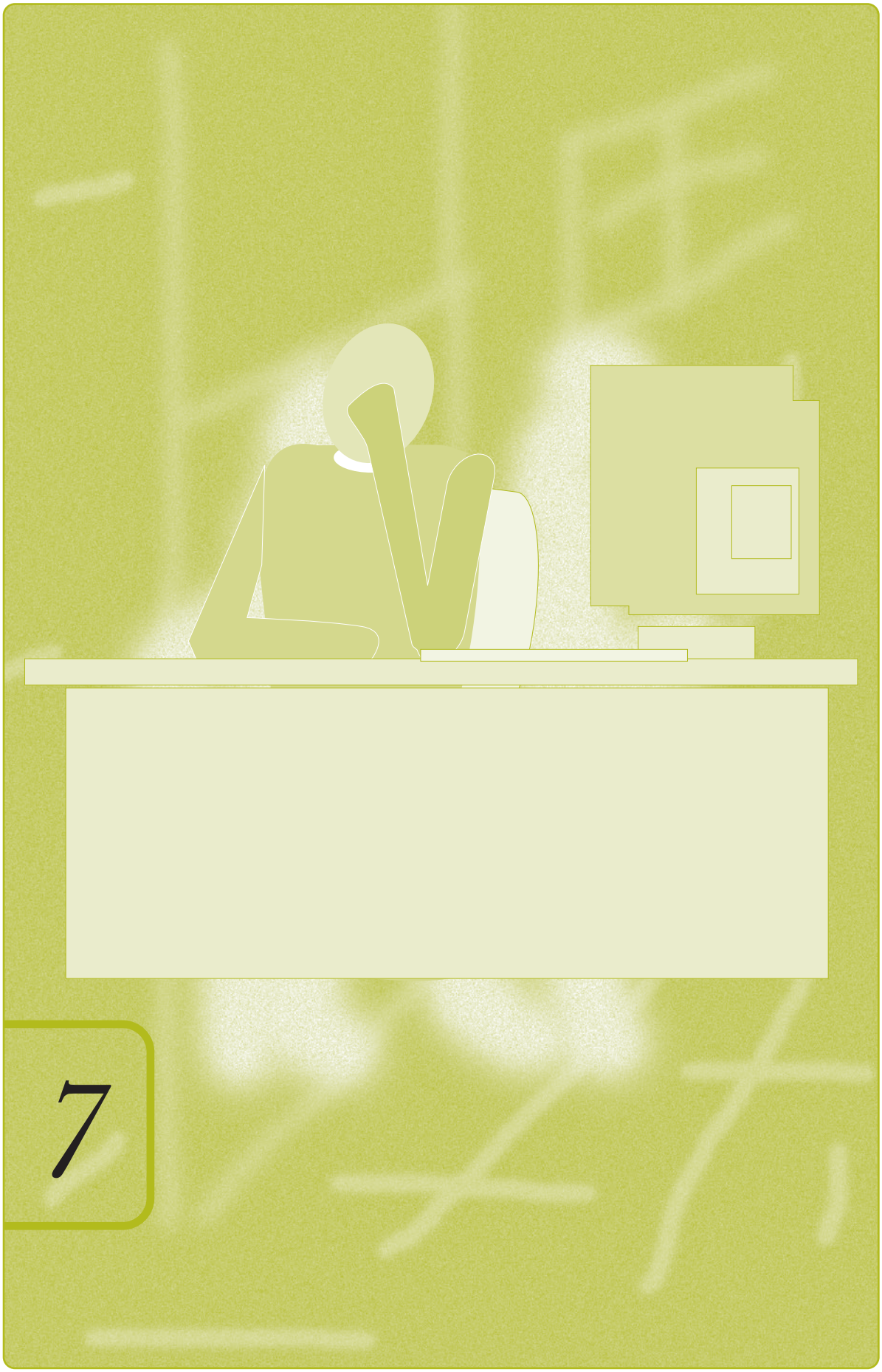
The poor economy in Swaziland and other countries in the world at large contributes to a lot of companies closing down. A high level of job losses in turn contributes to increased poverty, which along with reduced funds available for healthcare and poor nutrition encourages earlier onset of AIDS in those infected with HIV.

Lessons Drawn From The Programme

The hesitancy of many companies within the private sector to invest in HIV and AIDS may be related to lack of information and probably also of support measures such as technical assistance. Companies have a lot of strengths that they can draw from to make HIV and AIDS workplace programmes a success, and these include exploiting their strong points in order to strengthen their workplace programmes. The fact that places of employment bring together large numbers of people with similar backgrounds and expectations means workplaces are ideal places for carrying our prevention and awareness programmes. Peer pressure is an effective method of behaviour change. Workplaces also create possibilities for providing support and care.

Section 3.

Real Life: Working Programmes



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CHAPTER 7

POSITIVE ORGANISATION: Living And Working With The Invisible Impacts Of HIV And AIDS

by Sue Soal

In 2002, CDRA (Community Development Resource Association) started an investigation into the impact of HIV and AIDS on South African NGOs. This study was a real breakthrough in the discussions about how NGO's respond to HIV and AIDS issues on the shop floor in South Africa. The study culminated in the publishing of a ground breaking book 'Positive Organisation: Living and working with the Invisible Impact of HIV and AIDS, a resource for NGOs which was distributed in South Africa.

CDRA – ia a centre for developmental practice, a service-providing NGO that works largely with other NGOs, offering capacity building services in organisational consultancy and accompaniment, training, facilitated dialogue and research and publications. The study was inspired by the fact that much had been said about the material and economic consequences of the epidemic, but there was little understanding of HIV's long-term effects on staff morale and organisational culture. In the introduction to the book, Sue Soal, director of CDRA, motivates the decision to carry out the research: "If HIV and AIDS pervades throughout society, it will have a massive impact on both the context in which we work, and the organisations and people with whom we work", as indeed it has done in southern Africa.

The research was carried out by Katherine Everett, who has a firm background in health-related work and qualitative research methods. The initial response from NGOs willing to participate and share their experience of HIV and AIDS was somewhat disappointing.

Maybe the impact was not as wide as the researchers thought, or the impact itself was hidden from the organisation. Eventually, thirteen NGOs shared their experiences for the research. The study shows that even by 2002, South African NGOs were not equipped at any level – material , policy or cultural – to deal with the phenomenon of HIV.

The following excerpts from the study underline this:

Denial To The End

When one director pressed her staff member about her illness, she denied that she was physically ill and made great efforts to assure her that she could carry on working as normal:

> *'She did not take sick leave for a long time. I asked her what the problem was and why she did not take leave. She said, 'No it is not physical, it's emotional'. Problems with the husband. I told her, 'no matter what, I will not discriminate against you, I am prepared to support you'. All she did was she cried. She never opened up to me. She tried her best to carry on doing her work. Even when she was in and out of the hospital and she was wasting away, she still insisted that she did not know what she had and insisted that she wanted to come back to work'.*

This person's denial continued right up to her death.

For managers and colleagues it is not easy to accept the individual's choice not to disclose.

> *'I worked with her for more than 2 years, knowing that she was positive. It was her choice not to tell anyone in the office. In retrospect, I sometimes feel that if I had told her that I knew, she may have been alive today as a plan could have been made for medication'.*

Making decisions about how to deal with the continued employment of employees with AIDS proves very difficult for managers, and this is complicated further by their feelings of compassion. Many of them became very involved in trying to assist with medical care, as well as with financial and family problems.

> *'Twice we thought that he was on his death bed, but he bounces back with such heroic behaviour and wants to get back to work. When he comes back we treat it as he has been on holiday. He is way over his normal leave, but we have continued to pay his salary. While we can afford it, this is the way we will deal with it.'*

One of the reasons for denial is the stigmatisation of AIDS, primarily because it is a sexually transmitted disease. One respondent mentioned:

> *People think it is their fault that they have HIV and there is the shame because it is associated with sex. People are not ashamed of saying, 'I have been diagnosed with cancer'. Cancer patients are not in denial, but HIV patients are.*

At the community level, AIDS deaths are stigmatised because of their association with witchcraft:

> *'We had two staff members die last year. Everybody on the staff suspected that they had died of AIDS, but their families denied it completely. The one person had just had her fifth child and the family refused to take the child for testing. They said that she had her insides eaten out by a big yellow worm.'*

Impact On Staff Morale

'Within organisations, HIV and AIDS illness and death reveal existing fault lines, bringing hidden power dynamics and conflicts to the surface. It highlights the divisions between those who have access to healthcare and those who do not. The exclusion line between rich and poor that exists in client, partner or target communities, enters into the organisation, calling for tough ethical decisions around balancing individual and organisational needs, the allocation of funding and the provision of staff benefits. HIV and AIDS is not something 'out there', it profoundly affects the functioning, the capacity and the culture of organisations'.

> *'When she died, no one in the office had known that she had been HIV positive. It is an office that is run particularly openly, there is tremendous team stuff and something like that can damage the very essence of the way an office works'.*

> *'People have deep feelings about what happened and the way others handled it. It is not spoken about, but I think people need to. Because we are a small organisation, things will have an impact. There are negative vibes around and it has an impact on how we operate with each other".*

In one organisation, where the person with AIDS was in a leadership position, his sudden death left the organisation reeling. Because there had been no disclosure, staff were completely unprepared for his illness and death. His management style was authoritarian and when he died, the management of the organisation was thrown into disarray. "People were going against each other, because he wasn't there. There were camps forming all over".

One of the lessons learned for the managers of the NGOs involved in the research is to develop workable HIV and AIDS policies; to ensure that staff belong to a good pension fund and a medical aid scheme that includes cover for chronic illnesses. Involving staff and boards in devising such a policy through a consultative education process was seen as an important way of confronting HIV and AIDS. One director said that she was going for a test to set an example to the staff. The CDRA book gives useful ideas and tools for how to develop such a policy and how to build 'positive' NGOs.

Four Years Later.

Sue Soal comments four years later on the impact of the publication. "Looking back on the interest shown for the publication, most sales have come from international donor organisations, and anecdotal feedback suggests that it has been used more outside the borders of South Africa than within. Since completing the publication, CDRA's direct work on the topic has receded. Even while our clients clearly work more with HIV and AIDS issues than they did in the past.

What has shifted is the extent to which HIV and AIDS is visible in the work of our client organisations with their clients, beneficiaries and target groups. In 2006 it is almost impossible to talk about marginalisation, vulnerability and poverty – be it in rural or urban contexts – without confronting the presence of HIV and AIDS. Sometimes we find that the words are avoided, but everywhere, the impact of HIV and AIDS is evident – we hear talk of orphans, of the vulnerability of women, of home-care and of nothing happening in the fields because the adults are sick.

In addition to these stresses, it seems NGO staff absorb much of the secondary stress of what they witness whilst implementing their programmes, with very little formal support or debriefing. There are anxious debates about how best to strategise around these realities and big practice dilemmas about disclosure and non-disclosure, the merits of naming what is happening as opposed to going along with the euphemisms. The political context in South Africa is of particular concern, to the extent that HIV and AIDS remains a contested issue (right up to the present when the former Deputy President of the country recently claimed that a shower after unprotected sex can reduce one's chances of infection), and this exacerbates the stress and conflict carried by individual NGO workers where bottom-line common sense around HIV and AIDS is not established or given.

An observation now, four years later, is that our research in 2002 did not explore in special depth the issue of secondary impact, yet this is where it is beginning to be felt. It also could not have anticipated the extent to which South African society would become polarised around the issue of treatment and therefore, the extent to which working in the context of HIV and AIDS requires not just human skill, but also political skill.

Another lesson we noted after 2002 was that as AIDS manifests more fully – as it "mainstreams" itself - then the challenge will be, more urgently than ever, to extend developmental practice. Approaches that isolate parts of a system (be they an individual's health or single policies in organisations) are unlikely to yield satisfactory outcomes – not for the individuals directly concerned, not for those around them and not for organisations as a whole.

We asked, "What will it take to build organisations that are sufficiently robust to absorb the impacts of HIV and AIDS at all levels and from all directions, while providing humane, stable workplaces?"

We concluded that it is not possible to see HIV and AIDS and its impacts as the problem and responsibility of individuals. NGOs are particularly affected by the epidemic; through their HIV positive staff members; through staff members who are caregivers to HIV positive people and through their direct work with HIV affected and infected clients, beneficiaries and partners in the community. More than ever, we will have to work innovatively towards building organisations that strike an appropriate balance between the individual and the collective; between needs-based responses and strategic intent. We need to create 'Positive organisations' that live and work with HIV and AIDS and all its complex impacts as a part of their internal and external realities.

The CDRA publication is an example of a perfectly accomplished "mainstreaming" intervention. Yet, it is precisely in mainstreaming that HIV and AIDS ceases to be the preserve of specialist experts and comes to be owned and integrated by all who encounter it – both specialists and generalists alike".

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CHAPTER 8

The NGO Perspective: The Experiences Of Hivos Partners In Zimbabwe

by Ngoni Chibukire

Background Of The Project

What was once thought of as a disease that only impacted stigmatised sectors of society is now widely seen as a global and developmental crisis - a challenge the world is losing. Slowly, governments and civil society are awakening to the problem and the business sector is beginning to take up the opportunity to help turn the tide of the epidemic.

According to the World Economic Forum Report 2006, the impact of HIV and AIDS on the global economy in the next five years is likely to cause severe losses. *"Future concern is rising about the expected impact of HIV/AIDS on firms' operations over the next five years," Economic Forum (WEF) Report 2006 titled: Business & HIV/AIDS: A Healthier Partnership.* Business losses are predicted at 46% from 2005 compared to 37% in 2004.

NGOs play a key role in the fight against HIV and AIDS. They bring innovative education and advocacy products to people affected by the disease, and they work to bring new lifesaving therapies to the market. Many NGOs partner with local governments and communities and have successfully implemented programmes to provide products, education, training, and infrastructure resources to prevent HIV and AIDS.

However, there has been little emphasis on the internal capacities of NGOs to deal with the epidemic. Mainstreaming of HIV and AIDS in the workplace has been erroneously

addressed in a 'blanket' manner, thus overlooking specific needs in different sectors, i.e. the public, private and NGO sectors. Although numerous attempts have been made to develop uniform guidelines towards effective policies in workplaces, a critical lack of awareness and participation, combined with non-availability of funds has thwarted the success of HIV and AIDS mainstreaming in NGOs as workplaces.

Direct action is now needed in the NGO sector to ensure benefits that maintain the efficiency and productivity of operations, as well as protecting their greatest resource – that is their human resources. Further, the vibrancy of the NGOs' entrepreneurship, innovation and productivity can surmount existing barriers in the fight against HIV and improve the reach of current efforts.

In recognition of this need, in 2003, 2004 and 2005, HIVOS organised and conducted workshops in Zimbabwe, Malawi and Mozambique, to discuss the impact of HIV and AIDS, as well as mitigation strategies, at the organisational level among NGOs. The main objectives of the workshops were to encourage HIVOS partners to reflect on how HIV and AIDS affects NGO staff at a personal level and how it impacts on the capacity of an organisation. The next step was how to respond and how to operationalise HIV and AIDS workplace policies and programmes.

Towards the end of 2004, HIVOS did an impact assessment of fifteen partners in Zimbabwe that had participated in the two workshops, to ascertain how many had developed and operationalised policies. Sadly the numbers were low. Seven out of the fifteen had policies, but only three had operationalised them. Most of the partners acknowledged the need for such a policy, but gave it no priority, which is why many of the drafted policies ended up gathering dust on shelves

SAfAIDS was then contracted by Hivos to offer technical assistance to all its parners in Zimbabwe in HIV and AIDS workplace policy development and programme implementation.

The Purpose Of the Project

SAfAIDS has developed a specific Workplace Capacity Development Model, which involves two phases. The first phase involves an HIV and AIDS Knowledge, Attitudes and Practice (KAP) survey or baseline assessment, which helps to identify gaps and information needs that inform programme activities. This was carried out with the Hivos partners in Zimbabwe in June 2005 and identified the challenges partners were encountering in policy development and programme implementation.

The baseline survey revealed that 12% of the respondents had little understanding of the impact of HIV and AIDS on their organisations and 1,3% mentioned lack of time. However, most organisations testified that staff turnover has increased in recent years. This was attributed to deaths, absenteeism, reduced productivity and work overload, as a result of AIDS.

Phase two focused on the formulation of the policies and designing implementation plans. This phase involved awareness raising and the sensitisation of staff and Boards by offering knowledge and skills. The process was highly consultative with the involvement of most employees, to ensure total commitment and programme ownership during implementation, monitoring, resourcing and reviewing of policies and programmes.

NGOs' awareness of the epidemic

A wide variety of case studies emerged, which provided many examples of positive initiatives demonstrating the ability and commitment of NGOs to respond positively and solve their development problems. GALZ (Gays and Lesbians of Zimbabwe), ZWRCN (Zimbabwe Women's Resource Centre Network) and Msasa Project are among the partners that have shown a positive response to HIV and AIDS in the workplace.

The key aspects that emerged as critical for mainstreaming HIV and AIDS in the workplace are:

- Financial security to sustain HIV and AIDS programmes.
- Mobilisation of resources, knowledge and awareness raising about HIV and AIDS-related issues in the world of work.
- Commitment, and elimination of stigma and discrimination.

Several NGOs are moving towards the development of HIV and AIDS workplace policies for their employees and staff, but management acceptance or buy-in and the provision of resources are fundamental to a broad-based workplace development strategy. The range of current policies of Hivos partners is organisation specific and policy provisions are based on the available resources.

Some NGOs provide incentives for staff to disclose their status and promote increased access to ARVs through medical schemes such as Cimas +CD which includes the provision of ARVs and the necessary laboratory tests, in addition to providing cover for general healthcare.

The Legislative Background

In supporting organisations to develop their HIV and AIDS workplace policies and programmes, SAFAIDS refers to existing guidelines such as the ILO Code of Practice on HIV and AIDS, the SADC code, as well as to the national statutes on HIV and AIDS in the workplace. It is important also to refer to national laws and for this project, reference was made to the Zimbabwe Statutory Instrument 202 of 1998 which governs and regulates HIV and AIDS in the world of work.

Key Issues And Challenges For Effective Programme Implementation

Lack of Top Management Support and Commitment

During the consultation process it emerged that senior management are generally not committed to implementing effective workplace programmes as they view themselves as immune to HIV infection. The perception is that HIV and AIDS issues affect low-level employees, yet the problem affects all layers of employment including top executives. For confirmation of this see chapter 7, which discusses denial. As we have said earlier, effective workplace programming requires genuine commitment from management to avail resources, including the assurance that senior management is underpinning the interventions.

Fighting Stigma and Discrimination

This is critically important as the basis for comprehensive HIV programmes. Issues around testing, confidentiality and disclosure are seen as major challenges in most work places. Country partners were encouraged to develop user-friendly, supportive HIV and AIDS

workplace policies and to create an environment for openness, acceptance and disclosure, which remain difficult issues even for organisations where greater openness and acceptance might be expected. Guarantees around job status and security were recommended and should include continued employment for as long as employees are still medically fit to work. Care and support initiatives came out very strongly during the consultations. Support mechanisms range from providing nutritional support to psychosocial counselling.

Limited Financial Resources

Most NGOs mentioned lack of financial resources as their primary limitation in implementing effective and sustainable workplace interventions such as the provision of ARVs. However, a workplace policy isn't all about money. Training, awareness-raising, a collective visit to a test centre, or free provision of condoms, don't need huge amounts of money. Besides, Hivos and other donors have committed themselves to supporting not only the development of the workplace policy, but also to support organisations in the implementation of comprehensive programmes.

Nonetheless, given the resource problems many NGO's are facing in Zimbabwe, to invest in workplace policies is apparently not a priority. A few NGOs such as GALZ have been innovative in sustaining their workplace programmes by fundraising internally from members through their Positive Image scheme, as well as putting aside an organisational budget extended towards workplace programmes. The Positive Image Scheme ensures that both staff and members who require ARVS will continue to receive treatment for as long as they retain their GALZ membership. Nonetheless, top-up financing is still needed for those requiring ARVS whilst serving their 'qualifying period' for the medical aid scheme.

Achieving Buy-in

Experiences in working with these NGOs have shown that while SAfAIDS is providing the technical services in policy development and programme implementation, the process dies a premature death because the NGOs remain unconvinced of the importance of comprehensive internal mainstreaming of HIV. Donors are also sometimes at fault in not recognising this internal organisational task as a priority they should include in their funding.

It is ironic that even some HIV and AIDS service organisations and women's NGOs that deal with reproductive health, did not have a workplace policy, blaming it on lack of funds or donor fatigue. It must be asked whether it is reasonable to expect other organisations to prioritise workplace programmes, if those organisations dealing with HIV and AIDS issues in their day-to-day work do not see the need to have one themselves. As is often the case with HIV, individuals and organisations appear to be in some kind of denial about the extent and reality of the problem.

Mobilisation of Resources, Knowledge and Awareness

Management commitment is essential and some NGOs with this commitment show impressive efforts directed at mobilising resources as a result. However, a significant percentage (27.8%) noted that they cannot implement or develop because of lack of adequate training and knowledge about HIV. Among the case studies that seem to fall in this category are those with a staff complement of fewer than ten employees.

It should be noted that the experience with NGOs and resource mobilisation towards HIV and AIDS workplace policies is fairly recent, the movement towards mobilisation is ongoing and developing and the story is as yet incomplete. It is also a universally acknowledged truth that progress inevitably generates new challenges and opportunities. Hivos has pledged further support towards innovative ideas in the development of workplace policies.

One possible reason for the reluctance of organisations to commit additional financial resources towards workplace programmes may lie in Zimbabwe's unique AIDS levy. Many partners and individuals interviewed during the survey noted that they contribute 3% of their pay as you earn income tax (PAYE) as AIDS levy to the National AIDS Trust. While recognising this as an important initiative, partners went on to question how the money was being used and who was benefiting from the Trust Fund. Concern was also expressed that the AIDS levy did not directly benefit those who contributed. Several called for increased visibility of the National AIDS Council's (NAC) activities within communities, and improved transparency in how the AIDS Trust Fund is disbursed.

Paving The Way For Sustainable Policies

There is need to find a way to convince NGO decision-makers that their effectiveness as well as their financial well-being, are inextricably linked to the overall impact of HIV and AIDS. Like other organisations, NGOs can achieve enormous benefits in relation to offsetting costs, as well as other unexpected benefits that go beyond the bottom line, such as staff loyalty and commitment.

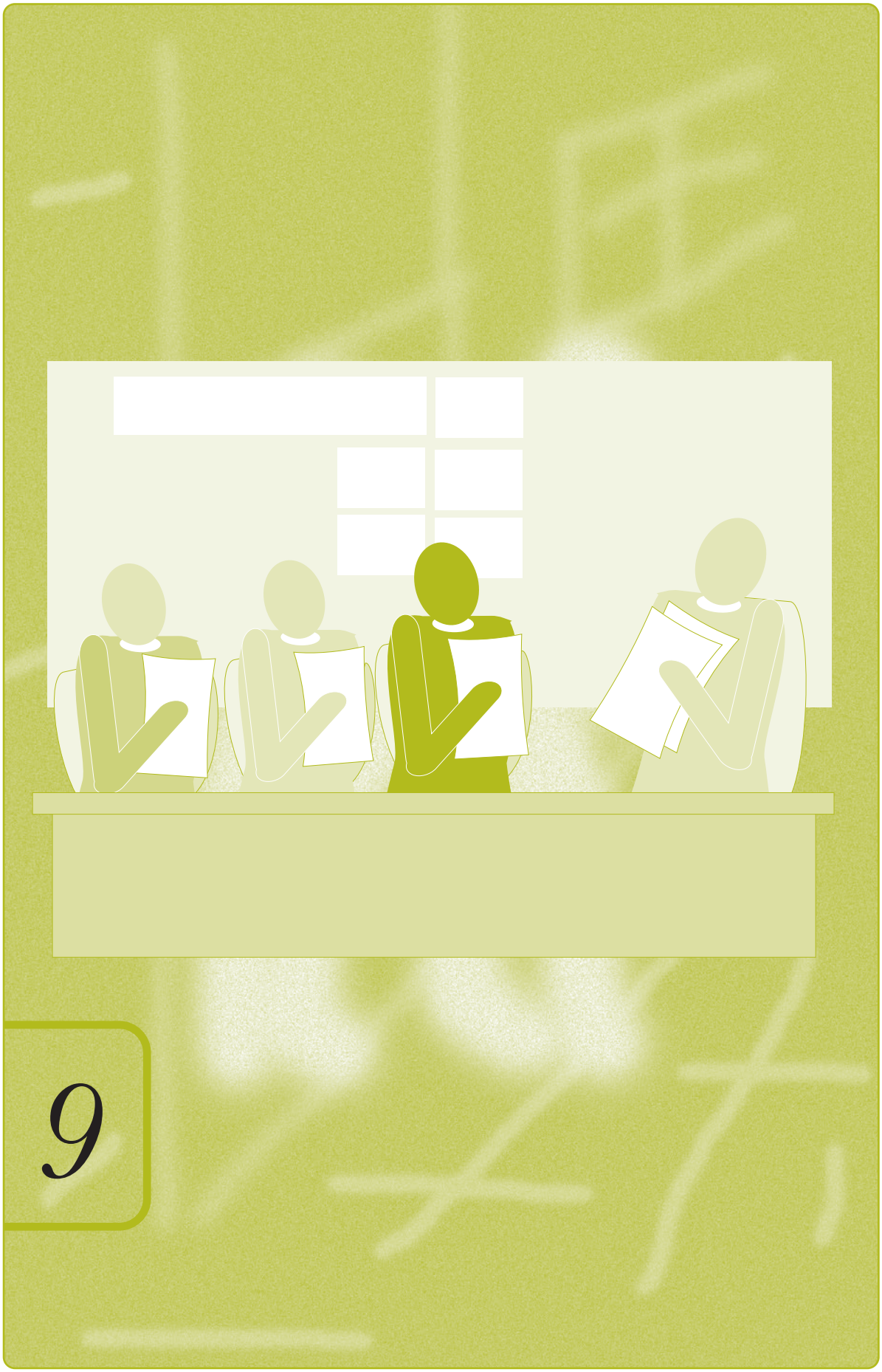
NGOs, like other employers, can reduce the negative effects of HIV-related illness among employees, by providing care, treatment and support, thus enabling them to remain productive and active in the workforce for a longer period of time. Retention of employees also allows for skills handover and the possibility of retaining knowledge within the organisation, even though an employee may no longer be working in their original position.

The consultative process revealed the keenness of Country Partners to enroll their employees on a medical health insurance scheme that covers HIV treatment and care. However, the cost of paying for such cover is often viewed negatively by donors, who see it as an unnecessary or unacceptable overhead.

Clearly there is a challenge here that needs to be faced. While some donors may be reluctant to commit funds to HIV workplace programmes, it should be a priority for all NGOs working in high-prevalence regions to emphasise this reality and its corresponding impact on their work, in all their funding proposals. If there were sufficient commitment from senior management, then it should be possible to highlight the urgent need for NGOs to retain skilled staff by ensuring that they do not die prematurely, and also to ensure that staff are able to give their full concentration to work, since any health concerns they may have, have been met by their employers.

Another area of emphasis was the importance of simultaneously developing and implementing a comprehensive HIV prevention, treatment, care and support programme, to achieve desired outcomes.

SAfAIDS and Hivos are consistently responding to the demand for supportive materials in the development of HIV workplace policies and the project continues to be a work in progress. To date, a total of eleven Hivos partners have been assisted. As already mentioned, two have existing policies in place, namely GALZ and ZWRCN, and in these cases the main focus of the consultative process was on the implementation aspects of the policy. By the beginning of 2006, nine more partners had developed their programmes and a review of the implementation strategies is underway. Hivos has realised the need to extend this support to their partners in the region and plans are now underway to commence the work in Malawi and Mozambique.



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CHAPTER 9

Managing HIV And AIDS In The World Of Work

by South African Revenue Service

Introduction

The South African Revenue Service (SARS) has reached a stage of development at which its human capital should be fully aligned with the organisation's goals while operating at optimal efficiency to achieve its strategic objectives. In ensuring this is so, SARS has established an Employee Wellbeing Programme (EWP).

There is substantial evidence to support the assertion that the EWP enhances the performance and reputation of organisations, and more than 95% of Fortune 500 companies in the United States have comprehensive EWPs in place. The business case for an EWP is built on simple assumptions and supported by a wealth of empirical research. The business case assumes that improvements in the personal wellbeing of employees as a result of EWP interventions, result in improvements in workplace morale, loyalty and performance as well as associated reductions in organisational operating costs. A plethora of research detailed in the most reputable international literature clearly supports this assertion.

In essence, this demonstrates that employees' personal and work-related problems result in decreased energy and efficiency and impact negatively on productivity, performance and behaviour in the workplace. As people with stresses, pressures and distractions are using only part of their talents, skills and energy whilst at work, business is negatively impacted - in both the short and long term.

Policy Development

SARS has developed a strategic, integrated and holistic Employee Wellbeing approach – branded "*Kulani-no-Hlayisa* (meaning "Grow while caring") governed by a common framework that includes the following:

- Human Resource practices and policies;
- Employee Assistance Programme (EAP);
- HIV and AIDS Management;
- Wellness screening;
- Absenteeism management; and
- Incapacity processes.

SARS' HIV and AIDS management is integrated into the comprehensive health management policy. This approach aims at minimising HIV and AIDS stigmatisation and therefore HIV is not managed as an isolated medical problem.

The advantages of a fully integrated employee wellness solution are that it;

- Provides a holistic approach to the individual employee as well as to the organisation. The employee has access to a vast range of supportive and wellness interventions (e.g. employees living with HIV have access to preventive, treatment, ongoing counselling, care and support services) - while for the employer, information is housed in one place, and thus management of health and behaviour risks is effective.

- Eliminates duplication of services and costs and prevents gaps in cover.

- Integrates data compilation of appropriate health indicators for the organisation compiled from providers, medical schemes, insurances, etc.

- Ensures ongoing measurement of the effectiveness of the organisation's health strategy and plan including:

    - Quality of service and skills of the healthcare providers
    - Measurement of absenteeism, staff turnover and other productivity indicators (e.g. in cases where reasonable accommodation needs to be made when people living with AIDS or other debilitating diseases become unproductive, due to deteriorating health)
    - Measurement of financial trends in the funding of the various health care benefits (e.g. increase/decrease in funding required for antiretroviral treatment for employees) and
    - Measurement of disease/wellness trends and impact.

Furthermore, the *Kulani no Hlayisa* programme informs and skills employees to take ownership of their wellbeing (physical, psychological and social) and to provide them with the necessary support to make informed decisions regarding their work and personal lives.

The service model was designed around SARS' unique make-up, its people and the overall human resource strategy of the organisation. Every effort has been made to:

- integrate wellbeing into the fabric of the organisation
- enhance individual functioning
- promote better work satisfaction and morale
- improve the quality and productivity of work and
- create a supportive workplace climate and culture.

Another potential advantage of this approach is that insurance companies are prepared to reduce premiums for disability and incapacity, where the outcome of these cases is effectively managed through the integrated approach.

The SARS EWP ("*Kulani no Hlayisa*") policy was developed in a "Phased implementation approach model", to achieve the following:

- Ensure that the vast range of services provided to employees through the programme continues uninterrupted in cases where an employee needs cross referral from one service provider to another. For example, employees that test positive during our in-house Voluntary Counselling and Testing campaign and need to be referred to other service providers for post-diagnostic care and support services and treatment, are referred within this continuous and uninterrupted framework.

- Implementation of the services which make up the programme is phased in a structured manner which is acceptable to employees. These phases are identified as follows:

  Structural Analysis
  A Wellness Committee, consisting of all stakeholders (Management, Labour and service-providers), was established, a needs analysis conducted and this resulted in the development of a Policy and Benefit Document.

  Risk Appraisal
  A behavioural Risk Management Audit (including HIV and AIDS Assessment) was conducted and a Human Capital Health Risk Profile was developed.

  Intervention Design
  The programme was customised and modified according to the identified needs and risk profile of the organisation.

  Operational Management
  Programme delivery. This is the actual implementation stage in the "Phased implementation approach model". This stage is characterised by the implementation of customised and modified programmes – as informed by, or in response to the needs and risk profile of the organisation. It addresses all the operational activities involved in the actual programme delivery and includes implementation, monitoring and evaluation of

the programme to ensure effectiveness, appropriateness and achievement of the set objectives.

Programme Implementation

SARS's Employee Wellness Programme (particularly the HIV and AIDS component) is provided by external service providers – to ensure optimum confidentiality and anonymity as compared to the traditional in-house EAP and disease management services.

The implementation of the SARS EWP aims at addressing the following key components:

- ***AIDS Awareness and Education*** – This includes formal education programme content, Peer Education, Industrial theatre and game shows, HIV and AIDS training and workshops, Quarterly Newsletters and an E-Learning programme.
- ***Online Services*** – Include a curriculum HIV, a comprehensive information and resources portal and e-mail communications.
- ***Wellness and Clinical Management*** – Outbound psychological and medical support, treatment support and adherence, STI management, 24-Hour medical and counselling assistance. (this is integrated with Employee benefits)
- ***Voluntary Counselling and Testing (VCT)*** – Planning and co-ordination, protocol and reporting, pre-test counselling and signed consent, HIV Testing and post-test counselling.
- ***Referrals*** – Any general practitioner, any laboratory services, any collection point (anywhere in the country) and palliative home-based care.

Beneficiaries Of The Programme

The EWP is accessible to all SARS employees, including their immediate dependents (e.g. spouses, children and extended family members). However, employees employed by external companies that are contracted to provide services to SARS (i.e. employees who are not on SARS's payroll) are excluded.

Costing Of The Programme

In order to justify SARS' investment in a comprehensive EWP, tangible, measurable evidence of the cost-effectiveness of this investment must be demonstrated. To estimate the potential return on investment of the proposed EWP, the quantifiable costs of the programme need to be compared with the quantifiable savings associated thereto.

The costing of the programme forms part of the Implementation Methodology for the Behaviour Risk Management (BRM) and Wellness programme. Costing for specific programme such as HIV and AIDS, the EAP, etc. is included within the integrated framework. This shows the **current impact of the EWP on SARS** with regard to the organisational costs, as shown in Figures 1 and 2 below. This provides a baseline measure for future evaluation of the effectiveness of the BRM and Wellness programme.

A return on investment model has also been included to demonstrate the potential benefit to SARS. According to this model, it is estimated that there will be a return of R4.71 for every R1.00 invested in the EWP – demonstrating that this employee wellness programme makes sound business sense as a strategic and value-adding intervention.

Figure 1.

SARS EWP Potential Return on Investment	
Number of employees	14 000
Average Annual Salary	(estimate) R 150 000.00
Cost of EWP per Employee per Month	R59.46
Predicted Utilisation Rate	15%

The cost of the "*Kulani no Hlayisa*" Employee Wellness Programme is R59.46 per employee per month. This is an all-inclusive fee for the full range of services which are provided on demand. The provider of service takes full risk for the provision of services for this fixed amount. SARS will not accrue any additional costs for any part of the programme.

Achievements/Successes

- An integrated Health Policy that allows a holistic approach in wellness management has been developed and implemented. This policy includes services that address HIV and AIDS Management, Employee Assistance, On-line wellness, a Border Post programme and an Executive Wellbeing programme.
- We have aligned our HIV and AIDS policy into the strategic business of the organisation thus ensuring management support and buy-in, consistency and prioritisation through the mainstreaming of HIV into the daily business of the organisation.
- The Employee Wellness Campaign (including HIV awareness) has been conducted and 76% of employees participated in the campaign. This shows an overwhelming support for the wellness programme.
- A VCT campaign for managers **"Lead by example"** has been successfully conducted.
- A Peer Educators programme (HIV and AIDS) has been developed and is up and running.
- An integrated technology and database system that ensures centralised, accurate and reliable information has been developed. This allows us to access information from one source, and to conduct scientifically informed analysis of various employee wellness issues.
- Employees are able to access services under one roof (one-stop-shop)
- Latest reports show evidence of increased utilisation of services by employees (i.e. from 8% in July 2005 to 14.4% in September 2006).
- A 24-hour service (Helpline) has been developed and is operational. All employees are able to access telephonic counselling support services, as well as face-to-face counselling when necessary.
- The use of external service-providers ensures confidentiality and anonymity, and therefore minimises stigmatisation around HIV and AIDS.

Figure 2.

SARS EWP Potential Savings	
Productivity savings from distracted employees using the EWP:	R19,293,750.00
Savings attributable to reduced absenteeism among employees accessing EWP:	R27,720,000.00
Total Savings from EWP	R47,013,750.00
Total cost of EWP for whole workforce:	R9,989,280.00
Return on investment	R1 : R4.71

Challenges

- SARS has offices scattered across the country – including ports and border posts (i.e. across all nine South African provinces). These offices are exposed to different wellness and behavioural risk factors, therefore different interventional approaches are necessary to address individual offices' needs. This complex demographic situation poses serious logistical challenges on effective management of wellness services.
- For an organisation with such different and complex demographic characteristics as SARS, adequate human and material resources are necessary. Therefore distribution of resources to meet the individual wellness needs of all the offices is a serious challenge.
- Customs officials who are manning the ports and border posts are exposed to hazardous substances and are prone to contracting various communicable diseases (e.g. Malaria, Cholera, Congo fever, etc) due to the nature of their work.
- Unhealthy living conditions, lack of recreational facilities and separation from their families are some of the factors that are likely to lead employees based in remote border posts and ports into engaging in health-risk behaviour.
- The roles of the Occupational Health and Safety (OHS) and Employee Wellness departments often overlap – thus resulting in duplication of services between these departments. This sometimes leads to situations where certain services are omitted as it is unclear who is responsible for them.
- Access to wellness services presents huge challenges; particularly in offices that are situated in areas where technology is underdeveloped such as border posts and rural areas (e.g. lack of landline telephones in cases where employees need to access the 24-hour toll-free EWP helpline services; lack of access to Information Technology resulting in inability to access EWP web portal by some employees).

Remedial Measures To Address Challenges

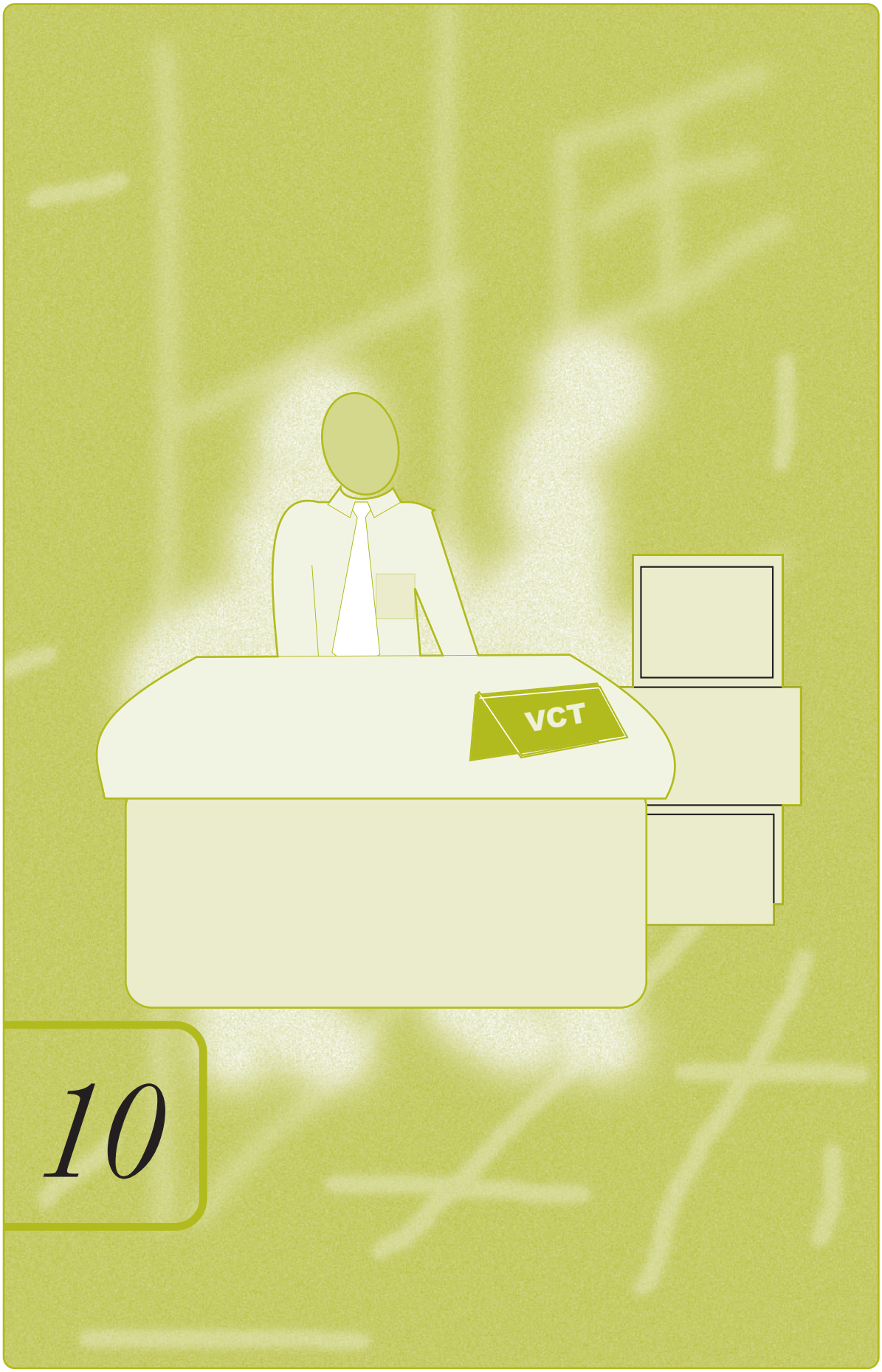
- In order to effectively address varying needs arising from the complex demographic nature of SARS offices, wellness services need to be customised to suit each specific office (a "one-size fits all" approach should be avoided).

- Adequate provision of resources and management thereof is crucial in addressing the complex needs of such a huge organisation. The demands of these unique offices require adequate and efficient allocation of both human and material resources.
- Efficient and adequate Occupational Risk management systems to address living conditions, health hazards and occupational injuries need to be consistently maintained.
- In order to address overlapping of services between OHS & EWP, the roles of both departments need to be clearly defined and where this cannot be avoided, both departments should be engaged in joint interventions.
- Improved access to telephone lines and IT facilities to facilitate communication with EWP services.

Lessons Learned And Way Forward

An integrated health management model alleviates stigmatisation around HIV and provides for holistic and accessible wellness services. This approach is cost effective because employees are able to access various wellness services in their workplace - thus bringing the services 'where employees are'.

As the costing analysis shows, even for an organisation with widely dispersed employees, operating under different conditions and circumstances, a comprehensive EWP is invaluable and well worth the effort required to establish and maintain it.



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CHAPTER 10

Treatment, Care And Support Programme: Experiences On Hippo Valley Estates

by Dr. R. Davy

How The Programme Started

Hippo Valley Estates is a large company situated in the Lowveld of Zimbabwe that has been growing and processing sugar cane for the past 50 years. The employees and most of their dependants live on the Estates and Hippo Valley Estates recognises that HIV presents a very real and significant threat to its employees and their families, to the local community and to the company and its stakeholders. From the outset, the company has been committed to trying by all means possible, to counter the effects of HIV on this population numbering approximately 26,000 in all.

In 1985, the company recorded one of the earliest, confirmed, cases of HIV in Zimbabwe and in that year, a vigorous education and awareness campaign was instituted. In those early days, our approach, was to try and scare our population into changing their lifestyle, with pictures of skulls and crossbones etc. This probably had little effect. The lag period between infection and manifestation of illness was just too long for scare tactics to be believable in those days.

The Hippo Valley Programme

From our initial efforts simply to inform and warn, the programme gradually developed into a far more comprehensive one. One of the most significant steps forward was the creation of a specific department within the medical division, devoted entirely to addressing all issues relating to HIV and AIDS; our Community Health Department.

Today's expanded programme has three arms:

Education And Promotion Of HIV And AIDS Awareness

- The awareness programme targets all vulnerable groups, by means of health personnel, Peer Educators (over 200), drama groups, community home-based care groups, youth groups, drama groups and trained teachers.

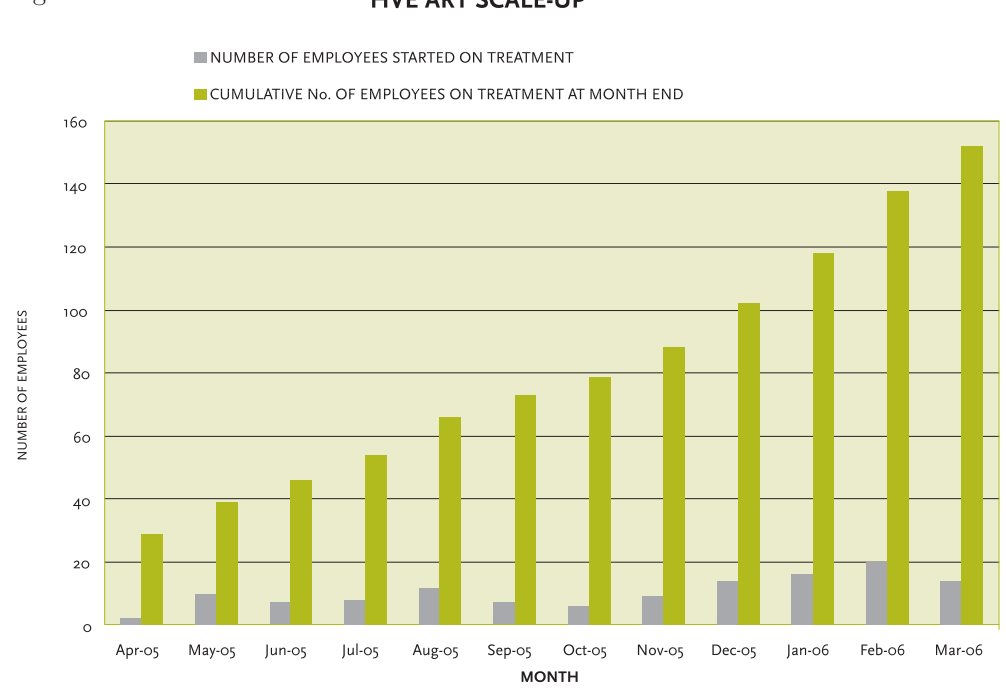
Prevention Of Transmission

- Voluntary Counselling and Testing (VCT) is available at the central clinic and also by means of an outreach programme to the various workplaces and the villages. The "opt out" approach is adopted in our medical centre. VCT is the gateway to a successful ART programme.
- Prevention of Parent-to-Child Transmission (PPTCT) is made available to all employees and spouses.
- Counselling service - covers pre and post-test counselling, counselling for sexually transmitted infections, ill health retirement and any other issues an employee or resident might raise.
- Provision of protective equipment for those at high risk, such as medical personnel and first aid workers. There is a post-exposure prophylaxis protocol and all the necessary drugs are available.
- Sexually Transmitted Infection programme, using the syndromic management approach.
- Provision of condoms, both male and female, free of charge, at all workplaces, clinics and village beerhalls.

Mitigation Of The Effects Of HIV And Provision Of Care And Support To Those Infected And Affected.

- Provision of prophylactic treatment against *Pneumocystis* pneumonia and tuberculosis, using cotrimoxazole and isoniazid, respectively.
- Treatment of opportunistic infections, when they present, such as thrush, tuberculosis, herpes zoster, cryptococcal meningitis and others. The HIV and AIDS and TB programmes are now fully integrated.
- Provision of a Wellness Clinic to provide counselling, nutritional and lifestyle advice, as well as preventive and curative treatment.
- Provision of a Home-based care programme, with support groups in the villages.
- Assistance with the care of orphans living on the Estates.
- Provision of antiretroviral treatment (ART) to all employees and spouses who need it. CD4 testing and most other investigations needed can now be done on site. Figure 1 illustrates the steady uptake of ART by our employees since this programme started.

Figure 1



- If all else fails, and an employee is not responding adequately to treatment and is unable to perform his or her normal work, a careful medical review is performed by a panel of two doctors. Ill Health Retirement, which has prescribed benefits, may then be recommended. All efforts will be made to pass the patient on to another ART programme in the area he is retiring to.

Other Aspects Of The Programme

- In addition to the three arms, we have an Estates AIDS Committee that meets regularly and is representative of a wide spectrum of groups on the Estates.
- We also have a comprehensive Policy on HIV and AIDS which has been signed off by both the worker leadership and management and is available for all to see.

How The Programme Is Financed

- The greater proportion of the financing of the programme comes from the Company. This includes all staff costs, some training costs, the cost of ART for employees, transport costs, consumables, and most drugs used in the treatment of opportunistic infections. Research in other companies has demonstrated a clear cost benefit in spending money to avoid or mitigate the effects of HIV and AIDS.
- The Global Fund Against TB, AIDS and Malaria provides all antiretroviral drugs for non-employees. The Fund also assisted with the cost of two additional building.
- TB drugs, most of the HIV test kits and the nevirapine used in the PPTCT programme are provided by the Ministry of Health and Child Welfare.
- Fluconazole, for the treatment of cryptococcal meningitis, is provided courtesy of Pfizer and sourced through the local government hospital.

- We have recently acquired a CD4 counter on loan from the Centres for Disease Control (CDC), which will be made available for the benefit of the community. Most other tests required can also be done in our laboratory.
- Additional training of doctors, nurses, laboratory scientists and Primary Care Counsellors has been provided through the Ministry of Health and Child Welfare.
- Some consumables and transport assistance have been channelled through to us from the National AIDS Council.

The Challenges We Face

- We continue to grapple with the inability of some to change their lifestyles and their fatalistic approach to their own lives.
- We are challenged by the intersection of traditional and conventional medicine, resulting in late presentation of patients for treatment, interference with ART and the addition of traditional remedies.
- Increasing workload: a prevalence survey conducted in 2003, shows that our ART programme has the potential to be treating over 3,000 people by the end of 2009. A number as large as this needs an incremental number of staff in terms of doctors, nurses, laboratory scientists, dispensary staff and others; all of whom must be funded by the Company.
- The need to ensure that our patients on ART take their drugs regularly and do not default on treatment, even when they go home. We encourage the "buddy" concept, for that purpose.
- Ensuring that mothers who have entered our PPTCT programme do, in fact, take their nevirapine and that their babies receive it also. Post-natal follow up remains less than adequate.
- The need to find alternative ART programmes for our patients who leave the company and the district.
- The need to keep the threat of HIV infection always in the minds of our people, particularly as each new wave of sexually mature scholars hits the rocky shore of adulthood.

What Lessons Have We Learnt?

Among many other things, we have learnt that:

- there is a vast resource of outside help available, within and outside the country, and that we cannot do it alone. We now interact with many organisations, governmental and non-governmental, to our great benefit.
- all the medical institutions in our district need to pull together and share xpertise, resources and experience.
- it is essential to educate and interact with the local traditional healers.
- there is a huge quantity of information readily available on the internet and by e-mail updates.
- despite the availability of drugs, not everyone will rush to take them.
- the fear of exposure and stigma runs deep and many are reluctant to come to terms with it.
- when employees on ART make the decision to "go public", their example and positive testimony can make a huge impact on those who are undecided about even being tested.

- despite some remarkable turnarounds, in general we are still starting treatment too late.
- the management of HIV and AIDS is a fast-evolving field and that the only constant is change.

Testimony

We end with a recent testimony from one of our employees, who has seen the benefits of being on ART and is happy to talk about his own status and progress in public, in the hope of persuading others to follow suite.

> *My name is Ishmael Zvinowanda, aged 31 years, married with two children. I was employed at Hippo Valley in 2001 as a permanent worker. I worked very well and was promoted until I started feeling unwell for six months. I decided to take up Voluntary Counselling and Testing in 2004. That is when I learnt that I was HIV positive.*
>
> *I have benefited a lot from the Hippo Valley ART programme, such that I am part of the VCT campaign team and go around encouraging other employees to know their HIV status. I am looking forward to a longer life.*

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CHAPTER 11

Sustaining Workplace-based Medical Insurance Schemes: Cimas Medical Aid Society Experience

by Dr. Maria M. Mupanomunda and MacDonald T. Chaora

As one of the oldest medical aid cover providers in Zimbabwe operating in a high HIV prevalence environment, Cimas medical aid society decided on an innovative approach in responding to the pandemic by providing a cover that included ARV medications and the blood tests necessary to monitor treatment effectiveness.

Background

The advent of antiretroviral drugs (ARVS) in 1996 ushered in new hope for people living with HIV and AIDS. World wide there are an estimated 42 million people living with HIV, six million of whom require antiretroviral therapy. The Ministry of Health and Child Welfare estimates that about 342,000 people in Zimbabwe require antiretroviral therapy (ART).

Antiretroviral therapy has now been widely documented to reduce HIV and AIDS-related morbidity and mortality and to improve the quality of life of people living with HIV and AIDS. In April 2004 the National Antiretroviral Therapy programme was initiated in Zimbabwe to offer antiretroviral therapy through the public sector. Before then, antiretroviral therapy was available mostly through the private sector and some research projects as well as mission hospitals.

Brief History Of Cimas Medical Aid Society

The idea of establishing a medical aid society or a mutual fund for the private sector, was first mooted some time before the Second World War, by the Chambers of Commerce and Industry in the then Southern Rhodesia. However, it was only after the war that on 1st of October 1945 the "Commercial and Industrial Medical Aid Society" opened its doors for business. Membership was open to those firms and employees who were members of the constituent chambers. In 1953, membership opened beyond industry and commerce and in 1968, the Society joined the International Federation of Health Plans (IFHP). In 1985, the Commercial and Industrial Medical Aid Society changed its name to Cimas Medical Aid Society. Today Cimas Medical Aid Society offers a bouquet of packages that cater for different groups ranging from top executives, to shop floor workers. Contributions for the different packages are based on community rating.

Cimas Medical Aid Society's Response to the HIV and AIDS Epidemic

The high prevalence of HIV in Zimbabwe coupled with the increased availability of ARVS challenges the private sector to play a more active role in complementing government efforts at promoting primary prevention and providing access to antiretroviral therapy. Some employers operate in-house programmes to pay for antiretroviral treatment for their employees, while individuals who can afford it, pay for ART out of pocket. However, the cost of drugs and the cost of the tests required for appropriate monitoring of treatment remain relatively high for individuals or individual employer groups. Cimas Medical Aid Society therefore recognised the need for a mechanism of risk pooling and the collection of the additional funds required to meet the costs of treatment at an affordable price. Furthermore, in order to minimise the emergence of drug resistance a co-ordinated access-to-care initiative was needed to ensure uninterrupted access to ARVS.

Consequently, the Society decided to offer its membership the 'Chronic Disease Add-on'. The Chronic Disease Add-on was launched in July 2003, specifically to address the issue of ARV funding for Cimas members. It is the culmination of a co-operative response to the HIV and AIDS pandemic involving Cimas Medical Aid Society, employer groups and various players within the health sector:

Table 1 Proportion of Cimas Beneficiaries on Chronic disease add-on

	Total	**%**
Beneficiaries on CDA-O	121,867	33.6%
Cimas Beneficiaries	362,195	

- Cimas Medical Aid Society co-ordinates the funding mechanism for drugs and for the payment of consultation and laboratory services. The Society also co-ordinates drug and laboratory logistics.
- Cimas member firms are mostly employer groups who have agreed to pay the additional contributions for their employees and their dependents.
- A network of health service providers offers diagnostic, treatment and counselling services and prescribes and dispenses ARVS in line with approved treatment guidelines.
- The Ministry of Health and Child Welfare spearheads training on ART usage and the production and review of national ARV treatment guidelines.

How To Enroll On Chronic Disease Add-on

The Add-on is not a stand alone package but is an add-on to existing Cimas packages. In other words one needs to be a member of Cimas to be eligible to join the Add-on. It is available to Cimas members at account level to cover the costs of treating HIV and AIDS. Once an employer decides to join the Add-on scheme, all beneficiaries ordinarily covered under that employer are required to enroll. There are several reasons why Cimas decided to offer the Add-on in this way:

- Confidentiality; everyone at work is covered and therefore employees are not obliged to disclose their HIV status to their employers as a prerequisite for accessing treatment.
- All family members and dependents who are ordinarily covered under Cimas packages have access to treatment. This helps to optimise treatment and reduces the risk of sharing of medicines among family members.
- Adverse selection, where only the sick obtain coverage, is reduced, risk pooling is maintained and therefore contributions remain affordable.

For the sake of treatment adherence and successful outcome, member firms are encouraged to remain on the Chronic Disease Add-on once they have joined. Members who leave employment or move to a firm that is not on the Add-on have an option to continue as individual contributors.

Benefits Of Chronic Disease Add-on

Cimas Medical Aid Society supports treatment protocols that are in line with the National Guidelines for Antiretroviral Therapy in Zimbabwe. Generally, first line treatment for adults consists of two nucleoside reverse transcriptase inhibitors and one non-nucleoside reverse transcriptase inhibitor. Second line treatment contains two reverse transcriptase inhibitors that were not included in the first regime, and a protease inhibitor (e.g. lopinavir/ritonavir).

Table 2 Access to ARVS by membership Status

Status	Total	%
Active	1,019	90.0%
Inactive	113	10.0%
Total since inception	1,132	100.0%

Access Procedure

Patients are attended to by their usual doctors who have received training on the use of antiretroviral drugs. Members on Add-on can access antiretroviral drugs at network pharmacies throughout the country. The full cost of ARVS is borne by the fund. Members only have to pay a small service fee to the dispensing pharmacist. Members can also access viral load and T-cell profile tests for monitoring therapy or disease progression.

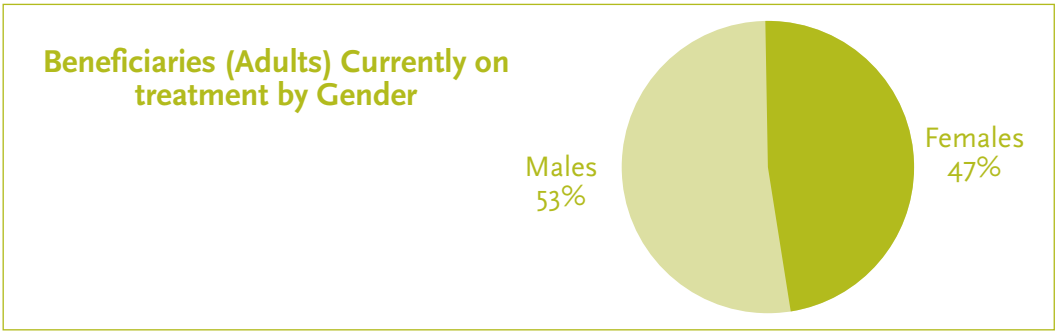
Cimas Co-ordinated Care Department, which falls directly under the Chief Medical Officer, maintains a register of antiretroviral use and utilisation of laboratory tests. Information

so obtained is treated with strict confidentiality and is used for procurement planning and for identification and follow up of inactive members.

Observations And Recommendations

- Utilisation is higher among members from employer groups who have wellness programmes in place, compared to those who do not.
- Cimas encourages employers to have workplace HIV and AIDS policies and programmes.
- To date there are over 120,000 lives covered under the Chronic Disease Add-on and over 1,000 beneficiaries are accessing antiretroviral therapy.
- Utilisation was low initially and we suspect this was due to a combination of factors including lack of information and the stigma associated with HIV, as well as cost. Cimas has stepped up information dissemination, targeting employer groups and service providers who are in regular and direct contact with members. We have noticed a sharp increase in utilisation over the past six months (mid-2006).
- Over 90 percent of those on treatment are on first line treatment. Adherence to treatment guidelines encourages rational use and helps to keep costs down.
- Eighty five percent of those on treatment are between the ages of 15-49 years. Forty five percent of those on treatment are women. Children comprise 6% of those on treatment. More information dissemination needs to be directed to the family unit to improve utilisation by dependents.
- Cimas continuously evaluates and improves upon the Add-on product, in response to market demands and professional inputs. To this end regular feedback workshops and presentations are held with members and health service providers.
- To enhance service provision the Society has initiated the development of primary care clinics.

Figure 1



Sustainability

The Chronic Disease Add-on is now in its third year of operation. Annual financial reports show that the product has performed well. An actuarial evaluation carried out in 2004 confirmed the same. Add-on contributions have remained relatively low in the face of escalating drug prices. We attribute this, in part, to cross subsidy, risk pooling and to the fact that the product is structured under the principles of managed care. It is our view that the programme is sustainable as long as it continues to run under the managed care approach. Current contributions are ZW$ 150,000.00 for an adult, against monthly drug costs ranging from ZW$13,000 for first line treatment to over ZW$50,000 for second line treatment (exchange rate as at September 2006 is ZW$250:US$1).

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CHAPTER 12

Access To Affordable Private Health Care: The Experience Of Okambilimbili Project In Namibia

by Ingrid de Beer

Introduction

Namibia is often termed the land of contrasts and opportunities. This is also a good description of the country's health care industry. In terms of access, the vast majority of the people in Namibia (84%) rely solely on the public sector. With the country's average HIV prevalence being just over 19%, the burden on the public sector to provide adequate health care and treatment for those affected by the HIV epidemic is extremely high.

Project Okambilimbili is an initiative of PharmAccess Foundation (based in the Netherlands) and aims to establish a strong basis for sustainable HIV and AIDS treatment in Namibia through a network of partnerships. It is recognised that HIV and AIDS treatment is more efficient when addressed in the context of general health care and when linked to a significant treatment literacy effort.

The project is managed by PharmAccess Namibia and is implemented as a joint venture with the Namibia Business Coalition on AIDS (NABCOA), Lironga Eparu (the Namibian National Association of People Living with HIV and AIDS) and the Namibia Red Cross Society. This initiative is funded by the Dutch Postcodeloterij, Stop AIDS Now, Hivos and the AIDS Fund.

In Namibia, only an estimated 16% (290,000 people) have access to private health care, either through medical aid, employer insurance schemes or out of pocket funding. Though most private sector companies, public sector and civil society organisations have policies in place to assist with the cost of private medical insurance for their employees, the cost of medical care remains unaffordable for many. As a result, less than half of the formally employed have access to private medical insurance in Namibia.
Given the potential capacity in the private sector, it is estimated that if the formally employed were to have access to affordable private health care, the burden on public health facilities could be reduced from 84% to 40% of the population.

The Approach

With these figures in mind, Okambilimbili set out to develop an affordable HIV and AIDS care and treatment mechanism, integrated into general health care facilities. The project partnered initially with Diamond Health Services, a newcomer in the Namibian private health care industry. This network of service providers offered an affordable primary health care product that included Highly Active Antiretroviral Therapy (HAART) to the uninsured employed population. As the product was partly paid for by the employers and subsidised by PharmAccess, through the grant received from Stop AIDS Now! Hivos and the AIDS Fund, the cost for employees was kept low. During 2005, the project subsidised 40% of the premium of N$163 (□20). With the employer paying 50% of the premium and the project paying 40%, the cost to the employee was only N$16.30 ((□2) per month. Soon it was recognised that the engagement of the wider medical aid industry was needed to scale up access to treatment. PharmAccess initiated negotiations with other players in the private health sector industry to develop affordable health care options including HAART, for the low to middle income employed. The intensive rounds of talks and negotiations undertaken by PharmAccess with health insurance providers led to a milestone achievement in 2005. By the end of that year, three new affordable health care packages were available on the Namibian market, including primary health care, HAART and basic hospitalisation. These products are partially subsidised through project Okambilimbili, to make them even more affordable to low and middle income employees.

Risk Sharing

The concept of insurance schemes based on solidarity has been encouraged through the project, as these can increase access for the currently uninsured employed and at the same time, stimulate investment in health infrastructure.

To share the risk posed to the insurance industry through the high HIV prevalence, the project supported the establishment of a risk equalisation fund by the Prosperity Health Group (a Namibian medical insurance company), called HEALTH-IS-VITAL. In this fund, employer-based insured and previously uninsured groups participate in sharing the financial risk of HIV and AIDS, by contributing a monthly premium per individual to a risk pool with a defined set of HIV and AIDS treatment benefits. This HIV and AIDS treatment benefit called 'Vitality' provides each beneficiary with N$100,000 for the care and treatment of HIV and AIDS per annum, including hospitalisation, medication, pathology, radiology, counselling and doctor consultations. The participating medical aid funds thus all provide a standard HIV and AIDS benefit through Vitality, as an add-on to their existing benefit structure.

The fund is approved by the Namibian Financial Institutions Supervisory Authority (NAMFISA) and governed by a board representing all major Namibian medical aid funds, NAMFISA and PharmAccess.

To support the administration and management of the risk fund, a joint administration and disease management company was established to pool support resources, through a local central information system. This company is externally quality-assured by PharmAccess through its international medical network and embedding in the Academic Medical Centre of the University of Amsterdam in the Netherlands.

Project Okambilimbili is enabled by the grant from Hivos, Aidsfonds and Stop AIDS Now!, to facilitate various uptake strategies to increase access to private health care, HIV testing and HAART through a dedicated HIV and AIDS treatment literacy campaign. Through this campaign, project partners focus their strategies on:

- Awareness raising and mobilisation in the business community, public sector and civil society to ensure that organisations realise that an appropriate response to HIV in the workplace must include access to health care and HAART for all employees and dependents.
- Awareness raising and mobilisation of employee groups and communities, to ensuring that individuals are aware that HIV is a manageable disease and that treatment is available.
- Treatment Education to ensure that once members of target groups report to health care settings for treatment, they and their immediate care-givers and supporters are provided with additional, more detailed information about their own health, the extent to which HIV has progressed and what can be done for target group members to remain as healthy as possible for as long as possible, thereby preventing the further spread of the virus.
- Encourage initiatives in the business community, public sector and civil society target community that provide support to deal with the impact of HIV and share information on the disease and its impact.
- Advocacy to ensure that actions and activities are realised that support the sustainable development of private health care funding mechanisms and infrastructure which provide greater access to care and treatment for a greater number of people living with HIV and AIDS.

Status And Results

The Health is Vital insurance fund was registered in February 2006 and marketing of the fund and the associated products started in March 2006. On the basis of available funding, the agreements with the associated products aim to mobilise 21,000 beneficiaries to access their choice of affordable product by the end of 2006.

Treatment literacy activities particularly focus on the mobilisation of private sector companies and organisations to implement policies whereby private health care insurance for their currently uninsured employee groups is facilitated. Specific emphasis is placed on treatment awareness for individuals, to facilitate a broader understanding that HIV is a manageable disease and that treatment is available.

Project Okambilimbili has brought together a network of civil society and private sector organisations to work jointly on providing access to sustainable private healthcare in Namibia. This resulted in the Namibian medical insurance industry opening up to a low margin, high volume market, and to develop low priced quality insurance for general healthcare

and HAART. A continued concerted effort by the partners in Namibia to mobilise the private sector, public sector and civil society organisations to provide private medical insurance to their currently uninsured employee groups aims to significantly contribute to the reduction of the burden on the public health facilities and increase access to HAART.

This project begins to exemplify the private sector's ability to complement the public sector and contribute significantly to a national response to HIV.

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CHAPTER 13

At The Diplomatic Core: Implementing An HIV And AIDS Workplace Policy For The Royal Netherlands Embassy In Zambia

by Mary Mweemba

Afya Mzuri is a Zambian non-governmental organisation (NGO), specialising in the implementation of HIV and AIDS programmes for workplaces and their host communities. The organisation started in June 2000 as the Zambia HIV/AIDS Business Sector (ZHABS) Project with three members of staff. This was a four year project funded by the Department for International Development (DFID) to support workplace programmes in Commonwealth Development Cooperation (CDC) Companies in Zambia.

Prior to the completion of the project in June 2003, the organisation registered as an NGO called Afya Mzuri. This enabled the organisation to offer its services to other organisations, including the public sector, embassies, NGOs and non-CDC companies, and to expand its activities to meet the full needs of employers, employees and their families in relation to addressing the impact of HIV. By April 2006, there were over twenty technical staff employed to provide services to over 100 workplace sites. The head office is in the capital city of Zambia (Lusaka), and there are satellite offices in Kitwe in the Copperbelt Region, and Choma in the Southern Province of the country.

Services provided by Afya Mzuri include:

- Support for workplace policy development and programme implementation;
- Peer educator and focal person training for HIV prevention and awareness programmes;
- Seminars for all employee cadres, including senior management;

- Design and implementation of anti-stigma training;
- Host community programmes for employees' families who live on-site;
- Outreach activities from the workplace to reach employees' families;
- Support in building the capacity of company clinical services, as well as community-based and public sector treatment, care and support services;
- Provision of information and IEC materials through resource centres in all three offices;
- Monitoring and evaluation of all activities, including baseline and follow-up behavioural surveillance surveys, programme evaluations, quarterly programme implementation status reports, and HIV prevalence surveys; and
- Operational research.

Royal Netherlands Embassy Workplace Programme

The Dutch Ministry of Foreign Affairs started implementation of its workplace HIV policy in the Royal Netherlands Embassies of nineteen countries in Africa in 2003. PharmAccess was contracted directly by the Netherlands Ministry of Foreign Affairs to implement the policy throughout Africa, and achieves this by sub-contracting a local agency within each country. Afya Mzuri was sub-contracted in December 2004 as the prevention partner for the Royal Netherlands Embassy (RNE) HIV programme in Zambia. At this stage, RNE (Zambia) had already developed its HIV Workplace policy and established an HIV Committee, by requesting that the Embassy's mission or works council take on a double role as HIV and AIDS Committee.

The 'Netherlands Ministry of Foreign Affairs HIV and AIDS personnel policy' is based on two key components:

- HIV and AIDS prevention and awareness, including Voluntary Counselling and Testing (VCT); and
- Provision of qualitative care and treatment for HIV positive employees, including antiretroviral (ARV) treatment.

The aims of the policy are to:

- Prevent HIV infection,
- Eradicate prejudice and misunderstanding about HIV and AIDS,
- Provide information about better access to VCT, and
- Promote proper care and support to PLHIV.

Key Programme Components

The key components of the programme implemented by Afya Mzuri are as follows:

1. Development, distribution and analysis of a survey to gather baseline data on knowledge, attitudes and practices (KAP) relating to HIV and AIDS, prevention, testing and treatment.
2. Conduct training for the HIV and AIDS Committee and peer educators.
3. Provision of IEC materials.
4. Provision of condoms and condom promotion.
5. Organisation of an internal and external launch of the HIV policy and programme.

6. Provision of monthly information updates on HIV-related issues.
7. Conduct focused activities on VCT, including events for spouses, youth and domestic staff.
8. Conduct follow-up KAP survey.

The activities carried out during the course of the programme were as follows.

In December 2004, the KAP survey to gather baseline data on knowledge attitude and practice relating to HIV and AIDS, prevention, testing and treatment was conducted.

The workplace policy was finally concluded in January 2005 and a week before the launch, the policy was distributed to all RNE staff, followed by the actual launch of the policy. The activities that were carried out during the launch were:

- Discussion of HIV and AIDS policy – the benefits, roles and responsibilities of employees;
- The proposed workplace programme to be implemented by Afya Mzuri;
- Introduction to the HIV and AIDS committee members, their roles and responsibilities;
- Introduction of peer educators

In February 2005, Afya Mzuri conducted a sensitisation workshop for the RNE HIV and AIDS Committee, to develop the terms of reference for the stakeholders. This was followed by five trainings of two peer educators

The external launch of the HIV and AIDS policy was done in April 2005 and was attended by all RNE staff and spouses. The launch was facilitated by staff from Afya Mzuri and local clinics.

Implementation of the policy began in April 2005 with seminar programmes conducted on the third Wednesday of each month. So far, the following topics have been covered:

- VCT
- HIV and AIDS Stigma and discrimination
- Myths and misconceptions about HIV and AIDS
- Sexually transmitted infections
- Positive living

In November 2005, a one day peer educators' training was held for two members of the international staff, to encourage one to one discussions amongst the international staff working at the Embassy.

In March and April 2006 the Embassy held a workshop for all local and international staff with their spouses. The workshop focused on VCT and on-site testing services that were provided through another local service provider, New Start Centre. Awareness sessions, as well as video shows and IEC materials, were provided by Afya Mzuri. Other activities included a barbecue and approximately 80% of those attending the workshop opted to be tested that day.

The second major activity was a similar workshop for the domestic staff and their spouses (cleaners, gardeners, domestic workers, etc.) of all RNE diplomatic staff. Awareness sessions were provided in local languages and other activities included a barbecue. Again all those who attended went for counseling and testing during the day.

A third activity was held in June 2006 at the demand of the domestic staff themselves, focussing on information and awareness. The emphasis was on awareness and the dissemination of information on "positive living" and living a healthy and worthwhile lifestyle whether one had tested negative or positive.

Who Is Involved?

The RNE in Zambia has an HIV and AIDS Committee comprising both local and international staff, that co-ordinates the workplace programme. One member from the committee has been appointed as the 'confidence person' whose role is to advise workers on HIV and AIDS. Two local and two international staff have been trained as peer educators, with an equal gender divide for local and international staff. In addition, both local and international staff are involved in most activities, particularly the monthly seminars on HIV-related activities. Selected activities have been for local staff only, such as the workshop for domestic staff.

Monitoring And Evaluation

PharmAccess is responsible for monitoring the effectiveness of HIV activities implemented by Afya Mzuri, including monitoring the staff response in terms of attendance at sessions. They also collect reports from the clinics on treatment uptake.

To evaluate the impact of the programme, the KAP survey will be repeated after approximately eighteen months. This will provide information on changes in knowledge, attitudes and practices relating to HIV as a result of the workplace programme.

Lessons Learned

Providing services to a multi-cultural workforce has been challenging, given the different expectations about teaching methods and approaches to addressing HIV, as well as the varying levels of education. The use of a variety of teaching methods and approaches has resulted in a valuable service that is meaningful for the embassy's diverse staff.

Recommendations

- The RNE in Zambia has adopted a positive approach to implementing its programme and has a comprehensive policy in place, which details the benefits available to all. All staff are involved in the programme at all levels. Other embassies would gain by emulating the approach to HIV programme and policy implementation adopted by RNE in Zambia.

- The Embassy should consider expanding its sponsorship of the implementation of similar workplace programmes in other organisations across the country, which do not have the resources to cover the necessary costs – e.g. small and medium sized businesses, farming communities, etc. using current channels of funding such as subgranting agencies CHAZ and ZNAN. RNE has already begun this, as evidenced in the Monze/Mazabuka Farm health project.

- The Embassy can further expand its activities by including programmes which provide care and support to those that are infected, such as psychosocial counselling, nutrition and assistance for the formation of support groups.

Conclusion

The RNE programme has resulted in RNE staff being well-versed in HIV-related issues and an eagerness to act on the information received. This is evidenced by the on-site response to VCT. Management's leadership role has also been a critical factor in the success of the policy.

Section 4.

Identifying Challenges: Responding To Needs

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CHAPTER 14

Comprehensive Peer Education Programmes

by Theo Machoko

What Is Peer Education?

HIV peer education in workplaces refers to the process of workers educating other workers. Peers are people in the workplace who are similar to one another in age, background, job roles, experience and interests.

Peer education involves peers communicating HIV prevention information and strategies in ways that can lead to behavioural change.

Why Peer Education?

In addition to having formally trained health professionals and educators (e.g. medical clinic staff) conduct education activities, training employees to be peer educators for informal education is also very effective.

Peer education takes HIV education that step further than simply the provision of information, towards attempting to change attitudes and motivate people to change behavioural practices which place them at risk. The peer approach to HIV education is effective for a number of reasons:

People are more likely to listen to and follow the advice of their peers. Peers have greater influence on each other than non-peers, a significant factor which lends credibility to behaviour change messages. It also removes some of the impediments to broader, more open discussion in the social environment, by creating insiders who are well informed and able to support positive health decisions.

What Constitutes A Good Peer Education Programme?

From the Chamber of Mines of Namibia's experience, a good peer education programme requires the following:

1. Moral, financial and resource support by the company for prevention and care programmes, both within the gates and in surrounding communities
2. Full employee participation and support from labour organisations
3. Continuity of the programme
4. Supportive policies
5. Full commitment from top management
6. Ongoing monitoring and evaluation of the programme's successes and failures to inform future development

What Are The Incentives?

Peer educators have a hard job, which they often do in addition to their paying jobs. It is important to provide positive feed back to them about their work and find ways to motivate them to continue with their work.

Some Suggestions For Incentives Include

- An annual party or dinner for peer educators to thank them for their efforts.
- A certificate of appreciation from the company for their work
- Special individual recognition for extra efforts
- Some token of thanks for their contribution, such as a tee-shirt or hat.

Peer educators are important resources for addressing HIV and AIDS in the workplace and ensuring that prevention messages are kept alive.

Qualities of Good Peer Educators

A good peer educator has:

- Self-confidence and sound knowledge of the subject matter
- The ability to be flexible and comfortable with talking to both groups and individuals
- A willingness to treat male and female peers with respect
- A sense of humour
- The flexibility to make adjustments when time, activity or participant response has changed
- The ability to resolve a conflict or disagreement in the group
- Creativity
- Experience of facilitating as well as teaching
- Willingness to do a lot of advance preparation
- Genuine commitment to help others

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CHAPTER 15

Succession Planning As A Tool To Ensure Sustainability In An Organisation

By Theo Machoko

What Is Succession Planning?

Succession planning is making sure that an organisation develops and keeps the right people for key jobs. More successfully, it defines the competencies needed for the future and develops them in everyone who has the capability. This provides a pool of talent from which successors to important jobs can be drawn.

The traditional model for succession planning for senior positions is for the board or a committee of senior management to identify, secretly, a list of two or three potential successors for each top management or professional job. This process is normally up-dated annually. This may, however, cause problems.

Problems With Traditional Model

- The organisation gets stuck in one rigid structure.
- Roles are perpetuated when they might need to be changed.
- Committees tend to want 'clones' so there is no diversity and little new blood
- Identified high fliers tend to be male graduate recruits who stay with the company and are picked as having potential in their late 20s or early 30s – women who take child care breaks and other groups, risk being ignored.
- The focus is on the job, not on the unique skills and experience of individuals.

Call For Flexibility

Succession planning needs to adapt to more flexible working markets. It needs:

- To deal with fewer layers of management.
- To provide career development (including lateral moves and improving management or specialist competencies.
- To use the abilities of all the people in the organisation and not just the high fliers.

Limitations Of Traditional Model

The most common problems companies have found in dealing with succession planning are:

- Mismatch – once plans are drawn up, those on the plan leave if not offered the job when it comes up.
- Only high fliers get opportunities.
- With de-layered organisations there are fewer opportunities for promotion so plans stagnate.
- Managers' development plans may moulder without monitoring by both Human Resources and the individual's manager.
- The worst outcome is when a highly regarded individual leaves, thinking he or she has no further prospects.

Succession planning means different things to different people and to organisations from a sole trader to complex conglomerates.

In the corporate world most Succession Planning has been targeted at key leadership positions only. Today's organisation dictates that the process must include key positions in a variety of job categories. Succession Planning has also been evolving. Methods used in the past may not necessarily be effective in the current environment. In fact, succession planning is a process of ensuring business continuity or sustainability:

- Human Capital – numbers, skills and leadership.
- Financial
- Ownership (depending on size and mode of business)

Imperatives In Today's World

Its imperative for an organisation to understand:

- Where it is
- Where it wants to go
- What route it should take to get there.

Only then is it prepared to face the future. Succession Planning therefore is no mean task. Mapping out the future involves more than the display of a company's hierarchy on a chart.

We need to know:

- Which employees possess what particular skills.
- What competencies are required to assume higher positions on the corporate ladder.
- What talents will be required in the future.
- How best to train employees for management/specialist positions or hire from outside.

As can be seen, the task of talent planning is difficult to define, let alone implement.

The Business Case For Succession/Talent Planning

Being prepared is better than being surprised.

- Businesses are talking a lot about skills loss due to HIV but what are we doing to mitigate the loss? Suggestions are as follows:
- Succession/Talent planning is a systematic, fully integrated organisational process that involves proactively planning ahead to avoid talent losses.
- It is based on the assumption that a company can be staffed more efficiently if it forecasts its talent needs and actual supply of talent. The activity must assume the same if not more gravity and discipline as that applied to financial planning.
- By planning ahead, Human Resources can provide an organisation with the right number of people, with the right skills in the right place and at the right time.

The process integrates:

- Recruiting
- Retention
- Redeployment
- Leadership/Employee development

Beyond The Traditional Model

- Businesses that just wait and then attempt to react to current events will not survive. The challenge is to provide the business with warnings and action plans to combat full-blown problems ahead of time.
- The rate of change on the talent market is dynamic and dramatic. Succession Planning is now becoming synonymous with Talent Planning and is fundamental.
- It is time to manage talent pipelines by starting to manage current Talent Inventories – [Current company employee base.]

Major Components Of Succession Planning In The New Model

There is no standard formula. No one-size-fits-all model. Some plans contain many components while others contain just a succession for senior managers.

Common Components

Forecasting and Assessment - Estimates, for example, of the internal/external supply and demand; labor costs company growth rates and company revenue.

Succession Planning - Designating, for example, the progression plan for key positions.

Leadership Development - Designating high-potential employees; coaching; mentoring; rotating people into different projects.

Secondments and Attachments

Retention - Forecasting turnover rates; identifying who is at risk and how to keep them.

Redeployment - Deciding who is eligible for redeployment, and from where to where.

Contingent Workforce - Designating the percentage of employees who will be contingent, and in what positions.

Potential Retirements - Figuring out who is eligible, when they are eligible, who will replace them, and what alternative work arrangements are available that could prevent a retirement problem.

Performance Management - Instituting 'forced ranking' or identifying who should be 'managed out'.

Career Path - Career counseling for employees to help them move up.

Training/Development - Skilling:

- Basic
- Advanced

Internal Placement - Developing job-posting systems for internal employees to get a bite into new openings.

Environmental Forecast - Forecasts of industry and environmental trends as well as a competitor assessment.

Identifying job and competency needs - Doing a skills-and-interest inventory.

Metrics - Identifying metrics to determine the effectiveness of workforce planning.

Who does what in the game of planning

An effective Talent/Succession Plan requires the involvement of all levels of the organisation.

ACTIVITIES	LEADERSHIP	HUMAN RESOURCES	LINE MANAGERS
Conduct strategic planning	X	X	X
Conduct workforce planning	X	X	X
Develop Human Resources strategies		X	
Align employee expectations with			
Human Resources strategies	X	X	X
Design/Chart organisation	X	X	
Identify business functions			X
Conduct environmental scan		X	
Assess/forecast demand		X	
Assess/forecast surplus		X	
Analyse workload gap/surplus		X	X
Create staffing plans		X	X
Identify competencies	X	X	X
Create development plans		X	X
Implement development plans			X
Envision desired workforce	X	X	X
Measure results		X	
Undertake process re-engineering			X
Assess efficiency/effectiveness			X
Conduct succession planning		X	
Develop capabilities	X	X	X
Develop effective managers	X	X	X
Enable/evaluate performance	X	X	X
Share success communication	X	X	X
Develop retention strategies		X	
Achieve diversity	X	X	X
Assess budget implications	X	X	X
Coordinate strategic IT planning	X		

Impact Of Good Talent Planning

Some of the multiple significant impacts of good Talent/Succession Planning are:

1. Eliminating surprises

HR should limit the stressful "trauma" related to being surprised. HR should have the time to prepare processes and answers.

Rapid talent replacement*:* Having the capability to rapidly figure out positions that are vacant due to sudden (or unavoidable) turnover so that production or services don't miss a beat.

2. Smoothing out business cycles

You can smooth out the cycles by developing processes that ramp up and down your talent inventory and work effectively during both good times and lean times.

No delays. Ensuring that the company can meet production goals by having the people.

The right skills. Ultimately increasing product-development speed because the company has the brightest people with the right skills to take products through to their launch on time.

Employee development. The ability to ramp up rapidly on new projects because the company has prepared and trained internal talent to meet the project needs.

3. Identifying problems early

If you have a smoke-detector system in place to notify managers before a talent fire gets out of hand, it will be much easier to minimise the potential damage. HR should develop a system of "alerts" to warn managers of minor problems (that they can rectify with little effort) before they turn into major problems.

4. Preventing problems

Having to fix problems is expensive and painful. A superior approach is to prevent problems from ever occurring.

Lower turnover rates. Employees are continually groomed for new opportunities that fit their career interests and capabilities. They transition easily and rapidly to them.

Low labour cost. The capability is developed to rapidly reduce labour costs without the need for large-scale layoffs of permanent employees.

No layoffs. Avoiding the need for layoffs by managing the head count ensures that the company won't have a "surplus" of talent.

5. **Taking advantage of opportunities**
Given sufficient lead-time, you can gather resources and the talent necessary to take advantage of positive opportunities. When you're constantly fighting fires, you generally miss even seeing the opportunities, and there is seldom enough energy left to respond to them.

> ***Take advantage of opportunities.*** Efficient management will free up HR professionals so that they can take advantage of talent-sourcing opportunities (like weekend poaching) from a competitor as a way to find exceptional talent during tough economic times.

6. **Improving your image**
Looking like you're constantly in a frantic state does nothing to inspire confidence or improve your department's image. By being well prepared for any eventuality, you build your image, your brand, and your credibility, so Finance Directors will be more likely to invest.

Key Areas Of Talent Planning

The talent forecast

Talent forecasting is a strategic process for predicting upcoming changes in the demand for and the supply of talent. Forecasts are generally broken down into four areas:

a) Estimated increases or decreases in company growth, output, and revenue.
b) Estimates of the corresponding change in talent needs that come from that growth. Estimates can include the number and type of employees as well as where and when they will be needed.
c) Projections of future vacancies.
d) Estimates of the internal and external availability of the talent needed to meet forecasts.

The predictions that result from the forecast have two basic purposes:

- To educate or provide a heads-up to managers and HR about what they should expect on the talent front.

- To provide specific information on the supply of and demand for talent across industries. In this way, specific action plans can be developed in the next part of the talent-planning process (talent action plans) to provide the company with an advantage over its competitors. Action plans are generally developed in each of the different forecasted areas, including recruitment, retention, redeployment, contingent workforce, leadership development, and succession planning.

Talent Action Plans

Action plans can be broken down into three general activities:

1 ***Sourcing and recruiting an adequate supply of leaders and key talent***
Maintaining an external recruiting capability to identify and court a supply of future leaders (and top talent in key positions) to ensure that the company's growth and profitability are not restricted by an inability to find and hire the right employees.

2 ***Internal development and supply of qualified leaders and key talent***
Identifying and grooming internal talent and providing learning opportunities to increase the internal supply of future leaders (and top talent in key positions) to ensure that the company's growth and profitability are not restricted by a lack of leadership talent.

3 ***Forecasting the gap between talent needs and its availability:***
Providing talent, diversity, and leadership supply and need requirements to management so that they are aware of, and are considering solutions for, the gap between the company's overall talent needs and the identifiable supply of talent.

The Integration Plan

Action plans must be fully implemented if a company is going to meet its forecasted talent needs. Unfortunately, most talent plans fail or drop off when they come to the implementation phase.

Written plans can sit on shelves, whereas action plans can be independent of normal, day-to-day operations. For action plans to be effective, succession planning and the process of being "future-focused" must be fully integrated into every aspect of Human Resources management.

In addition to being seamlessly integrated into every aspect of HR, workforce planning must become a way of thinking for managers as well. The integration plan has many aspects, including communication, a business case, and the identification of potential supporters and resisters. Metrics and rewards are also used to encourage action and overcome resistance.

Outlook

If done properly, talent/succession planning:

- increases productivity,
- cuts labour costs,
- cuts time to market because you have the right numbers of people
  - with the right skills,
  - in the right places,
  - at the right time.

It works because it forces everyone:

- to be forward looking and
- prevents surprises
- it requires managers to –
  - plan ahead and
  - to consider all eventualities.

In other words, Succession/Talent Planning:

- Expects the unexpected
- Transcends current assumptions and trends
- It anticipates and resolves
- It approximates thinking and organisational culture

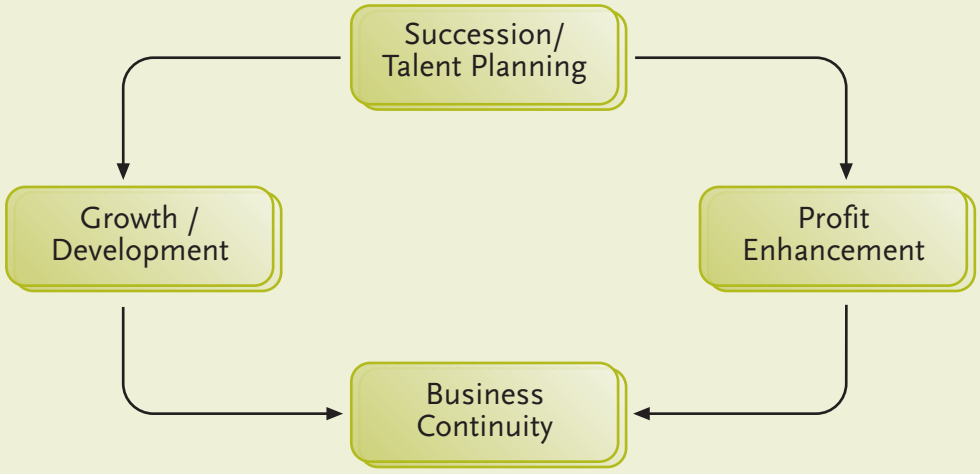
Talent/Succession Planning is for the entire organisation not just for Executives, that is why it is critical.

Succession Planning ensures:

- Profit enhancement
- Continuity
- Business Growth

Hence it must be taken seriously.

Figure 1



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CHAPTER 16

Principles of Good Practice in Workplace HIV and AIDS Programming

by John Mandisarisa

Introduction

Workplace prevention education, care, and support programs are the core of an organisation's response to HIV and AIDS. Effective programmes are not one-time events but a variety of co-ordinated and ongoing activities and services. A well-designed HIV and AIDS prevention education, care, and support programme usually includes a comprehensive set of complementary components. The ILO recommends that employers and labour leaders consider developing and implementing prevention education, care, and support activities (ILO. 2002).

Definition Of Good Practice

Good Practice is a management idea which asserts that there is a technique, method, process, activity, incentive or reward that is more effective at delivering a particular outcome than any other technique, method, process, etc. The idea is that with proper processes, checks, and testing, a project can be rolled out and completed with fewer problems and unforeseen complications (Webmaster, 2006). In real-world application, Good Practice is a very useful concept and does not commit people or companies to one inflexible, unchanging practice. Instead, Best Practices is a philosophical approach based around continuous learning and continual improvement (Badcock-Walters P and Whiteside A, 2000.) and includes the need to improve on processes as times change and things evolve.

10 Key Principles of Good Practice in Workplace HIV and AIDS Programming

1. *Consultation, participation and partnership*
2. *Leadership*
3. *An enabling environment of laws and rights*
4. *Conditions of trust and non-discrimination*
5. *Building on structures already in place*
6. *A continuum of prevention, care and support, and access to treatment*
7. *Going beyond the workplace*
8. *Communication*
9. *Gender-specific programmes*
10. *Equity considerations: ensuring access for those in need*

ILO, 2006

Good Practice In Workplace HIV And AIDS Programming

Begins with inculcation of positive values, beliefs and attitudes towards HIV and AIDS. It is most effective when it reflects an understanding of HIV and AIDS programming as multidimensional, integrated, and revealed in performance over time.

Workplace HIV programming is not an end in itself but a vehicle for overall knowledge, attitudes and practice improvement. Complex as the subject of HIV and AIDS is, there is a lot to learn for both employees and employers. Its effective practice, then, begins with and enacts a vision of the kinds of learning we most value for workers, and strives to help them achieve the best of HIV- and AIDS– related behaviour change.

Programming observes the principle that learning is a complex process. It entails not only what workers know but what they can do with what they know; it involves not only knowledge and abilities but values, attitudes, and habits of mind that affect both performance and success in HIV prevention beyond the workplace. Programming should reflect these understandings by employing a diverse array of methods, including those that call for actual performance, using them over time so as to reveal change, growth, and increasing degrees of integration. Such an approach aims for a more complete and accurate picture of learning, and therefore firmer bases for improving our workers' practical experience.

When the programmes it seeks to improve have clear, explicitly stated purposes. Workplace HIV and AIDS programming is a goal-oriented process. It entails comparing behaviour change performance with HIV prevention purposes and expectations - these are derived from the institution's mission, from workplace intentions in prevention programme design, and from knowledge of workers' own goals. Where programme purposes lack specificity or agreement, HIV programming as a process pushes a workplace toward clarity

about where to aim and what standards to apply; HIV programming also prompts attention to where and how programme goals will be taught and learned. Clear, shared, implementable goals are the cornerstone for HIV programming that is focused and useful.

Requires attention to outcomes but also and equally to the experiences that lead to those outcomes. Information about outcomes is of high importance - where workers "end up" matters greatly. But to improve outcomes, we need to know about workers' experiences along the way - about the curricula, facilitation, and kind of workers' effort that lead to particular outcomes. HIV programming can help us understand which workers learn best under what conditions. With such knowledge comes the capacity to improve the whole of their learning.

Works best when it is ongoing, not episodic. Workplace HIV and AIDS programming is a process whose power is cumulative. Though isolated, "one-shot" interventions can be better than none, improvement over time is best fostered when programming entails a linked series of cohorts of workers; it may mean collecting the same examples of worker performance or using the same approach time after time. The point is to monitor progress toward intended goals in a spirit of continuous improvement. Along the way, the programming process itself should be evaluated and refined in light of emerging insights.

Fosters wider improvements when representatives from across the workplace community are involved. Worker learning is a workplace-wide responsibility, and programme activities are a way of enacting that responsibility. Thus, while programming efforts may start small, the aim over time is to involve people from across the workplace community. Management plays an especially important role, but workplace HIV programming's questions cannot be fully addressed without participation by workers committees, peer educators and other internal facilitators, administrators, and workers including the promotion of gender equality.

Workplace HIV and AIDS programming may also involve individuals from ***beyond the workplace*** (external facilitators, trustees, employers) whose experience can enrich the sense of appropriate aims and standards for HIV prevention, care and mitigation. Thus understood, Workplace HIV and AIDS programming is not a task for small groups of experts but a collaborative activity; its aim is wider, better-informed attention to worker needs by all parties with a stake in its improvement. Activities also need to reach beyond the workplace and extend services to families and communities, in partnership with government and donors if necessary (ILO, 2006).

Makes a difference when it begins with issues of use and illuminates questions that people really care about. Workplace HIV and AIDS programming recognises the value of information in the process of improvement. But to be useful, information must be connected to issues or questions that people really care about. This implies Workplace HIV and AIDS programming approaches that produce evidence that relevant parties will find credible, suggestive, and applicable to decisions that need to be made. It means thinking in advance about how the information will be used, and by whom. The point of HIV impact assessments is not to gather data and return "results"; it is a process that starts with the questions of decision-makers, that involves them in the gathering and interpreting of data, and that informs and helps guide continuous improvement

Is most likely to lead to improvements when it is part of a larger set of conditions that promote change. Workplace HIV and AIDS programming alone changes little. Its greatest contribution comes in workplaces where the quality of work and a healthy lifestyle is visibly valued and worked at. In such workplaces, the push to improve worker performance is a visible and primary goal of leadership; improving the quality of workers' performance is central to the institution's planning, budgeting, and personnel decisions. In such workplaces, information about healthy outcomes is seen as an integral part of decision making, and avidly sought.

Creates a situation where employers meet their corporate social responsibilities to workers and to the public. There is a compelling public stake in productivity. Employers have a responsibility to the publics that support or depend on them, to provide information about the ways in which their workers meet goals and expectations. But that responsibility goes beyond the reporting of such information; the organisation's deeper obligation - to itself, to its workers, and to society - is to respect human dignity and human rights and to uphold the ethics that govern good business practice. Those to whom employers are accountable have a corresponding obligation to support such attempts at improvement.

Workplaces that uphold these principles strive to ensure that their workers, families and dependants (in the spirit of outreach), have access to comprehensive Workplace HIV and AIDS programmes that include but are not limited to the following:

1) **Formal and informal HIV and AIDS prevention education activities for all employees.**
2) **HIV prevention support,** including condom distribution systems that make condoms readily and consistently available and where appropriate, programmes that address drug use
3) **Sexually Transmitted Infection (STI)/Opportunistic Infection (OI) diagnosis and treatment** for employees, partners, and/or family members; this includes STIs other than HIV and Opportunistic Infections associated with HIV
4) **Access to VCT** within or outside the workplace.
5) **Counselling, care, and other support programmes** for HIV-positive employees and/or family members.
6) **Provision of more advanced treatment therapies** for employees and family members who are living with HIV and AIDS, such as provision of ARVs or HAART

It is possible to develop a workplace programme that does not include all of these components. However, experience in other workplace settings indicates that the most effective programmes ensure that these complementary components are readily available to employees, either in the workplace or in the surrounding community. The lack of available services in many communities places greater pressure on the employer to directly provide services, and calls for careful prioritisation of services based on need, benefit, cost, capacity, and other factors.

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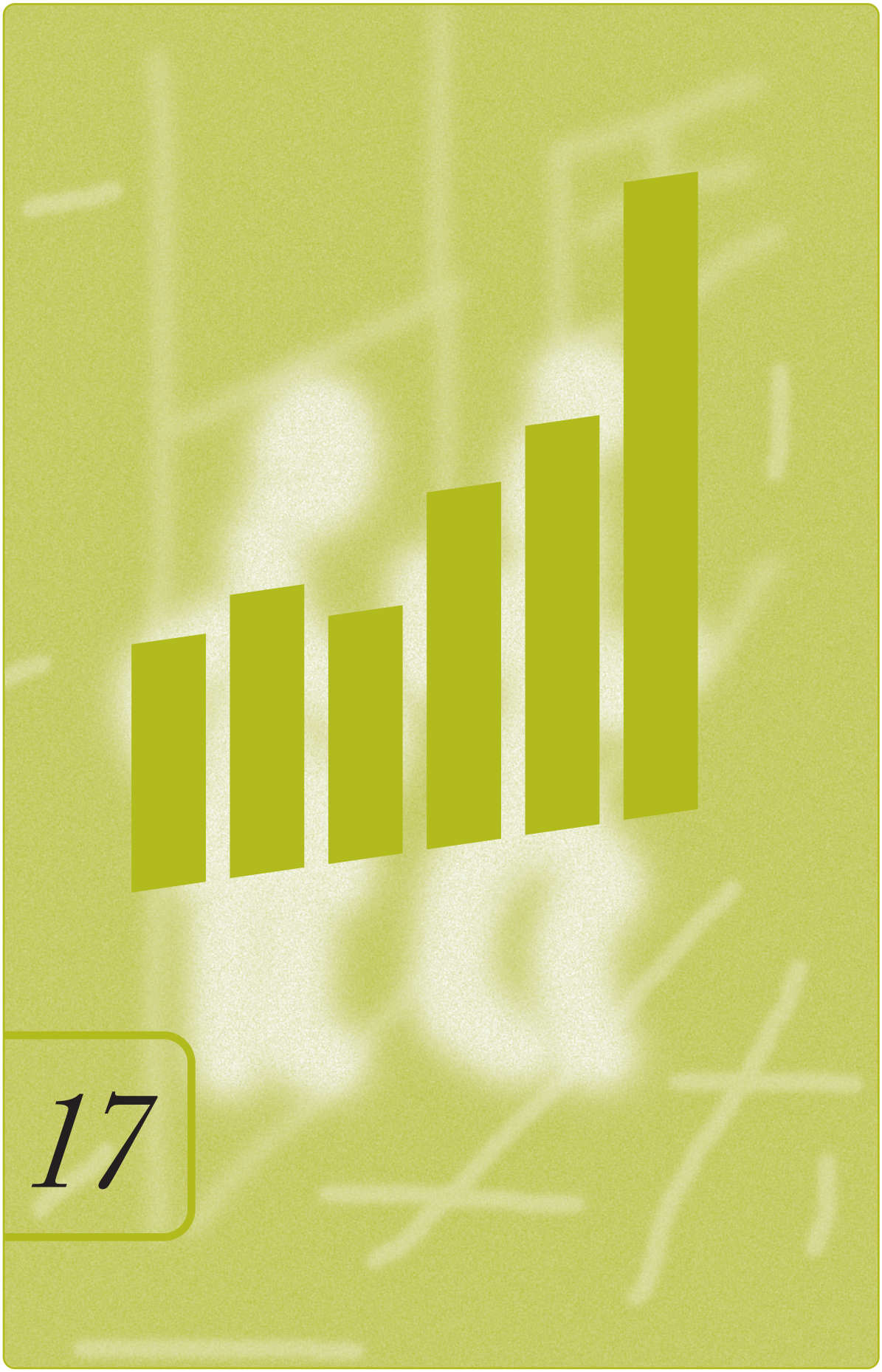

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CHAPTER 17

Monitoring, Evaluation And Reporting Of Workplace Based HIV And AIDS Programmes

by Godfrey Musuka and Verengai Mabika

Introduction

Monitoring is the systematic process of collecting and analysing routine information to track the **efficiency** of the organisation in achievement of goals, whereas, evaluation is the systematic collecting and analysing of information to assess the organisation's **effectiveness** in the achievement of its goals.

Monitoring, evaluation and reporting (MER) are essential elements of HIV and AIDS workplace programmes, providing a way to assess the progress towards achieving the programme goals and objectives and to report to key stakeholders and programme designers about the results. It also allows for programme changes to be made when the desired results are not achieved. For MER to be successful and to provide useful results, it must be incorporated into programmes at the design stage.

Workplace programmes at all levels, whether they consist of multiple integrated projects or single interventions, should include a detailed work plan. Such plans should highlight what information or data need to be collected, describe how best to collect it, and specify how to disseminate and use the results.

Monitoring addresses the following questions:

1. To what extent are planned activities actually realised? Are we making progress toward achieving our objectives?
2. What services are provided, to whom, when, how often, for how long, and in what context?
3. How well are the services provided?
4. What is the quality of the services provided?
5. What is the cost per unit of the service?

Evaluation addresses the following questions:

1. What outcomes are observed?
2. What do the outcomes mean?
3. Does the programme make a difference?

Tools used for collecting data on Workplace HIV and AIDS programmes

Focus Group Discussions (FGDs)

Focus group discussions are a useful tool for collecting qualitative data on workplace HIV and AIDS programmes. A moderator follows a predetermined interview guide to direct a discussion among between five and twelve people, with the purpose of collecting in-depth qualitative information about a group's perceptions, attitudes, and experiences on a defined topic.

Focus group interviewing is particularly suited for obtaining several perspectives on the same topic. The benefits of focus group research include gaining insights into people's shared understandings of everyday life and the ways in which others influence individuals in a group situation. Focus group discussions should be seen as complementary to other (more quantitative) research methods. It is useful to carry out a preliminary analysis of the survey data that will inform the questions to be asked in the groups. The commonly used method of analysing FGD data is content analysis, where data is explored in detail for common themes.

Individual In-depth Interviews

These take the form of a discussion between the interviewer and an individual with knowledge on the implementation of a workplace HIV and AIDS programme. In-depth interviews involve open-ended questions asked by a researcher to an individual. Interviewers use a topic guide but do not rely on a structured question set. Probing techniques are used to encourage respondents to give the fullest answer possible. They can look at how respondents' answers to the questions relate to their actual experiences. This technique can also be used to explore topics in their own right, to provide more depth about a subject or individual cases than a quantitative survey would, or to complement quantitative enquiry. Issues can be explored in detail with participants. The commonly used method of analysing in-depth interviews is content analysis, where data is explored in detail for common themes.

Knowledge, Attitude, Practice And Belief Surveys

Many of the major health problems facing society today, including HIV and AIDS require interventions that will influence the change of personal behaviour. Use of Knowledge, Attitude, Practice and belief surveys (KAP) to monitor and evaluate workplace HIV and AIDS programmes is based on the theory that individuals' knowledge, combined with their

attitudes and beliefs, may predict their health related behaviour. This method collects standardised information from a large number of people. This approach uses a pre-tested questionnaire with both closed and open-ended questions. There are several options in implanting the questionnaire, namely, whether interviewer administered or self-administered. A key limitation of KAPB questions is that respondents will give the answers 'expected of them' and these may be different from the respondents' actual behaviour. KAP survey data are normally analysed descriptively, with response preferences being associated with demographic and sociological characteristics.

Reporting Of Workplace HIV And AIDS Monitoring And Evaluation Data

A key component of any workplace HIV and AIDS monitoring and evaluation system is reporting. There is not much point in collecting data unless you know how and by whom that data will be used. Data from workplace HIV and AIDS monitoring and evaluation programmes should be converted into useful information for the different audiences (workers and managers).

The report of workplace HIV and AIDS monitoring and evaluation programmes should contain descriptive information, outline progress made, difficulties encountered, successes and lessons learnt during the implementation of programmes and activities. A good report should assess performance of the programme over the past reporting period using established indicators, schedules, baselines and targets. Secondly, it should clearly state whether and by how much progress or results surpassed, met, or fell short of expectations and give at least tentative reasons why.

After The Reporting

After the reporting has been done, it is up to management to read and analyse the findings in order to come up with ways of ensuring that the in-house HIV and AIDS programme continues to develop. All too often it is this last, crucial step that is ignored or given insufficient attention. Management need to remember that it is they who set the pace for the organisation. If they do not put their full weight behind HIV and AIDS workplace programmes, then they will fail and as is indicated by the evidence elsewhere in this book, failure is a very expensive option.

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