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Access to treatment in the private-sector workplace

The provision of antiretroviral therapy by three companies in South Africa

UNAIDS BEST PRACTICE COLLECTION



This best practice publication was researched and written by Lindsay Knight.

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Access to treatment in the private-sector workplace

A joint publication of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the International Labour Organization (ILO), the World Health Organization (WHO), and the Global Business Coalition on HIV/AIDS



Joint United Nations Programme on HIV/AIDS

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**World Health
Organization**



GLOBAL BUSINESS COALITION ON HIV/AIDS

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Preface

Over the past two decades, it has become increasingly clear that the only way to effectively respond to the AIDS epidemic is through involving all sectors of society—including business. Although some in the business sector are still slow to act, others recognize that engaging in the response to HIV and AIDS is part of their corporate and social responsibility. The private sector is now emerging as a major participant in the response.

Some companies have been running HIV education and prevention programmes in the workplace for many years, partly because they had the foresight to anticipate the challenges of the epidemic. The working populations of many countries are being decimated by AIDS. It is reversing gains in development and economic growth and depressing business production levels.

In fact, businesses in seriously affected countries in sub-Saharan Africa have had to accept that even innovative and comprehensive prevention programmes are not enough to stem the tide if not coupled with effective treatment initiatives. This case study describes the work of three companies in South Africa—Anglo American, BHP Billiton, and Eskom—in providing their employees with antiretroviral therapy (ART).

These companies set a powerful example to the business sector: antiretroviral therapy prolongs people's lives, allowing them to remain in the workforce, continue as parents to their children and be effective citizens. In South Africa, in particular, where the government is gradually rolling out a nationwide programme of treatment, companies such as these are pioneering ways of effectively providing access to antiretroviral therapy.

Their experience shows that partnerships between industry, labour, government, communities and civil society represent the most promising approach to effectively responding to the AIDS epidemic.

UNAIDS, ILO, WHO, Global Business Coalition on HIV/AIDS

1. Introduction

The availability of antiretroviral therapy from 1996 onwards has made a huge impact on the lives of those people living with HIV who can afford the drugs. But most of the beneficiaries of the new drugs live in the world's high-income countries. For many of them, AIDS has become a manageable chronic condition rather than a death sentence. Affluent countries have seen a 70% decline in AIDS-related deaths since the introduction of antiretroviral therapy.¹

In countries in which antiretroviral drugs are provided on a large scale (in Brazil, for example), the impact is remarkable. The number of hospital patients with AIDS is greatly reduced, people living with AIDS return to their families and jobs, and AIDS-related morbidity and mortality fall dramatically.²

However, for the huge majority of people living with HIV in low- and middle-income countries, it is a different story. Neither they nor their countries' health-care services can afford to annually pay the huge amounts of money that the drugs cost, even taking into account recent reductions in drug prices.

Cost has not been the only barrier to wide-scale provision of antiretroviral therapy in low- and middle-income countries. Health experts have expressed concerns about providing drugs to large numbers of people in settings where health-care services do not even offer adequate basic care, let alone the support and monitoring needed for antiretroviral therapy. The slow progress in antiretroviral provision has meant that although five to six million people need antiretroviral therapy in low- and middle-income countries, only about 700 000 had access to it by the end of 2004. In sub-Saharan Africa, more than four million people need treatment, but only 310 000 had access³ by the end of 2004.

'There is a growing, global movement of people living with HIV and their advocates, civil society organizations, health professionals, philanthropic foundations, international agencies, governments and private sector corporations who are now working to reverse this injustice [i.e., the disparity in access to antiretroviral therapy]. Their efforts have helped shape a global consensus that believes it is intolerable to allow millions of deaths from a treatable disease, and that prevention strategies alone are not enough to contain the HIV epidemic. Treatment and care are therefore the crucial, missing link in the global response because, by alleviating suffering, reducing stigma and mitigating the economic and social impact of the disease, they can reinforce the fight against HIV/AIDS.'

— *Public health approaches to expand antiretroviral treatment*, WHO, 2003

Various programmes in low-income countries⁴ have demonstrated that antiretroviral therapy can be provided in countries that do not have the sophisticated health service infrastructure of industrialized nations. In South Africa, for example, in the Khayelitsha township outside Cape Town, *Médecins sans Frontières* has been providing antiretroviral therapy to people in need since May 2001 through dedicated HIV and AIDS clinics in primary health-care centres.⁵ Similar programmes in Haiti and Uganda are yielding good clinical results.

¹ See *The "3 by 5" Initiative*. (<http://www.who.int>).

² *Public health approaches to expand antiretroviral treatment*. Geneva, World Health Organization, 2003.

³ *A Commitment to Action for Expanded Access to HIV/AIDS Treatment*. International HIV Treatment Access Coalition. Geneva, World Health Organization, December 2002.

⁴ *Ibid.*

⁵ *Antiretroviral Therapy in Primary Health Care: South African experience*. Geneva, World Health Organization, 2003.

Access to antiretroviral therapy will be facilitated by an increase in available funding and in the support for health infrastructure. New funding to support treatment and care is available through the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), through the US President's Emergency Plan for AIDS Relief (PEPFAR), and via the World Bank Multi-country AIDS Programme (MAP), among others. In Haiti, for example, money from the Global Fund is being used to provide HIV prevention and treatment throughout the country.

However, globally the amount of money available for care and treatment, particularly antiretroviral therapy is far below what is really needed. One broad area in which the funding gap is having a serious impact on provision of treatment is in strengthening health sector infrastructure, including training and retention of doctors, nurses, laboratory technicians, community health workers and other human resources. For example, the 3 by 5 initiative, launched initially by WHO and UNAIDS to mobilize access to antiretroviral treatment for 3 million people in need by the end of 2005, is unlikely to meet its target due in large part to insufficient human resources in the health sector.

Both private and public workplaces provide many opportunities for extending access to treatment through occupational health services and health insurance schemes. The International Labour Organization (ILO), the Global Fund, and other partners are working together to support expanding public-private partnerships in the world of work. This includes community outreach: the employer covers the costs of antiretroviral drugs for the workforce and the Global Fund or other donors extend access to these drugs to families and the local community. A fundamental principle is that public health provision should be strengthened, not undermined, by the contribution of the private sector to AIDS treatment.

A number of companies now have experience in providing antiretroviral therapy to their employees. Given the potentially negative impacts of the epidemic on productivity and sustainable profits, there is a clear business case for offering access to treatment, and in doing so, businesses are seen as good corporate citizens. These companies have faced some of the same challenges as the public sector, such as ensuring sustainable provision of drugs and tackling the lack of health-care infrastructure. Some (notably in South Africa) have gone ahead with such programmes before the roll-out of a public-sector universal treatment plan.

After a brief description of important components of HIV and AIDS workplace programmes, this study focuses on access to treatment in the private-sector workplace. It features three companies in South Africa that are providing antiretroviral therapy to their employees. Detailed descriptions are given of the companies' care, support and treatment programmes, and their differing approaches and shared challenges are analysed.

Although antiretroviral therapy is the main component of treatment discussed, care and support programmes also include advice and support on diet and nutrition, exercise, psychological issues, and other methods which appear to boost the immune system.

2. Impact of HIV and AIDS on business

“HIV/AIDS is the worst health crisis in at least 600 years. It is perhaps the worst in history ... HIV/AIDS has also become an unprecedented threat to global security, stability and economic growth ... it devastates economies and markets, as we are now witnessing in southern Africa. ... Business has too often been an untapped partner [in the response]. It is an inescapable fact that the sector, as a whole, has been slow to respond to AIDS. Yet businesses not only have a responsibility to act, but an opportunity to play a crucial role in the global fight against the epidemic, particularly within their own workplace.”

— Richard Holbrooke, President and Chief Executive Officer (CEO)
of the Global Business Coalition on HIV/AIDS

Recognizing that the AIDS epidemic is a workplace issue

‘HIV/AIDS is a workplace issue and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.’

—The *ILO Code of Practice: Key principles (4.1)*

The AIDS epidemic is having a major impact on enterprises—on employers, managers and workers—especially in countries with high HIV prevalence. There is a direct impact on companies’ profitability and even survival. AIDS causes productivity to decline, increases business costs and has a negative impact on the wider economic climate in which companies operate.

Business’s most valuable asset—its workforce—is shrinking in all countries seriously affected by the AIDS epidemic. Of the approximately 40 million people living with HIV worldwide, at least 26 million are workers in their productive prime—that is, between the ages of 15 and 49. The size of the labour force in high-prevalence countries will be 10%–35% smaller by 2020 than it would have been without the AIDS epidemic.⁶ The remaining workforce will contain a higher proportion of younger workers who are less experienced and less well-educated than the current group. Furthermore, dramatic reductions in life expectancy are predicted in some of the worst-affected countries.

The full impact of the epidemic is not easy to assess. In most countries, the worst is yet to come, with mounting morbidity and mortality; the time lag between HIV infection and progression to AIDS can be several years, making it difficult to measure impact. Even in South Africa, for example, there is very little reliable information about the true costs of HIV and AIDS to enterprises.⁷ The media has reported productivity losses of between 2% and 50%.⁸

Collecting accurate data on HIV and AIDS is problematic, both for technical reasons relating to the capacity for data collection, and because people living with HIV fear being subjected to stigma and discrimination, which leads to significant underreporting.

⁶ *HIV/AIDS and work: global estimates, impact and response*. Geneva, International Labour Organization, 2004.

⁷ Rosen S et al. Care and treatment to extend the working lives of HIV-positive employees: calculating the benefits to business. *South African Journal of Science*, 2000.

⁸ Michael K. Unbelievable: AIDS reporting in the business press. *AIDS Analysis Africa* 10(4), December 1999/January 2000.

A January 2004 survey conducted by the South African Business Coalition on HIV and AIDS (SABCOHA) asked 106 South African businesses about the impact of the epidemic. One third indicated that HIV and AIDS already had a significant adverse impact on their business, reducing labour productivity or increasing absenteeism and raising the cost of employee benefits. Some 30% reported higher labour turnover rates; 27% indicated that they had lost experience and skills; and 24% incurred extra recruitment and training costs due to the epidemic. Asked to rank the HIV- and AIDS-related costs, they cited the following as having the largest impact on company costs:

1. lower labour productivity and increased absenteeism
2. higher employee benefit costs
3. lost experience and skills.

A higher percentage of the large companies (more than 75%) reported a significantly stronger impact than smaller companies, but this may be because of their greater capacity to monitor and measure impact.

The SABCOHA report explains that companies' vulnerability to HIV and AIDS will vary, depending on a number of factors:

- labour intensity of the company;
- the risk profile or susceptibility of its workers;
- the skills of affected employees and the ease of substitution between workers;
- the structure of employee benefit schemes;
- the degree to which companies have implemented strategies to cope with the epidemic's impact; and
- the impact of AIDS on suppliers of key production inputs, as well as on the company's target market.

Declining productivity and increasing costs

Productivity is hit as employees fall ill, take leaves of absence to care for sick family members, attend funerals, or die. The loss of experienced semi-skilled workers or those with higher education can have a particularly strong impact on productivity and costs. It may well be difficult to replace them, and costly to pay for recruitment, training and extra supervision. The same is true for managers. High staff turnover can also result in organizational disruption and the loss of corporate memory. As a result, more errors may be made by younger and less-experienced workers, and the quality of products and services may decline.

Contractors and suppliers are also affected by the epidemic, and this may contribute to falling productivity and profitability—for example, as a result of delays in supplying essential parts.

The cost to a company of a day of paid absenteeism for an employee is 'conservatively estimated' at twice his or her daily salary.⁹ Comparative studies of East African businesses have shown that absenteeism due to HIV and AIDS can account for as much as 25%–54% of company costs.¹⁰ Other HIV- and AIDS-related costs include:

⁹ Rosen quoting Morris CN and Cheevers EJ. The direct costs of HIV/AIDS in a South African sugar mill, *AIDS Analysis Africa* 10(5) 2000; and Greener R. *Impact of HIV/AIDS and options for intervention: results of a five-company pilot study*. Botswana Institute of Development Policy Analysis, Working Paper 10, 1997.

¹⁰ *Report on the Global HIV/AIDS Epidemic*. Geneva, Joint United Nations Programme on HIV/AIDS, 2002.

- an increase in insurance premiums;
- an increase in pension fund commitments;
- an increase in health benefits and the use of health-care facilities when these are provided by the company;
- an increase in funeral costs; and
- planning and managing the epidemic's consequences—reassigning tasks, or possibly having to reduce the size of the company's premises.

A major South African insurance company estimated the potential benefit liabilities of the epidemic to the corporate sector, and showed that three benefits—a lump-sum payment on death, a spouse's pension and a disability pension—rise in the face of increased mortality and morbidity. In 1995, the cost of these three benefits comprised about 7% of the payroll. By 2010, this figure could rise to 18%.¹¹

Less easy to quantify, but an important issue stressed by managers and trade unions, is the effect on morale and motivation of workers as they see their colleagues and friends develop symptoms and eventually die. This effect may be made worse by the stigma attached to HIV and AIDS, which creates a culture of silence and denial.

By 2001, HIV and AIDS had caused salary costs in many South African companies to rise by 2%–6%.¹² Estimates of the annual cost of HIV and AIDS per employee range widely, from about US\$ 17 to US\$ 300.¹³ But it is not easy to calculate the costs of the impact of HIV and AIDS. Actual costs to an organization will depend on the status of the epidemic, the employee profile, structure of the work and available benefits. There are barriers to collecting accurate data. For example, it is hard to identify which employees have died of AIDS-related illnesses; the stigma attached to the condition makes doctors reluctant to state the real cause of death. Some studies¹⁴ have correlated trends in deaths in organizations with HIV prevalence in the general population and assumed that increased mortality was due to AIDS. For example, by the mid-1990s, the Uganda Railway Corporation had an annual employee turnover rate of 15%. There were suggestions that more than 10% of its workforce had died from AIDS-related illnesses.¹⁵

Companies' profits are also affected by a decline in demand for its products and services as incomes are cut and savings used to pay for medicines and care. Authors Barnett and Whiteside cite examples of companies in South Africa, including a furniture retailer and a soft-drinks manufacturer, which are expecting reductions in sales of as much as 12.5%.¹⁶

Economic growth and development

The effects of HIV and AIDS on productivity, profits, investments and markets combine to undermine economic growth in many low- and middle-income countries. Governments receive smaller tax revenues while at the same time they have to increase spending on health and social services. They also have fewer resources to invest in economic development, and foreign investors may lose confidence in these countries. The annual economic growth rate in

¹¹ Kramer S. HIV and AIDS: Getting down to business, 2001. Personal communication to Barnett and Whiteside. Quoted in Barnett T and Whiteside A: *AIDS in the Twenty-First Century*. Basingstoke, Palgrave Macmillan, 2002.

¹² *Workplace HIV/AIDS Programs*. Research Triangle Park (North Carolina), Family Health International, 2002.

¹³ Bollinger L and Stover J. *The Economic Impact of AIDS*. Washington, DC, Futures Group International, 1999.

¹⁴ Quoted in Barnett T and Whiteside A: *AIDS in the Twenty-First Century*, Basingstoke, Palgrave Macmillan, 2002.

¹⁵ Barnett and Whiteside.

¹⁶ *Ibid.*

sub-Saharan Africa is estimated to have already fallen by 2%–4% because of AIDS. By the year 2020, the World Bank has estimated¹⁷ that the macroeconomic impact of the epidemic may be enough to reduce the growth of national income by up to one third in countries with adult HIV prevalence of 10%.

Development gains in many countries have been reversed by the effects of the epidemic. Key workers are being lost in huge numbers; in 25 African countries, for instance, seven million agricultural workers have been lost to AIDS since 1985, thus threatening food security and nutritional levels. In South Africa, in 1998 it was estimated that one in seven civil servants was HIV-positive.¹⁸

Access to education is seriously compromised because teachers are dying, government resources are diverted from schools and other educational institutions, and school-age children, especially girls, miss school in order to care for ill or dying relatives. Business depends on the education sector for its future workers, managers and business leaders. Thus, in the most affected countries in Africa, AIDS is causing the deaths of employees with skills and experience that are not easily replaced. At the same time, there is also a reduction in the capacity of schools, universities, technical and other training institutions to re-supply graduates with the necessary education and skills.¹⁹ The situation is compounded as the informal transfer of skills is interrupted through young people losing the parents, mentors and co-workers who would have provided guidance and care.

¹⁷ *Employers' Handbook on HIV/AIDS. A guide for action.* Geneva, International Organisation of Employers, 2002.

¹⁸ *HIV/AIDS as a security issue.* Washington and Brussels, International Crisis Group, 2001.

¹⁹ Cohen D. *Human capital and the HIV epidemic in sub-Saharan Africa.* Geneva, International Labour Organization, 2002.

3. The business sector response

For many years, the response to HIV and AIDS was managed as a health issue by national and international health services. It was difficult to foresee the extent of the spread and impact of the epidemic, partly because of the time lag between infection with HIV and the development of AIDS. All concerned parties (including business and organized labour) were slow to understand the need for a response that brought together all sectors of society.

Nevertheless, a growing number of companies are taking innovative and effective action against HIV. Companies in some countries started workplace programmes as early as the mid-1980s. Trade unions have also responded by offering awareness-raising and education activities, training peer educators and taking action against discrimination. Increasingly, recognizing their common interest in effectively responding to the epidemic, employers and unions are cooperating with each other on AIDS-related issues.

Responding to HIV and AIDS together: A programme for future engagement

In May 2003, the International Organisation of Employers (IOE) and the International Confederation of Free Trade Unions (ICFTU) signed a joint agreement and plan to respond to HIV and AIDS. The two organizations recognize and stress 'the crucial added value of labour-management cooperation to combat' the spread of the epidemic, and call on their affiliates and members to give the issue the highest priority, and to 'work together to generate and maintain the momentum necessary for successful interventions'. Joint strategies focus on young people and gender dimensions of the AIDS epidemic, and on encouraging governments in all countries to focus on health-care delivery systems and infrastructure development, international funding to help poor countries meet their health-care needs, and the effective and safe use of the best health-care interventions. They are putting in place joint action plans to be piloted in eight African countries.

The Global Business Coalition on HIV/AIDS is an alliance of international companies dedicated to responding to the AIDS epidemic 'through the business sector's unique skills and expertise'. Since 2001, membership in the Coalition has increased from 17 companies to more than 200, representing nearly 4 million employees in 178 countries.

A growing number of national business coalitions have been set up to respond to the epidemic, and they support and advise small- and medium-sized enterprises as well as large companies. Several large corporations have also involved suppliers and distributors in their workplace programmes on HIV and AIDS.

The ILO is the lead agency within the UN system for action against AIDS in the world of work. It mobilizes its tripartite constituents—government, employers and workers—and strengthens their capacity to contribute to national efforts to reduce the spread and impact of the epidemic. It supports the planning and implementation of workplace policies and programmes through research and information, policy advice and capacity-building in the framework of The ILO *Code of Practice on HIV/AIDS and the world of work*. The *Code* establishes key principles for policy development and practical guidelines for programming in the key areas of prevention, care and the protection of human rights.

The experience gained over the past 15 or so years has resulted in a fairly general consensus about the key components of effective workplace action. The following section summarizes these components, drawing on a number of key documents (see page 47 for full references), plus the websites of major participants such as the Global Business Coalition on HIV/AIDS and the World Economic Forum's (WEF) Global Health Initiative. A 2003 report from the ILO²⁰ provides a detailed analysis of best practices in workplace policies and programmes, and a 2004 ILO report²¹ provides modelling and estimates on the impact of the epidemic in the world of work.

The ILO recently carried out a pilot survey of HIV and AIDS activities undertaken by companies in 11 countries; five in Africa, five in Latin America and the Caribbean, and in China. Preliminary returns from the 42 surveyed companies revealed that the size of their workforces—which ranged between 12 and 310,000 employees—was a major factor. Most of them provided on-site occupational health services, applied The ILO Code of Practice *on HIV/AIDS and the world of work*, and had workplace programmes to prevent HIV. However, all three services were more likely to be found in larger companies.

On the other hand, few companies provided antiretroviral treatment, care and support services to family members or to the community. Size remained an advantage in providing most of these services, but did not necessarily determine whether companies offered community outreach services. It was just as likely that small companies would extend workplace action to the community as large ones, indicating that small companies may have had the advantage of being closer to the community. These preliminary findings suggest that any additional research should focus on whether a company's size and resources and its relationship with the community are determining factors in the strength of its commitment to HIV and AIDS workplace action.

²⁰ *Workplace action on HIV/AIDS: identifying and sharing best practice*, a background report for the Tripartite Interregional meeting on Best Practices in HIV/AIDS Workplace Policies and Programmes. Geneva, December 2003.

²¹ *HIV/AIDS and work: global estimates, impact and response*. Geneva, International Labour Organization, 2004.

4. Key components

1. Define the scale of the problem and the HIV- and AIDS-related risk to the company

Conducting a prevalence survey of HIV across a company presents the most comprehensive data, which then becomes a basis for action. Many companies have undertaken these surveys and have found it useful to include some questions on HIV-related knowledge, attitudes and behaviour. This can appear difficult or time-consuming, but advice and sample surveys exist to help employers. Another method is to assume that the national or provincial/regional prevalence data reflect the situation within a company and obtain the relevant information from the country's ministry of health or AIDS-control agency. In any case, it is essential that a baseline be established in some way against which the impact of workplace programmes can be measured.

It is also useful to review existing data from the human resources department or occupational health service (if any), such as rates of absenteeism, staff turnover, medical costs, insurance claims, retirements due to ill health, plus health statistics such as rates of sexually transmitted infections. These are indicators that can be used to assess the impact of the epidemic on productivity and profitability, as long as principles of confidentiality are respected.²²

2. Formulate a workplace policy and programme on HIV and AIDS based on the information collected. The policy 'states the company's position and practices for preventing the transmission of HIV and for handling HIV infection among employees'.²³

All policies and programmes need to focus on preventing stigma and discrimination against people living with HIV, and encourage greater involvement of, and support for, people living with the virus. They should ensure confidentiality for all employees, and confidentiality procedures need to be seen as completely reliable by staff. Policies and programmes should be developed and implemented with the full cooperation of employees and labour organizations. The policies should inform employees of their rights and responsibilities, outline management commitment to tackling AIDS-related issues, and be in line with national legislation responding to AIDS in the workplace.

Policies need to be regularly reviewed and updated if there are changes in prevalence rates, knowledge of the epidemic and its progress, and new information about prevention and treatment. Monitoring and evaluating a policy's implementation and effectiveness are essential. Leadership at various levels of the company is key to the success of workplace programmes. This includes leadership from:

- top-level executives, which communicates that a company is serious about the scheme and expects managers and workers to take it seriously;
- senior staff, which can help to ensure the success of an initiative; and
- unions, which can reassure workers, convey credibility,²⁴ and support community outreach.

²² *Protection of workers' personal data: an ILO code of practice*. Geneva, International Labour Organization, 1997.

²³ *Employers' Handbook on HIV/AIDS. A Guide for Action*. Geneva, International Organisation of Employers/Joint United Nations Programme on HIV/AIDS, 2002

²⁴ *ILO background report on workplace programmes*. Geneva, International Labour Organization, 2003.

It is also effective to forge **partnerships** with other stakeholders such as local and national governments, civil society including nongovernmental organizations, communities, and groups of people living with HIV. Businesses should share and develop best practices with other companies operating nearby; dealing with the AIDS epidemic is not an area for competitiveness or commercial privilege.

3. Workplace programmes for HIV and AIDS need to ensure a continuum of prevention, treatment, care and support

Prevention. HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies, which are appropriately targeted to national conditions and which are gender aware and culturally sensitive. (The ILO Code of Practice, section 4.9 and section 6). Information is the starting point, followed by participatory education to promote personal risk assessment and behaviour change, reinforced by practical measures such as condom distribution.

Education and training. In consultation with workers and their representatives, employers need to initiate and support workplace programmes that inform, educate and train employees in HIV prevention, care and support and the company's AIDS policy. Workers also need to be briefed on company measures to reduce discrimination against people infected with or affected by HIV or AIDS, and need to know about specific staff benefits and entitlements. (The ILO Code of Practice, section 5.2 c).

Education and awareness-raising programmes have proved effective in the workplace, resulting in changes in attitudes and behaviour. People need more than an understanding of the processes of HIV transmission; they also need to know how their individual actions can reduce their own likelihood of being exposed to HIV. It is also essential that all programmes should be run in ways that dispel stigma and discrimination, foster a willingness to be tested for HIV, and lead to all involved being supportive of HIV-positive workers. Programmes should target employees at all levels, including senior management. They should be mandatory for all staff and take place during working hours.

Information on the basic facts of HIV—for example, assessment of risk, methods of transmission, and safer sex—can be broadcast through a variety of means in the workplace. Written material in various local languages is useful, and may include leaflets, posters, newsletters and billboards. There is plenty of existing information available from different sources so that companies do not always need to produce their own. However, other methods may be more powerful. Many companies use industrial or street theatre—for example, Tata Steel in India regularly uses theatre to teach its employees and people in the surrounding local communities about HIV and AIDS. Some organizations have produced videos, while others have found that using peer educators is very effective, especially if they include people living with HIV. People living with HIV show the 'human face' of the epidemic and encourage non-discrimination and openness. Peer educators are a powerful complement to HIV programmes and may include in-house counsellors and medical staff.

Peer educators use tools such as role-play that allow people to 'practise' handling and responding to difficult situations. Working in women- or men-only groups helps individuals to be more open and confident in expressing their own feelings. Personal risk assessments should also include practical sessions about, for example, negotiating condom use and discussing HIV testing with a potential partner. Peer educators can facilitate the risk-assessment process but also need support, ideally through regular additional training.

Education programmes need to address sensitive issues relating to gender—for example, if women are subjected to sexual harassment or abuse on and off the job, and if monetary or material inducements are used to gain sexual favours. ‘Education should help both women and men to understand and act upon the unequal power relations between them in employment and personal situations.’ (*The ILO Code of Practice*, section 6.3c).

Specific prevention measures should include providing employees with sensitive, accurate and up-to-date information about risk-reduction strategies; making male and female condoms available free or at low-cost in the workplace may be a suitable strategy. Other measures encourage people to go for diagnosis and treatment of tuberculosis (TB) and sexually transmitted infections (STIs), as well as for voluntary HIV counselling and testing. These services are often provided in company health clinics, or outside in the community. Many companies have forged useful partnerships with nongovernmental organizations or government agencies to offer confidential voluntary counselling and testing to their employees. The ILO supports ‘Know your status’ campaigns at the workplace and can supply materials. However, it is essential that staff understand that such tests and the results are strictly confidential, *are never* compulsory and have no links to the hiring or firing processes.

Treatment, care and support are essential elements of an effective response to HIV. They diminish the virus’s impact on HIV-positive workers and their families, prolong their working lives, and help them to maintain a reasonable quality of life.

Access to care and support also contributes to HIV prevention. Employees living with HIV and their partners are encouraged to practise safer sex and, when necessary, to prevent mother-to-child transmission. When companies are seen to offer a range of care and support services to employees living with HIV, they are also effectively responding to stigma and discrimination and encouraging more openness about HIV among their employees.

Solidarity, care and support are critical elements that need to guide workplace policies in responding to HIV. Mechanisms should be created to encourage openness, acceptance and support for those workers who disclose their HIV status, and to ensure that they are not discriminated against or subjected to stigma. To mitigate the impact of the AIDS epidemic in the workplace, employers should endeavour to provide counselling and other forms of social support to workers infected and affected by HIV and AIDS. If health-care services exist at the workplace, appropriate treatment should be provided. If these services are not possible, workers should be informed about the location of available outside services. Companies that create links with external care and treatment clinics have the advantage of reaching beyond the workers to cover their families—in particular, their children. Partnership between employers and governmental and nongovernmental organizations ensures effective delivery of services and saves money. (*The ILO Code of Practice*, section 9).

The ILO emphasizes that comprehensive care and support need to involve a range of responsive services in the areas of treatment, material and psychological support and protection against discrimination and exclusion.²⁵ Ideally, these would include:

- health-care services and appropriate treatment of HIV and related infections. If there are no health services at the workplace, workers should be informed about the availability of external services. Health authorities may wish to consider supporting the delivery of health-care services at the workplace if community provision is lacking;

²⁵ *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual*, Module 7. Geneva, International Labour Organization, 2002.

- confidential voluntary counselling and testing;
- an open, accepting and supportive environment for workers who disclose their HIV-positive status, and legal provisions against discrimination;
- psychosocial support and counselling of individuals who test HIV-positive, and their families;
- reasonable accommodation—adjusting tasks (for example, offering less physically-demanding work), the workplace or working conditions (including hours and breaks), so that workers living with HIV can continue to do their jobs;
- family-planning services;
- healthy-living programmes, including advice on diet and exercise, and when possible, providing nutritional supplements to boost workers’ immune systems;
- social protection, including access to benefits provided by the state and/or the employer;
- access to free or affordable treatment for prevention of mother-to-child transmission (or referral to community services) for female employees/spouses;
- information and training on HIV transmission prevention, and care for caregivers at home; and
- care and support for family members after the death of the primary breadwinner.

Employers may also cooperate with state authorities to contribute to financial support, training or income-generating opportunities for people who lose employment because of their HIV-positive status, and for the family members of those with AIDS.

The ILO *Code* (section 9.1) states that HIV and AIDS should be treated ‘no less favourably’ than other serious illnesses in recognition of the fact that special treatment could be necessary, such as counselling or practical support and antiretroviral therapy.

Until fairly recently, it was rare for companies to provide workers with antiretroviral therapy—therapy that can allow people to live with AIDS as a condition that is chronic and manageable. Now, as this case study shows, a number of major corporations have decided to offer free or low-cost antiretroviral therapy to employees through a sense of corporate social responsibility, and an understanding that this approach will ultimately be less costly than not doing so. Reductions in drug prices, as well as the development of public-private partnerships, mean that the workplace can make an important contribution to expanding access to treatment. But companies need to plan thoroughly for both the short- and the long-term.

The decision to provide antiretroviral therapy for HIV-positive employees (and perhaps their dependents) requires careful review of existing company policies on treating chronic illnesses (of which HIV is one), the types of medical coverage available to employees, the benefits derived from keeping employees on the job and, of course, the costs involved. The decision involves a long-term perspective since the drug therapy and accompanying medical support are themselves long-term commitments.²⁶

²⁶ *FHI workplace HIV/AIDS Programmes. An action guide for Managers*. Research Triangle Park (North Carolina), Family Health International, 2002.

4. Monitoring implementation and effectiveness

Monitoring implementation and effectiveness of HIV and AIDS treatment is an essential part of workplace programmes, especially when antiretroviral therapy is being provided. It enables companies to measure progress against stated goals and to develop and modify programmes to make them more effective.

It is useful to have regular consultations with a range of staff, and to report any treatment-related issues that arise to senior management. Some companies have found it helpful to have a dedicated cost centre for their HIV- and AIDS-related activities.

Monitoring can include tracking changes against key indicators, such as prevalence, when available, and factors such as rates of absenteeism, medical retirements, production delays or disruptions, funerals, and costs of clinical equipment, drugs and other medical supplies. Data on these factors will help a company to measure the impact of the epidemic, and the effectiveness of its programmes to respond to it. Some companies use outside agencies to carry out monitoring at certain intervals, such as every three or four years.

5. Access to treatment in the private-sector workplace: the experience of three South African companies

1. ANGLO AMERICAN plc

Anglo American plc is one of the world's largest mining and natural resources companies, made up of subsidiaries, joint ventures and associates. It has eight commodity divisions—gold, platinum, diamonds, paper and packaging, coal, base metals, ferrous metals and industries, and industrial minerals. In 2003, its total turnover was US\$ 4.9 billion.

The company has 193 000 employees in 61 countries, with by far the largest number (139 000 employees) in eastern and southern Africa. The Anglo American Corporation of South Africa Limited is the largest company in South Africa.

In 1986, Anglo American was involved in one of the the first important prevalence studies of HIV in southern Africa, conducted by the Chamber of Mines in Botswana, Lesotho, Malawi, Mozambique, South Africa and Swaziland. At that time, no black South Africans were known to be HIV-positive, only white gay men. Of the 18 450 mineworkers in South Africa tested for the study, four tested HIV-positive—prevalence of 0.02% compared with 0.34% of mineworkers in Botswana and 3.76% of mineworkers in Malawi at that time.

However, as knowledge of HIV and AIDS grew, it became increasingly clear that for a number of reasons, the majority of Anglo American's employees in South Africa (its mining workers) were at risk of contracting HIV infection. They earn far more than the average South African—in 2003, on average US\$ 6500 per year, compared with the per capita income in South Africa of US\$ 2900. About 80% of the miners live away from home in company hostels; large numbers are migrant workers with homes both within and outside South Africa. They have the money and opportunity to attract and use sex workers. At the same time, they live in a culture in which sex is surrounded by secrecy and denial. This creates an ideal environment for HIV to spread.

As infection rates were seen to be rising in the late 1980s, the company was one of the first to recognize the need to establish a policy and programmes to prevent the spread of HIV, and it initiated education and awareness-raising programmes. In the early 1990s, Anglo American appointed an AIDS Education Adviser at a senior level, to provide updates about the epidemic and its impact, and to give guidance on how to develop and implement prevention and disease-management programmes.

The whole group programme is coordinated by Dr Brian Brink, Senior Vice-President of Health Services. He said, "It is rather like a UN role within Anglo American with a strong emphasis on coordination of HIV and AIDS activities." In 1999, he wrote a paper on the epidemic for Anglo's senior executives, explaining that, if 25%–30% of the country's productive adults were on track to become sick and die from AIDS, the implications for the Corporation were huge, affecting labour supply, productivity, markets, and health-care costs.

HIV and AIDS workplace policy

Anglo American's policy supports key responses to the epidemic, namely: elimination of stigma and discrimination on the basis of real or perceived HIV status; prevention of new

infections; care and support of employees infected with and affected by HIV; and management and mitigation of the impact of both.

The company believes that ‘non-discrimination, as well as consultation, inclusivity and encouraging full participation of all stakeholders are key principles which ... should underpin its HIV and AIDS responses.’

Recognizing the magnitude of the problem, the policy stresses the necessity to work in partnership with national and provincial governments and local authorities, international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and appropriate nongovernmental organizations and communities, in order to build the capacity needed for an effective response.

There is an overall company HIV and AIDS policy, and related initiatives are guided by senior Anglo American management. Because circumstances and situations differ across the company, divisions and operating units develop their own detailed policies in conjunction with employees and their representative unions. These operational policies need to comply with the company’s guidelines. Anglo American is in the process of implementing selected key performance indicators to monitor its overall response to the epidemic. These include HIV prevalence, uptake of confidential voluntary counselling and testing, enrolment in HIV wellness programmes, employees on antiretroviral therapy, absenteeism, deaths while working, and early retirement due to ill-health.

‘... the root causes of the epidemic ... lie in poverty, poor health, social disruption, poor education and unemployment. We believe that Anglo American’s response to the AIDS epidemic is a significant contribution to sustainable development and will help to ensure the continued profitability of our businesses.’

— From the opening statement of Anglo American Plc Group’s HIV and AIDS policy

The policy is regularly reviewed to take account of the epidemic’s progression; developments in medical care; experience in preventing new infections and managing HIV and AIDS in the workplace; its impact on employee benefit schemes; and changes to relevant legislation.

HIV and AIDS workplace programmes

Knowing the epidemic and its impact on the workplace is key to all activities that respond to HIV and AIDS, and Anglo American tries to conduct voluntary, anonymous HIV prevalence surveys at all its operations on an annual basis.

Education and awareness-raising campaigns are a vital part of the group’s HIV and AIDS strategy. Song and drama are effective ways of conveying sensitive messages and widely used across the group. Peer educators from among the employees are trained to use interactive techniques such as role playing. The initiators of the programmes stress the importance of ensuring that prevention messages, including training materials and educational publications, are sensitive to different cultural mores and lifestyles, and are produced in local languages.

Every business unit has an HIV and AIDS coordinator. Anglo American’s health facilities offer a range of preventative services, as well as health promotion. Male and female condoms are widely distributed, and sexually transmitted infections and opportunistic infections such as TB are prevented and/or treated. Some clinics employ health-care workers who are

living with HIV. As well as treating employees, the company clinics reach out to the sex workers who work around the mines.

Confidential voluntary counselling and testing is vigorously promoted and is available in every medical centre and mine hostel medical station. There are full-time counsellors at every health centre, but employees are still reluctant to go for testing. For example, in two years only about 10% of the workforce at Anglo Gold had sought testing. Brink's target is to have 100% of employees tested annually, although he accepts that it will take time to reach this level of HIV awareness. He explained that confidential voluntary counselling and testing is essential to linking prevention to care, and that this is currently the focus of all Anglo American's HIV and AIDS initiatives.

Surveys among the workforce have indicated that 'awareness among employees is high'.²⁷ But 'less dramatic ... is a change in attitude about personal risk profile and in the mindset of those already infected, as well as in reported behaviour change'.²⁸ The failure to achieve behaviour change, although certainly not unique to Anglo American, is reflected in the rise in prevalence from 0.02% in 1986 to an estimated 24% in all the company's South African operations (excluding De Beers) some 16 years later. The rates ranged from 29% among gold-mine employees to 12% among those working in paper and packaging.

As prevalence has risen considerably, providing care for employees living with HIV has become a major priority. There is also increasing evidence that early care and support improve the quality and length of life of people living with HIV. Not only do these employees benefit, but when a company provides treatment and care it conveys an important message about overcoming stigma and discrimination to the whole workforce. When people living with HIV are seen to be treated sympathetically, their colleagues may be more receptive to prevention messages and to coming forward for voluntary counselling and testing.

A core concept of Anglo American's HIV and AIDS strategy is that 'treatment is the single intervention that will make a difference to the way the AIDS epidemic unfolds, both in the workplace and in the communities within which we operate. Providing treatment is a direct challenge to the ignorance, denial and stigma that have fuelled the AIDS epidemic since its inception.'

For some years, the Anglo American Group has implemented wellness programmes for HIV-positive employees through its in-house health-care services. These programmes aim to:

- keep HIV-positive employees healthy and productive for as long as possible;
- help HIV-positive employees understand the disease;
- encourage a healthy lifestyle;
- offer nutritional advice, supplements and therapy to boost the immune system; and
- prevent and treat opportunistic infections, especially TB.

When necessary, adjustments are made to tasks and working time and conditions so that an employee can continue working (known generally as 'reasonable accommodation'). Retirements due to ill-health are only implemented as a last resort.

²⁷ *Anglo American's Response to the AIDS crisis in Southern Africa*. London, Anglo American plc, 1999.

²⁸ *Ibid.*

Anglo American recognizes the need for home-based care when sick people return home, and it has been working with the Employment Bureau of Africa (TEBA) to provide home-based care by training caregivers and village workers. The challenge is not just to provide medical care, but also to help people to gain access to welfare grants. In South Africa, many people do not have proper identity documents, and this makes it hard to obtain grants for some orphans.

For some years, Anglo American had been considering providing antiretroviral therapy to those employees who needed it. But expense was a major issue. However, in 2000, Brink persuaded Anglo American's executive committee to approve ART in principle. A pilot study, to be undertaken before the full roll-out, was announced in May 2001. At that time, anti-retroviral therapy for one patient cost US\$ 12 000 a year.²⁹ In addition, there was the cost of developing a sound, sustainable system of dispensing the drugs and monitoring the treatment. Anglo American felt that it could not go it alone on such a far-reaching initiative and sought to develop a partnership with other mining companies, the trade unions and the South African Government.

By spring 2002, the Anglo American Executive Committee was under pressure to rethink its position on antiretroviral therapy. Prices of the drugs were tumbling—to about US\$ 1200 per person a year—and scientific reports were documenting the profound effectiveness of treatment and the simplification of antiretroviral regimens. There were also business pressures; financial analysts were asking pointed questions about the epidemic's impact on the financial performance and profits of the company's South African operations.

Soon after the international AIDS conference held in Barcelona, Spain, in July 2002 the Chief Executive Officer met Brink to discuss the changing AIDS treatment scenario and agreed that Anglo American should provide employees with antiretroviral therapy. He said, "This crisis is not going to go away. If there is a lead to be taken, Anglo American will take it. It's a leap of faith."

There was one condition. As a starting point, only employees would receive free antiretroviral therapy from workplace clinics equipped to implement the treatment protocols to the required standard. Dependants would not qualify for company funding because of cost and access issues. This has been a controversial decision and Brink and his colleagues are now working with communities to tackle the issue from a different direction (see below).

Providing antiretroviral therapy

Anglo American has several different health-care benefit arrangements. Some employees contribute 50% of the cost of their health insurance which also covers their families, and most of these employees have had access to antiretroviral therapy for several years. But, since the majority of workers in the company's mines are migrants living far from home and their families, they all receive free health care in the company's clinics and hospitals. This now includes antiretroviral therapy. Their families rely on the public health system to meet their health-care needs, whether in South Africa or in neighbouring countries. Up until 2004, antiretroviral therapy was not provided by any South African public health system, but the Government is now in the process of implementing an ambitious programme of antiretroviral provision to those in need throughout the country.

²⁹By that time a number of multinational pharmaceutical companies had announced prices of antiretrovirals for sub-Saharan African countries that were well below this level. However, apparently these prices were not offered to private corporations.

When the company's free provision of antiretroviral therapy was announced in August 2002, Anglo American estimated that about 23% of its employees in southern Africa were HIV-positive. It also estimated that in any one year, between 10% and 15% of those employees might progress to a stage of the disease at which treatment is indicated—that is, the onset of AIDS.

The programme began in November 2002. It is unique in its breadth and scope since there are an estimated 33 000 employees living with HIV (out of a total of almost 140 000 in eastern and southern Africa). Anglo American is now the largest single business customer for AIDS drugs in the world, and had about 1300 employees on antiretroviral therapy by the end of the first quarter of 2004. Anglo American's antiretroviral therapy programme objectives are to:

- ensure a high-quality, integrated antiretroviral therapy programme using a standardized model of delivery;
- expand access to antiretroviral drugs;
- build local capacity;
- evaluate the clinical and economic feasibility of treatment; and
- provide a framework for research.

How antiretroviral drugs are provided

In order to create good adherence to antiretroviral therapy, a sound, sustainable infrastructure guaranteeing a standardized model of delivery is essential to ensure the continuous delivery of drugs, follow-up care, trained staff and monitoring and evaluation. Anglo American is doing this through Aurum Health Research (a wholly-owned subsidiary of Anglo Gold), which has been contracted to manage implementing the antiretroviral therapy programme across company-owned and -operated health-care facilities. Aurum developed Anglo Gold's wellness programmes for people living with HIV and has also carried out prevalence surveys for the company.

Aurum is an industrial health-research company that conducts research of international standing focusing on occupational and public health issues that are relevant to employees. Cooperating institutions include the University of Natal, the South Africa HIV Clinicians Society, the University of Cape Town and the London School of Hygiene and Tropical Medicine, UNAIDS and Johns Hopkins University.

In developing the system for delivering antiretroviral therapy, Aurum has researched international best practice and has produced a wealth of clinical and operational guidelines, data forms, and a computerized database.

Available human resources and capacity-building

Many of the doctors and nurses employed at Anglo American's hospitals and clinics have been caring for people living with HIV for some years, and have completed a basic course on HIV and AIDS. Specialist training courses for the antiretroviral therapy programme have been developed, and doctors and nurses need to attend these two-day courses before being accredited to provide antiretroviral therapy. By March 2004, 80 therapy delivery sites had been registered, and Aurum staff had trained 73 doctors and 143 nurses in providing antiretroviral therapy and care.

How patients are selected

Patients are chosen according to internationally-recognized guidelines: they must have a CD4 count of less than 250 irrespective of the stage of the illness they have reached; or they must be at Stage 4 (according to the WHO classification) irrespective of CD4 count; or be at WHO Stage 3 and have a CD4 count of between 250 and 350.

When a patient is considered a suitable candidate for antiretroviral therapy, a very thorough medical history is taken. It is important to screen for drug toxicity risk factors, such as other existing medical conditions that may interact with or be made worse by antiretroviral therapy—for example, tuberculosis, hepatitis or diabetes. The patient is given information on the treatment, including possible side effects and the importance of adherence, and has a counselling session with a trained counsellor in a company clinic or health-care centre.

Staff need to ensure that the patient understands the major implications of taking a combination of drugs every day for the rest of his³⁰ life— and need to advise him on dealing with his partner and family, avoiding alcohol and cigarettes, and practising safe sex. He needs to be convinced that the benefits of the drugs outweigh any possible detrimental effects. Patients are encouraged to take responsibility for their health and treatment, and also to speak to their partners/families about their status if they have not already done so.

On average, counselling sessions last about 45 minutes. An important component of the session is education about antiretroviral therapy; for instance the counsellor explains very simply about CD4 counts and viral load testing. The patient is then given two weeks in which to decide whether or not to have treatment. Then he is required to sign a consent form before starting treatment; this form is offered in six local languages.

To ensure patient compliance, patients are informed of drug side effects (which are anticipated and treated), treatment plans and the goals of therapy. They will receive help to develop a plan that will include a meal schedule, daily routines and dosage intervals. The treatment regimens are designed to be practical with no meal restrictions, for example. Advice is given on good nutrition, and the importance of continuing to use condoms is stressed.

There is also a treatment helpline run by Aurum in association with the Southern African HIV Clinicians Society. There is a strict follow-up schedule every two weeks. As Brink explained, “These drugs are so new they have never been tested on men working three kilometres underground.” As another form of support, a clinician has provided training in antiretroviral therapy to most managers of Anglo American mines and business units.

“One patient was reluctant to accept antiretroviral therapy but he finally agreed. He had hidden himself away before because he had skin rashes. Some eight weeks later, I told him, ‘You look healthy.’ He grinned and said, ‘Not just healthy, I’m handsome again.’ He was also energetic and gaining weight and was going into town regularly. I gave him some lifestyle counselling on safe sex. I was concerned about that word ‘handsome’”.

— Sister at Carletonville Hospital

³⁰Most Anglo American employees are men.

Providing and dispensing drugs

Anglo American utilizes the following standardized antiretroviral regimens:

a) First-line combination (that is, the treatment of choice for greatest efficacy):

Zidovudine
Lamivudine
Efavirenz

b) Second-line combination (used when the first begins to lose efficacy or is not suitable for some reason):

Didanosine
Abacavir
Lopinavir-Ritonvir

When a new patient is prescribed antiretrovirals, the prescription is first faxed to Aurum, where it is checked by a nurse, and then by a doctor. It would be queried if, for example, it was not for the standard first-line regimen. The doctor needs to know who is on non-standard regimens and why. Once approved, the prescription is faxed to the central pharmacy for the drugs to be dispensed.

Brink stresses the importance of every patient having drugs at the right time, and never running out, “We could audit tablets from the time they are delivered to us until they are swallowed,” he says.

All Anglo American companies make use of a centralized procurement, distribution and dispensing service, either through S Buys Pharmacy or Anglo Platinum Health. Any shortage of stock is highly unlikely as the pharmacies plan their drug requirements 12 months in advance.

It is very important that the control and distribution of the medicine from the supplier to the patient be safeguarded. Incoming stock to the clinic has to be carefully checked, documented correctly and stored accurately. Very careful guidelines on delivery and storage are provided by the pharmacy to staff in the company’s clinics and hospitals. When a patient is given his medication (individually packed, sealed and numbered) he must open it and check it against the dispensing slip. Both the patient and the company nurse are required to sign the dispensing slip.

Adherence: The most common reason for treatment failure is the patient’s inability to fully adhere to antiretroviral therapy. Patients are encouraged to involve their partners and families—if they live with them—in helping them take their drugs regularly and continuously. There are also plans to introduce treatment supporters who will meet the patients once a week to talk about antiretroviral therapy. Ideally, treatment supporters will be people living with HIV who are on antiretroviral therapy, and with whom the patient can closely identify. In a 2003 company survey of patients on antiretroviral therapy, 86% said they would be willing to become treatment supporters. Aurum Health Research is also working with the activist nongovernmental organization Treatment Action Campaign (TAC) to set up treatment-support groups. Brink believes that this scheme would have a ripple effect, with people becoming more willing to disclose their status.

Monitoring and support: All data about the patients are captured onsite at the clinic and then faxed to Aurum’s headquarters in Johannesburg. Some staff members have complained about completing such long and detailed forms, but doing so is essential for Aurum’s monitoring process. At any one time, the personnel at Aurum know the percentages of patients at

different treatment stages. All adverse reactions to the drugs are recorded, however minor. In Carletonville Mine Hospital, for example, there have been about 15 (2%) adverse reactions so far, in 10 months of operating the programme.

At Aurum, a file is kept on each patient (identical to the one at the clinic), each numbered to ensure confidentiality. All data are captured twice by two different data processors at Aurum. For the first two months of treatment, information is taken and recorded every two weeks and, thereafter, once a month. The doctors at Aurum see every form, checking when patients stop or change treatment and why, and watching for any adverse reactions.

The regular follow-up at the clinic ensures that patients have continued psychosocial support (as well as treatment support and support groups) which enhances adherence. Clinicians from Aurum regularly visit every site where antiretroviral therapy is provided to advise on any clinical problems, to check patients' files and to ensure that manuals are updated. There is a three-monthly review meeting bringing together all the clinicians involved in the programme. A clinician is available on call to the clinic staff 24 hours a day.

At the beginning of the programme, clinic staff members were wary of the monitoring visits from Aurum personnel, but they soon realized the benefits because Aurum staff generally offered support for their work.

Brink stresses the importance of such close monitoring: "Best practice is about constantly seeking to improve performance." He is anxious to know, for example, whether the suicide of a man on the antiretroviral therapy programme is linked to the drug therapy. "We have to investigate all accidents and fatalities just as we do with accidents in the mines. It is also like book-keeping. We are taking liability so we must know what we are doing and what problems we are up against," he says.

"We really want to give antiretroviral therapy a try; most of my staff are very excited. Before, it was so frustrating because there was so little we could do and we saw patients die. Before, we felt so much of the wellness programme was monotonous. Now I'm happier and more confident as I see patients responding well to their treatment."

— Nurse at Carletonville Hospital

"Before the antiretroviral therapy programme, patients were rather negative, and asked, 'Why do I need to know my status?' Now they realize the benefits of knowing, so they are more positive."

— Counsellor at Carletonville Hospital

Patient numbers in the antiretroviral therapy programme

It is estimated that 33 000 of Anglo American's employees are HIV-positive and that, of those, about 5000 are at the clinical stage when they need antiretroviral therapy. But, in March 2004, only 1500 had started it—less than 20% of the potential beneficiaries. Brink is not happy with this. The aim is not just to reach the 5000 as soon as possible, but also to ensure that all employees living with HIV are enrolled in wellness programmes (about 4400 were enrolled as of March 2004). "When all 33 000 employees living with HIV are enrolled in wellness programmes, then we will be on the way to having HIV under control," says Brink.

Some results

The reported patient adherence rate for the programme is 90%—better than, for example, inner city programmes in the United States of America, said Brink. However, early data from viral load measurements taken six months after starting treatment suggest that actual adherence may not be as good as reported. Anglo American is vigorously tackling adherence issues throughout the programme.

At Carletonville Hospital, staff said they have seen patients improving. Out of 167 on antiretroviral therapy, only two had to receive some hospital treatment and that was not for serious symptoms. Across all the company's therapy-provision sites, 94% of the patients on antiretroviral therapy are working, and 83% of patients show good viral suppression six weeks after starting treatment. Minor adverse effects were noted in 34% of the patients, and serious adverse effects in 22 (1.4%).

A few have had treatment stopped because they did not respond to it. When patients leave the company, treatment is no longer provided. But in South Africa, continued treatment access is now available through the public health service. If and when there are cutbacks in the number of employees, Brink is recommending that the company should agree to pay for treatment for a period sufficient to ensure transition into an alternative treatment programme.

Economic evaluation

Aurum has employed a health economist to carry out a rigorous economic evaluation of the antiretroviral therapy programme and the impact of the epidemic. It is using the same modelling techniques across the whole group at all Anglo American business units. The study is being done over three-to-four years.

The epidemic's economic impact will be assessed across all companies within the group, with each company carrying out an annual prevalence survey. Brink stressed that the results of the economic evaluation will not in any way affect free provision of antiretrovirals. Rather, it will provide much useful information for future planning, particularly the cost-benefit ratio of antiretroviral therapy and its impact on sustaining productivity.

Work in communities

Anglo American is very aware of the social factors that contribute to the spread of HIV and has been attempting to deal with them for several years. Slowly ("too slowly", says Brink), workers are being encouraged to move out of hostels into housing where they can bring their families. They are given money to do this, but many then move to 'informal settlements' (i.e., squatter camps) where HIV prevalence is very high.

The company has been criticized for only providing antiretroviral therapy to employees and not to dependants. Brink and his colleagues hope to do this via another route—working in communities and in partnership with government, nongovernmental organizations and others. "Obviously, we cannot allow our operations to become islands of privilege," says Brink. Anglo American has worked in local communities for many years. Through its 'social upliftment projects', the company has funded education, income-generating projects, small and micro-business development, health-care provision and housing, general development and welfare. Several initiatives specifically target issues linked to HIV and AIDS—for example, government and local community projects involving sex workers, and other projects that extend primary health care to remote rural communities.

In October 2003, Anglo American announced a major new community initiative that aims to enhance and accelerate the provision of comprehensive HIV and AIDS services in government clinics. Ultimately, this should lead to access to antiretroviral therapy via community services.

The Anglo American Chairman's Fund (its corporate social investment arm) will provide funding of approximately R 30 million (US\$ 4.5 million) over three years to loveLife—South Africa's national HIV-prevention programme for young people. This funding will accelerate the roll-out of loveLife's National Adolescent Friendly Clinic Initiative (NAFCI). It was developed and implemented in partnership with the national Department of Health, and piloted in more than 60 clinics in communities associated with Anglo American's operations in South Africa.

Over and above the funding, Anglo American operations associated with the communities will commit time and expertise to working with loveLife and other partners to help build capacity in public-sector primary health-care clinics. Each operation will appoint a 'champion' to ensure that the programme works.

The overall goal is to enhance the health-sector response to HIV and AIDS at community level, ensuring easy access to comprehensive HIV-prevention services, voluntary counselling and testing, and enhanced care, support and treatment for people living with HIV. By expanding and strengthening the health-care infrastructure, the project is working towards the widespread provision of antiretroviral therapy. Initially, the initiative is operating within seven communities in six provinces and will develop comprehensive HIV and AIDS services in 38 government primary health-care clinics. It is part of a collaborative effort between the Department of Health, the US-based Henry J Kaiser Family Foundation, the Nelson Mandela Foundation, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Anglo American's community HIV and AIDS partnership was the first example of business co-investing in a project financed by the Global Fund.

It will help to ensure the integration of employer-based prevention and care programmes with the services provided by public-sector primary health-care clinics.

"[Anglo American's new community partnership] is an exciting example of how the Global Fund's investments can help leverage in-country partnerships and resources. This initiative will provide a strong model in Africa of a nationwide effort to establish comprehensive HIV and AIDS services, including prevention, treatment and care in public clinics."

—Richard Feachem, Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria

Anglo American also works on HIV and AIDS through its membership in the following bodies:

- the private-sector delegation to the Global Fund
- the South African Business Council on HIV/AIDS
- the Global Business Coalition on HIV/AIDS.

Costs

Anglo American obtains antiretroviral drugs from major research-based pharmaceutical manufacturers. A specific supply agreement has been concluded with GlaxoSmithKline, which guarantees continuity of supply. Since concluding this agreement, the price of the combined therapy lamivudine and zidovudine has dropped from US\$ 1.70 a day to US\$ 0.65 a day—a reduction of 62%.

Brink is very satisfied with the relationship that Anglo American has developed with the research-based pharmaceutical manufacturers. Generic antiretroviral medicines are not yet commercially available in South Africa. This is despite the fact that generics priced as low as US\$ 0.50 a day for a WHO-recommended triple combination are significantly less expensive than branded medicines. Obviously, generics will provide welcome competition as soon as they become available, says Brink.

The average cost of providing antiretroviral therapy in 2003 across Anglo American Group companies was R 19 700 (US\$ 2609) per patient per year. This cost includes all fixed and variable costs and programme management, including start-up costs. The cost is heavily affected by the Rand/US dollar exchange rate. At an average rate of R 7.55 to one US dollar, the cost has dropped to approximately US\$ 1700 per patient per year, which reflects economies of scale, strengthening of the Rand against the US dollar and ongoing price reductions. Brink expects the cost to come down to US\$ 1400 in the near future, but stresses that this cost reflects the total cost of delivering antiretroviral therapy, not just drug and laboratory costs.

Since the introduction of the antiretroviral therapy programme, in at least one company operation, hospital admissions of people living with HIV have been significantly reduced, resulting in a noticeable decrease in health-care costs. Aurum's economic impact evaluation will fully document the cost-benefits of antiretroviral therapy over a period of three years.

2. BHP BILLITON

BHP Billiton is the largest diversified resources company in the world. It is a global leader in providing aluminium, energy, coal and metallurgical coal, copper, ferro-alloys, iron ore and titanium minerals, and has substantial interests in oil, gas, liquefied natural gas, nickel, diamonds and silver.

The company was formed in June 2001 through a Dual Listed Companies merger between BHP Limited (now BHP Billiton Limited) and Billiton Plc (now BHP Billiton plc). It employs around 35 000 permanent employees; another 32 000 contractors are employed at various operation sites. About 30% of the company's operations are based in southern Africa (many in areas with very high prevalence of HIV and AIDS); 40% of the permanent employees work there.

Work on HIV and AIDS

The two companies that now form BHP Billiton have prided themselves on their commitment to health, safety, environmental responsibility and sustainable development. By the early 1990s, it was clear that the AIDS epidemic threatened all four aspects of these commitments. Faced with this, BHP Billiton's top management appointed one of its senior managers, Andre van der Bergh, to deal with the issues, and asked him to provide a report on the AIDS epidemic and its likely impact on the company from the point of view of risk management.

It soon became clear to van der Bergh that the company had to tackle a root cause—its employment of migrant workers—as well as introducing measures for prevention, care and support. The migrant workers constituted a significant part of the workforce, living in hostels miles from their wives and families, and inevitably mixing with sex workers. “Any amount of education on HIV and AIDS wouldn't have a lasting effect unless we addressed these underlying issues,” said van der Bergh.

Over the past decade or more, BHP Billiton has ranked HIV and AIDS as one of its most significant business and development issues. Its different operations have carried out prevalence surveys to measure levels of HIV. These are usually done every three years. In consultation with trade unions, many operations have arranged anonymous HIV testing of employees through saliva-based tests. The company says that, in general, these programmes have been well supported and have given all the sites involved a clear understanding of the prevalence of infection in the workforce. In all cases, the testing has shown that prevalence among the workforce is lower than that of the local community. Workforce prevalence has averaged 14%, which has been decreasing over the past three-to-four years. Three reasons are given for this reduction:

- HIV and AIDS education linked to behavioural change. A recent survey has shown that this is particularly true of the younger staff (aged 35 and under); prevalence is lower among this group than those aged over 35.
- Staff members tend to have higher education levels than those in other companies. The minimum qualification for most of the employees is secondary-level education.
- Current labour turnover is low.

In 2000, the company used actuarial analysis modelling to try to quantify the impact of the epidemic. Based on the assumption that prevalence will not exceed 16% by 2005, the model predicted that by then there would be a 5% increase in labour costs directly related to

HIV and AIDS. Van der Bergh now feels very comfortable that the company has managed to reduce the impact of HIV and AIDS more than anticipated.

BHP Billiton has tackled HIV on a number of fronts. It has developed and implemented broad educational and awareness programmes in all its operations, and increasingly focused on care, support, and treatment. Since 1995, it has also addressed the underlying social issues that drive the epidemic, such as the long-term separation of men from their families, the migrant labour systems, and gender-based inequalities.

'BHP Billiton's response to HIV and AIDS ... is designed not merely to address the disease and its consequences, but is rather aimed at changing the fundamental social factors that underpin the epidemic. For this reason, BHP Billiton has approached its HIV and AIDS response in the workplace and the broader community from the broader perspective of its commitment to human rights and sustainable development, as laid out in the BHP Billiton Charter. BHP Billiton sees it as its responsibility to incorporate HIV and AIDS into its business strategy so as to respond to the problem as it affects the communities around BHP Billiton's areas of operation and the country at large. This forms part of the group's corporate social responsibility programme.'

— BHP Billiton Report to the Global Business Coalition on HIV/AIDS, 2004

Prevention

For the past 10 to 12 years, the company's major focus has been on preventing HIV infection among its workforce through education programmes. In many communities where the company operates, awareness programmes have been extended into local schools and to sex workers. At the same time, the company promotes non-discrimination and openness around HIV and AIDS, and informs employees of their rights and benefits.

Periodic 'knowledge, attitude and practice' (KAP) surveys are conducted in all operations in South Africa across all grades of employees. The information gained is used to adapt HIV intervention programmes to suit specific employee needs. These surveys are repeated every 18 to 24 months to measure changes in behaviour and attitude, and to evaluate the effectiveness of the intervention programme.

The results of a KAP survey at the Hillside aluminium smelter, Richard's Bay, showed a considerable improvement in the knowledge, attitudes and practices of employees, presumably as a result of the HIV intervention programmes. They supported voluntary counselling and testing and the need for confidentiality of other people's HIV status. There was an encouraging reduction in the number of employees who were fearful of contracting HIV by working with, being served food by, or using toilet facilities shared with, people living with HIV. But they were still practising unsafe sex, with multiple partners and inconsistent condom use.

Van der Bergh says that in terms of prevention, the big challenge is keeping the 86% of the workforce free of HIV. Publications on HIV and AIDS are widely distributed and condoms are freely available in all the company's operations.

Programmes use peer educators trained by an organization called Lifeworks an independent disease management company. The training involves employees at all levels, and the peer educators encourage people to go for counselling and testing which is paid for by the company.

Free counselling and testing is available to all employees through on-site clinics and a network of carefully chosen and trained private doctors in local communities. There are also regular on-site campaigns to promote voluntary counselling and testing.

The company's policy on prevention has also included a change in recruiting practises; it now hires fewer migrant labourers and more locally-based employees. BHP Billiton was the first company in South Africa to address the major issue of using migrant labour. Its view is that, 'mining is a long-term investment that requires the employment of highly qualified people, and the long-term development of staff. This can only be achieved in a stable local environment.'³¹ Most of the company's employees in South Africa (15 400 out of 16 000) now live in homes of their own choice rather than hostels. This change in the company's policy on HIV and AIDS took several years to accomplish, and involved discussions with employees and trade unions. But it was made easier by the fact that most operations are now situated in large towns.

At first, employees were given housing allowances to encourage them to settle down with their families. Later, the company also decided to grant a bond allowance to help employees obtain mortgages in order to buy their own homes (which cannot be situated in an informal settlement). Housing allowances are granted to every employee at every level. If necessary, human resources personnel advise on housing. In some areas, the company is working closely with local governments to help them develop housing schemes.

Care, support and access to treatment

In the past, the workforces of all South African mining companies were mainly migrant labourers living in the company's hostels. A system of hospitals and clinics attached to the mines provided migrant workers and others with free health care. BHP Billiton has phased these out, integrating hospitals back into the local community, and donating land and buildings. It has established holistic health care for all employees. Its challenge was to create a shift from company-provided health care to privatized health care in order to address gaps in health-care coverage and to use the opportunity to provide equal care for all its employees.

Now, all employees of the company receive a subsidy to ensure that the family's basic health-care needs are met. Membership in a medical scheme is a condition of employment. Employees then choose a scheme (from nine approved medical aid companies) to suit their needs and those of their registered dependents. The same subsidy is given to all employees, regardless of their position in the company. The aim is to make access to health care totally equitable. Employees can contribute more financially if they wish to qualify for more benefits.

All employees also benefit from the company's wellness programme, which promotes healthy lifestyles—advice on diet, exercise, and safe sex, as well as information on alcohol abuse, smoking and drugs etc. The programme is intended to help employees living with HIV to bolster their immune systems.

For employees living with HIV, the basic option from all medical aid companies covers consulting and pathology, treatment of opportunistic infections and antiretroviral medication. A review was carried out on all the medical schemes used by employees to ensure that they provided a benefit for those living with HIV, over and above the usual benefits they would obtain from medication for any chronic condition. An independent board of trustees determines the contribution rates and benefit levels for each medical scheme, including the level of the HIV and AIDS benefits.

³¹ *BHP Billiton report*. Melbourne, BHP Billiton, 2004.

Recognizing some potential shortcomings in the medical schemes, BHP Billiton recently started implementing managed health-care programmes, with a particular focus on HIV and AIDS. These programmes aim to ensure consistent high-quality care for people who are HIV-positive, as well as confidential counselling, dietary programmes and quality monitoring of treating physicians.

The company has contracted Lifeworks—one of southern Africa’s specialists in identifying, measuring and managing health risks in organizations. Lifeworks has been managing the voluntary counselling and testing and treatment programmes within BHP Billiton’s aluminium division for two years. From February 2004, it has been contracted to manage the whole South African group and handles the care and treatment of all employees living with HIV, not just those on antiretroviral therapy.

Lifeworks emphasizes the need to proactively treat healthy HIV-positive people. This care involves regular medical consultations and monitoring, counselling, nutritional and vitamin supplements, treatment of opportunistic infections and other unrelated conditions. Lifeworks’ aim in caring for pre-antiretroviral therapy patients is to slow down the progression of HIV and delay the onset of AIDS or the requirement for antiretroviral therapy. Thirty-five per cent of all HIV patients at the company’s South African operations are receiving antiretrovirals.

Patients with HIV may be referred by an onsite clinic nurse but the majority (more than 75%) register directly with Lifeworks without their employers’ knowledge. They have access to Lifeworks’ independent, confidential registration process, and each patient has his or her own case manager who provides regular counselling at least once a month.

Through regular consultations and monitoring, supported centrally by Lifeworks’ medical team, company medical personnel decide when a patient needs antiretroviral therapy based on an assessment of his clinical condition, CD4 count levels (according to WHO guidelines), and assessment of compliance risk.

Lifeworks manages all aspects of diagnosis and treatment on a contractual, independent basis. Its intervention protocols adhere strictly to the guidelines of WHO, UNAIDS and the International HIV Clinicians’ Society. It operates a Preferred Provider Organization (PPO)—a network of 2400 private and public health-care professionals trained in HIV and AIDS, fully supported by Lifeworks to provide antiretroviral therapy, and paid on a needs basis.

Each medical doctor in this network develops a tailored treatment programme for each HIV-positive patient, and offers an individualized doctor/patient relationship. There is regular testing of CD4 counts and viral loads, as well as tracking of each individual’s response to the drugs.

Patients receive the minimum standard—triple therapy sourced only from the approved list of drugs. Patient compliance is verified through regular blood tests and monitoring general health and side effects, as well as regular proactive patient counselling (Lifeworks does not wait for patients to contact them).

Every drug prescription is approved by Lifeworks’ medical team before a patient begins treatment. A sustainable supply of drugs is ensured through regular contact with, and monitoring of, the pharmaceutical companies and suppliers of drugs.

Personnel at the company's onsite clinics are trained only to provide counselling and testing and patient monitoring. Peer educators are trained by Lifeworks to promote the HIV and AIDS programme, and explain its benefits and processes.

Free counselling is available through Lifeline—Lifework's free phone counselling service—or through referrals to local counsellors. This ensures consistency of care. The company has also made certain that employees and unions have approved its counselling methodology.

Lifeworks is not in a position to disclose patient numbers, but its staff say that so far, "medical results [of the antiretroviral therapy programme] are very pleasing." Obviously, side effects are a reality, but the compliance rate is 89% and is continuing to improve. Van der Bergh explains that he does not know the number of patients on antiretroviral therapy because employees receive medical benefits such as antiretrovirals through private medical schemes to which management does not have access. He estimates that about 10% of HIV-positive staff are now receiving antiretrovirals. He is somewhat disappointed with the slow uptake and is now promoting a communications campaign through Lifeworks.

Costs

The company estimates that the cost of treating an employee with antiretrovirals is R 6000 a year (approximately US\$ 990). The approved medical scheme network provides an average annual AIDS treatment benefit of R 18 000 (approximately US\$ 2980). The company also pays R 150 (approximately US\$ 25) a month for a counselling service for every employee who requires it.

"The issue is the business case," says van der Bergh. "I never forget we're running a business. The lowered prevalence rate is a clear indicator of investment in people and their health. The provision of ART and other care and support mechanisms nearly doubles the capacity of people living with HIV to continue working. So there is no debate about costs/benefits."

Challenges

BHP Billiton's management recognizes that it still faces risks on two fronts from the epidemic:

- Its labour turnover is low (the average rate at site operations and corporate offices is 5%). But over time, as people age, the company will have to recruit more staff from local communities where prevalence is higher than among its own employees. For example, Philip Hechter, General Manager of Metalloys, estimated prevalence to be about 30% in the surrounding community where there is huge poverty and unemployment.
- External contractors are being used more frequently than in the past due to the ongoing restructuring of the workforce. Surveys have shown that HIV prevalence among some outside contractors is about double that of the company's workforce.

Because of these challenges, and given its philosophy of sustainable development, all BHP Billiton operations work with local businesses and civil society to devise programmes and interventions to help minimize the impact of HIV and AIDS in the community. "If we're to strive for excellence, we cannot operate as an island in a sea of chaos," says Hechter.

The company's individual operations tend to have developed their own community initiatives, usually in partnership with a number of stakeholders such as local government, nongovernmental organizations and other businesses. The Hillside smelter at Richard's Bay, KwaZulu Natal, for example, is involved in the development of Amangue Village. This will provide a community health centre in a community with high rates of HIV and AIDS, poverty and unemployment, as well as a first-class hospital for people living with HIV. Many local nongovernmental organizations are involved, and provide volunteers for a wide range of activities. Antiretroviral therapy will be provided, but there is also a strong focus on good nutrition (organic fruit and vegetables and medicinal herbs are grown in the village's garden). There will be educational programmes, outreach into the community and care and support for children orphaned by AIDS.

The Metalloys operation, located in Guateng province, has converted its redundant Kotulong hostel complex into a community support centre the Family Care Centre that aims to improve the quality of life for people living with HIV, including employees and people from the local community of Sedibeng. This community has 60% unemployment and high rates of HIV and AIDS. In 2000, HIV prevalence among pregnant women at antenatal clinics was 29.4%. Initial start-up funding came from the BHP Billiton Development Trust, and there has been support from government departments, local government and communities, nongovernmental organizations, and local and international donors. The old hostel buildings are being converted into a hospice, foster care units for children orphaned by AIDS, community training facilities, and a resource centre.

3. ESKOM

Eskom is a public company that generates, transmits and distributes electricity. It was incorporated in July 2002 and is wholly owned by the South African Government. It generates approximately 95% of the electricity used in South Africa and has about 30 000 employees spread over 37 sites and divided between the two ‘arms’ of the company—distribution and generation. It is among the world’s top seven electricity utilities in terms of generation capacity, and the top nine in terms of sales.

By the mid-1980s, it was obvious that AIDS was going to present a major challenge to many African countries including South Africa. The newly appointed Chief Medical Officer at Eskom, Dr Charles Roos, explained the issues to its governing board in 1985. It was not an easy scenario to describe because, as he explained, “It was the time of predictors; no one really knew what the future would bring.” Two years later, Eskom management supported Roos in drawing up a policy on HIV and AIDS—probably the first formal workplace policy to be produced by a South African company. This policy was completed in 1988; it covered education, training and counselling. By 1988-1989, the company had informed every single employee about HIV and AIDS. But, said Roos, “whether we really got it over to them is a different matter.” From the early days, the company stressed the importance of confidentiality and non-discrimination in the context of HIV and AIDS.

However, in the late 1980s, Eskom was carrying out pre-employment testing—for insurance purposes (it ran its own pension and health insurance schemes) rather than for employment purposes, stressed Roos. But this policy attracted criticism and Roos realized that this testing was totally irrational since people were quite likely to become HIV-positive after joining the company. Since this time, Eskom has always been active in counteracting stigma and discrimination.

In 1995, Roos instituted a ‘landmark’ surveillance study of HIV within Eskom. The workforce was then around 42 000. He brought in an external epidemiologist to carry out the study, applying national statistics on the epidemic to the demographics of the organization. The results of the study indicated that, without any interventions, about 25% of Eskom’s workforce would be HIV-positive by 2003. These figures were then given to an actuarial company to measure the likely financial impact on the company. The cost was deemed to be considerable, mainly in terms of insurance benefits. Presented with such a dire forecast, Eskom’s board agreed to a much larger budget for HIV education and awareness-raising and made HIV a core strategic priority.

‘Eskom recognizes the seriousness and implications of HIV infection and AIDS for the individual, his/her family, for Eskom, its employees as well as co-workers of affected individuals. Eskom is committed to addressing HIV and AIDS in a positive, supportive and non-discriminatory manner, with the informed support and cooperation of all employees.’

— HIV and AIDS in the workplace, Eskom Directive, 2002

Eskom’s policy stresses the importance of education and information, confidentiality, voluntary counselling and testing, and non-discrimination. The company works in partnership with its workforce and labour organizations, and with nongovernmental organizations and other external partners, especially in terms of empowering communities.

At all of its sites, Eskom's prevention and awareness-raising programmes use proven methods such as industrial theatre covering care, prevention and human rights issues, and trained peer educators (over 1200 to date). Since the programmes began, there has been an ongoing audit by the company to improve their effectiveness.

Male condoms are available through dispensers in most company toilet facilities. Treatment for sexually transmitted infections is provided free of charge through company clinics. Sessions run by employees living with HIV help address stigma. Voluntary counselling and testing is vigorously promoted, and the first test is paid for by Eskom through any agency approved by the company.

The board's commitment to voluntary counselling and testing was shown during counselling and testing week in 2002 when all its members were tested in public. Counselling is easily available to staff, not just through the testing service, but also through the Employee Assistance programme (EAP) and from occupational nurses in the clinics. But many of Eskom's employees still resist being tested because of the stigma surrounding HIV and AIDS.

To address stigma, Eskom is working with the Horizons Programme (a global HIV and AIDS operations research programme) and Development Research Africa on an intervention programme in KwaZulu-Natal. Qualitative research has been carried out to explore how stigma and discrimination become apparent in the workplace, family and community. The goal is to contribute to developing appropriate quantitative measures to measure the depth of stigma; and to provide the basis for creating stigma-reduction interventions. Interviews and focus group discussions were conducted with male workers, their sexual partners, workplace managers, HIV and AIDS programme staff, and community leaders. Key findings include the following: in the workplace Eskom workers fear stigma from their colleagues more than discrimination by their employers, and the main expressions of stigma are social isolation and ridicule by colleagues.

Most male respondents (91%–96%) know that Eskom is involved in HIV-related activities and are satisfied with the HIV and AIDS education offered by the company. At the same time, many of the respondents displayed attitudes and behaviour that could give rise to rejection and discrimination. Some 46% of the men and 37% of the women 'strongly agreed' or 'agreed' that HIV and AIDS is a punishment for bad behaviour. The research also showed that fear of stigma is causing many workers to avoid using voluntary counselling and testing services in the workplace, since counselling is now almost exclusively associated with HIV.

The researchers concluded that HIV- and AIDS-related stigma and discrimination can seriously affect the workplace and hinder efforts to implement education and prevention programmes. But the study did find that non-discriminatory workplace AIDS policies can make HIV-positive workers feel relatively secure that they will not be fired from their jobs as a result of their status.

Company programmes have had to evolve as understanding of the epidemic has grown. Since more employees are developing AIDS-related illnesses, Eskom is focusing more on enhanced treatment, care and support without weakening its work on prevention.

In the early years of the epidemic, few Eskom employees showed symptoms of AIDS, and measurements such as in-service deaths and retirement due to ill-health reflect this fact. Carl Manser, Eskom's Corporate Consultant, HIV/AIDS Programmes, explained that the company based its earlier policies and programmes on the assumption that employees who were HIV-positive would take some years to develop AIDS—about seven to nine years. He

stressed this is because the company has ‘properly agreed conditions of service’ with obligatory health insurance. Therefore, the workforce is generally much healthier than the majority of South Africans who have no access to health-care services. If an HIV-positive worker develops an opportunistic infection such as oral thrush or herpes, he or she is efficiently treated at the company clinic.

But more employees have been showing symptoms of AIDS since the late 1990s and there have been several deaths. The rates vary from area to area, often reflecting the national picture; for example, there are higher death rates in KwaZulu-Natal, where prevalence is high. Overall in-service deaths are rising in number and, in 2001 AIDS accounted for 50% of retirements due to ill health. Manser estimates that about 10% of HIV-positive workers are at the clinical stage when they will benefit from antiretroviral therapy.

Another major issue for the company is how to help employees who are HIV-positive (but do not yet need antiretroviral drugs) to sustain their immune systems with basic nutritional and vitamin supplements, good nutrition and healthy living.

Treatment, care and support

Eskom offers a range of care, support and treatment programmes to its employees living with HIV. These programmes include:

- a. integration of HIV and AIDS into the wellness programme offered to all employees (including advice on nutrition and counteracting stress);
- b. antiretroviral treatment when appropriate;
- c. treatment for opportunistic infections such as TB;
- d. treatment for sexually transmitted infections;
- e. psychological support through counselling—provided both in-house and externally;
- f. support groups for people living with HIV;
- g. comprehensive employee assistance;
- h. reasonable accommodation such as change of work and ill-health retirements; and
- i. home-based-care programmes for both employees and families; Eskom is training nurses and home-based caregivers.

The wellness programme for all employees has been running at Eskom for about four years following a restructuring of the company’s health services. It aims to look at people in a holistic way; issues relating to HIV and AIDS are now well integrated into the programme in order to deal with stigma and people’s feelings of isolation. Integration also ensures a more cost- and time-efficient service, avoiding duplication of activities and databases.

A key objective is to empower individuals so they can make informed decisions about all aspects of their health. Information and education are therefore provided on diet, exercise, coping with stress (through relaxation exercises, for example), sexual behaviour, family planning, complementary and traditional medicine and, for women, self-defence classes and other forms of empowerment. People living with HIV can benefit from the programme in obvious ways and, as is the case with all employees, they are encouraged to take responsibility for their health—for example, by avoiding abuse of alcohol or tobacco.

Providing antiretroviral therapy

From the early 1990s, Eskom's own health insurance provided antiretroviral therapy to people living with HIV. It was one of the first companies in the world to do this. Until recently, a very small number (an estimated 15 to 17 out of 40 000 employees) were on triple therapy. From the mid-1990s, Eskom has outsourced its medical insurance to five medical aid companies. Every member of the workforce is obliged to belong to one of these companies. But there is a choice of package, and Eskom contributes two thirds of the cost. Each medical aid company uses a different HIV and AIDS disease-management company to treat and care for Eskom employees who are HIV-positive. Through these disease-management companies, employees and their dependants receive a range of care and support services, including testing, vitamin supplements and immune modulators, treatment for opportunistic infections, hospitalization if necessary, and antiretroviral therapy.

Every year Eskom employees on antiretrovirals usually run out of medical aid funds after nine months, so the company pays for the last three months of treatment. Eskom also provides 'top up' in funding for day-to-day care other than antiretrovirals, such as treatment for opportunistic infections; this is usually offered through the company's primary health-care services. It thus recognizes that it has a certain responsibility to ensure the treatment is sustainable. Because treatment is supplied through the medical aid companies, Eskom management does not know the exact numbers of its employees on antiretrovirals. It estimates that just over 3000 employees and over 10 000 dependants are HIV-positive.

Patients on antiretroviral therapy are closely monitored to check adherence and side effects from the drugs. Checks are carried out every three months by the disease-management company's case managers to whom patients are assigned. If a patient appears to have problems with adherence, he or she will be provided with a personal counsellor from the disease-management company. If necessary, the patient may have to be taken off antiretrovirals. The company does not have figures on adherence.

Towards the end of 2003, Eskom's HIV and AIDS team was grappling with the dilemma of a lack of balance and fairness in how antiretroviral therapy was provided through its different companies, and was examining how to eliminate this disparity. The company saw that it had three options:

1. To provide care and treatment for people living with HIV in-house, through the existing network of company clinics. To do this, the health service infrastructure would have to be strengthened. If this route is chosen, there are obviously issues of confidentiality and perceived credibility, as well as the risk of discrimination, since this option would only be for people living with HIV.
2. To approach the medical aid companies and ensure that they work on an equal basis by agreeing to minimal requirements.
3. To establish a quite separate external entity from the medical aid companies. Four groups have made presentations on this option, and it seems to be the one most favoured within Eskom.

A decision has yet to be taken.

The company's occupational health service provides primary health care in-house for all employees, although coverage is variable. It is harder to provide a good service to employees who work in the distribution arm and are scattered across the country, than to those in power stations that have a large workforce at one site.

The company's clinics throughout the country offer a range of care and support programmes for people living with HIV, including treatment for opportunistic infections and TB, and vitamin supplements to boost the immune system, as well as psychological support. All the occupational nurses employed by Eskom are receiving specialist training in HIV and AIDS, including advice on nutrition and vitamins as well as antiretroviral treatment, and procedures for taking CD4 counts and assessing viral loads.

Counselling is available from in-house counsellors, occupational nurses and outsourced EAP staff. Employees who do disclose their HIV status are also given a toll-free number for confidential advice and support. The same service can be used by family members. Occupational nurses make home visits to people living with HIV when they are sick, and help them gain access to government grants to which they are entitled.

Materials on prevention and positive living for people living with HIV are available in all the clinics, and people are encouraged to discuss their status and their fears. But stigma is a huge problem, acknowledged Belina Ramogase, Health Centre manager. "We tell people who are HIV-positive that they will never be discriminated against and stress their rights, which are displayed on the walls of the clinic. It is so important to reassure them that their jobs are secure until retirement and that accommodation can be made, because HIV thrives on stress."

A recent innovation (launched in 2002 by the wife of Eskom's chairman) is a self-help group set up specifically for people living with HIV (involving people living with HIV is not yet that common in workplace programmes despite its proven efficacy in prevention and in counteracting stigma). It is called Employees Living with HIV/AIDS (ELWA) and is being implemented by an employee who has been working for Eskom for several years and disclosed her status in mid-2002. She has been seconded to spend 40% of her working time on the HIV and AIDS programme and the support group. Issues dealt with in the group include positive living, the side effects of antiretroviral drugs and proper nutrition. The plan is that self-help support groups will be set up at all Eskom's sites. The aim is to create an environment where people feel able and secure enough to disclose their HIV status.

Manser and Roos are concerned that not enough employees who need antiretroviral therapy are coming forward. They say that this is due to stigma, and also fear and mistrust of drugs that have been dubbed 'toxic' by senior members of the government in South Africa. Roos says that some employees who have developed AIDS still prefer to go home and die, even though they know treatment is available.

GIPA³² workplace model: Eskom has been involved for several years in a pilot programme, developed through UNDP and WHO, called the GIPA (Greater Involvement of people living with HIV) Workplace Model. Through this programme, trained fieldworkers, living openly with HIV, are placed in various organizations in the private and public sectors. The aim is to 'set up, review or enrich workplace policies and programmes.' This adds credibility to HIV and AIDS programmes by personalizing the virus, and creating a supportive environment for people living with HIV and others to speak about issues related to it.

One GIPA fieldworker was placed with Eskom as Regional AIDS Programme Coordinator in KwaZulu-Natal. Another worked at Eskom's Generations Division where he focused on training peer educators and managers on HIV- and AIDS-related issues. From 2001,

³²GIPA stands for the 'greater involvement of people living with HIV/AIDS'. The GIPA principle was formalized in a declaration signed by 42 countries at the Paris AIDS Summit in 1994.

his role developed into broadening the expertise of peer educators to help in caring for and supporting people living with HIV, including providing information on nutrition and treatment therapies.

Eskom now ensures that the GIPA principle is an integral part of the design and implementation of its HIV/AIDS Business Plan and strategy. People living with HIV serve as mentors to people in the company and help the HIV and AIDS 'team' ensure it is doing the 'right thing'. People living with HIV also identify new areas of work on the epidemic.

Training doctors: Working with the Foundation for Professional Development (an organization within the South African Medical Association that supports and implements continuing education for doctors), Eskom has helped to develop the Africa AIDS Training Partnership. The company is spending R 6 million (approximately US\$ 966 000) over three years to finance antiretroviral use courses for doctors working in public health services, especially in rural areas. This type of training is vital to all antiretroviral therapy programmes. "We battle to find health-care workers to treat our employees in many areas," says Roos. Eskom is now working with the Foundation to expand the partnership.

This increase in capacity will be enormously beneficial as the South African Government continues its planned roll-out of providing antiretrovirals nationwide. By December 2003, the Africa AIDS Training Partnership had trained more than 2800 health-care practitioners in the region.

Vaccine research: Eskom is supporting research for an HIV vaccine through the Eskom Development Foundation, which carries out the company's corporate social investment initiatives. It has provided the South African AIDS Vaccine Initiative (SAAVI) with R 100 million (approximately US\$ 16 million). To date, this is the largest corporate sponsorship of a vaccine development initiative. SAAVI is coordinated by South Africa's Medical Research Council and was set up to test and develop an affordable vaccine for southern Africa.

The Eskom Development Foundation also works with nongovernmental organizations carrying out community work on HIV and AIDS issues, and funds a number of community projects, including the training of teachers.

Other Eskom partnerships include:

- membership in the private-sector delegation to the Global Fund to Fight AIDS, Tuberculosis and Malaria;
- founding membership in the South African Business Council on HIV/AIDS (SABCOHA);
- membership in the Global Business Coalition on HIV/AIDS;
- chairmanship of the SADC utilities forum on HIV/AIDS; and
- active membership in the Global Health Initiative of the World Economic Forum (WEF).

Monitoring and evaluation

Eskom strongly emphasizes monitoring and evaluation to ensure that its policies and programmes reflect the changing dynamic of the epidemic in the country. After the initial impact study in 1995, it commissioned a more sophisticated HIV-risk analysis in 1999, taking into account the demographics of employees. This analysis highlighted the epidemic's economic and financial impact on productivity and personnel, and on training needs and pension and medical costs.

In 2000, a full economic-impact analysis, conducted by the Harvard Institute for International Development, found that the HIV incidence rate (that is, new infections) had cost the company R 188 million (US\$ 31.2 million) in 1999—4% of the total manpower costs. This was made up of:

- pension fund 55%
- sick leave 13%
- training 10%
- productivity losses 8%
- recruitment 7%
- other 7%.

It was also estimated that the figure would be reduced to R 84 million (US\$ 13.6 million) by 2005 because of a reduction in HIV infection rates and in the size of the organization. Carl Manser says a current study on the economic impact would substantiate the figure. “You can't start early enough with HIV and AIDS interventions, but it is conversely never too late to start. ... we're still battling 17 or so years later. This is not a best practice, but rather a current practice; it's very much a living-on-the-edge job. We have, of course, made lots of mistakes but have tried to learn from them.”

Costs

Within the company budget, an HIV and AIDS cost centre was created in 1996 to monitor education, awareness and care costs. In 1999, direct costs (not including medical aid) amounted to R 125 (US\$ 20.75) per employee. The cost of treatment through Eskom's clinics is borne by and budgeted for within the Occupational Clinics, including treatment of opportunistic infections. The corporate guideline for 2004 was increased to R 375 (US\$ 62.25) per employee to include prevention initiatives such as condom education and training in voluntary counselling and testing.

6. Conclusion

The three companies have been working on HIV and AIDS for some time: Anglo American and Eskom since the late 1980s, BHP Billiton since the early 1990s. Their HIV and AIDS policies and programmes are viewed as pioneering efforts and examples of best practice. These companies carry out regular data collection on which to base their programmes and monitor their effectiveness. The work follows a continuum of prevention, care and support and access to treatment, and is carried out in consultation with the workforce and its labour organizations. There is strong leadership from senior management and their governing boards, and partnership with a wide range of other stakeholders—local and national government, civil society (including nongovernmental and community-based organizations), and medical and academic research institutions.

The HIV and AIDS programmes in all three companies are led by strong charismatic individuals, all of whom are wholly committed to their work and are not afraid to argue their case and speak their minds to top management. They exemplify the kind of champions needed to effectively respond to the worst epidemic the world has ever faced. Their different backgrounds—business management, engineering, and medicine—reflect the diversity of corporate attitudes to HIV and AIDS work, and support the multisectoral approach needed for such work to be effective.

Employing migrant labourers is common practice in South Africa and has proved to be a driver of the HIV epidemic there. All three companies, but especially Anglo American and BHP Billiton, have acknowledged the need to reform the practice of housing male workers in hostels long distances from their spouses and families. BHP Billiton has done more; it has closed most of its hostels and focuses on local recruitment. Anglo American has similar plans, but it faces a greater challenge because of its huge workforce. A framework for such action is provided by the 2003 agreement between the Chamber of Mines of South Africa and the National Union of Mineworkers.

Need for antiretroviral therapy

Before the introduction of antiretroviral therapy, the three companies provided a range of care and support including treatment for opportunistic and sexually transmitted infections, as well as large-scale prevention programmes. But, as prevalence increased, the personnel in charge of the HIV and AIDS programmes recognized the hard fact that even with large resource investments, changing behaviour was not easy. Confidential voluntary counselling and testing was widely available within the companies, but people were reluctant to come forward because of the stigma attached to HIV and AIDS. Company policies and programmes aimed to counteract stigma and discrimination, but it takes time to eradicate such culture-bound attitudes. Interestingly, a survey carried out among some Eskom employees showed that they were more fearful of discrimination from their peers than from the company itself.

For similar reasons, all three companies decided to provide antiretroviral therapy for their employees (although not necessarily also for family members). More employees and their family members were becoming sick and dying, and the impact on business and the communities in which they operated was considerable and was only going to get worse. Furthermore, the national government denied the link between HIV and AIDS and refused to make antiretroviral therapy available nationwide through the public health-care system.

However, the government has now changed its stance on antiretroviral therapy. This means that the example of South Africa may provide support for a belief among some international agencies and nongovernmental organizations³³ that private sector provision of treatment will put pressure on unenthusiastic governments to take action. Only a few weeks after Anglo American announced that it would provide free antiretroviral therapy to its workforce in South Africa, the national Government announced a feasibility study to consider a national roll-out. In November 2003, it announced that the roll-out would start in 2004.

Whether or not companies do have such influence over governments, they can offer invaluable expertise when the public sector goes ahead with antiretroviral therapy provision. As the largest business customer for AIDS drugs in the world, Anglo American has many lessons to offer to national and provincial governments. Such public/private partnership will considerably increase the efficacy of antiretroviral therapy programmes.

Brian Brink at Anglo American is not alone when he says that access to antiretroviral therapy may be the best prevention tool available, and a significant way of eliminating stigma and discrimination. Increased access to treatment is one of the most powerful incentives for a person to find out his or her HIV status, as well as a concrete demonstration that a company cares about its workforce and is against people being subjected to stigma because they are HIV-positive.

“Before, when people discovered they were HIV-positive,” says Brink, “all they confronted was death and despair. ART offers such a positive message.” People’s health visibly improves within a short space of time and they can return to work.

However, these companies do not see treatment as an alternative to prevention programmes. Education and awareness-raising programmes continue to be provided across the board. But even when prevalence is high, the fact is that most workers do not have HIV or AIDS and need to receive support so that they stay that way. In the meantime, workers who do have HIV or AIDS need to be able to obtain treatment as part of a comprehensive HIV and AIDS workplace programme.

Voluntary counselling and testing is a major focus for all three companies. Testing is done on a purely voluntary basis with guaranteed confidentiality, but Brink stresses that the major challenge still is to get all individuals to establish their current HIV status through testing. The current uptake of voluntary counselling and testing is still too low.

Providing antiretroviral therapy

BHP Billiton and Eskom have been providing antiretroviral therapy to employees in need for several years through their medical aid schemes. Access to treatment was a much greater financial and practical challenge to Anglo American, with its huge workforce in South Africa (many of whom are migrant workers living in hostels) and a much higher prevalence rate than the other two companies.

South African companies use different mechanisms to fund and provide antiretroviral therapy. Anglo American has its own comprehensive health-care services linked to all its operations, so it clearly made sense to provide treatment through these clinics and hospitals. It also has, perhaps unusually, its own health research subsidiary—Aurum Health Research—which is fulfilling the disease-management role. This has entailed major staff training programmes,

³³ *The role of the business sector in scaling up access to antiretroviral therapy*. New York, Global Business Coalition on HIV/AIDS, June 2003.

procurement of drugs, the design of processes to guarantee that treatment can be sustained, treatment adherence, and tight monitoring and evaluation.

At Anglo American, Brink stresses the importance of training all staff involved in HIV and AIDS management. The pillars of the company's antiretroviral therapy programme are professional nurses. Doctors are only used at key decision points and for dealing with problem cases.

On the other hand, BHP Billiton and Eskom have divested themselves of their in-house facilities and use medical aid societies to fund private health care for employees. However, Eskom's provision of antiretroviral therapy through medical aid societies is under review because of its inherent lack of fairness. The company is likely to contract out the disease-management role separately from the medical aid role, as BHP Billiton does. The management of HIV and AIDS workplace programmes is a growing business in itself in South Africa. There is some evidence³⁴ that employees welcome contracted-out service arrangements because they provide a greater sense of confidentiality and discretion since they are located and operated separately from the employer.

Brink and his colleagues at Anglo American eventually want to decentralize the antiretroviral therapy programme to primary health-care clinics to ensure greater convenience and efficiency in therapy delivery. They nevertheless believe that management must continue to follow the process carefully. Monitoring programme effectiveness is particularly important, especially checking for drug side effects and treatment adherence. The protocols and procedures that Aurum has developed provide an excellent template for any private or public antiretroviral therapy programme.

As the report of the World Economic Forum's Global Health Initiative (2002) explains, prerequisites for offering antiretrovirals to employees are:

- a guaranteed drug supply
- appropriate infrastructure for viral load and other laboratory testing
- adequate medical support for drug-related side effects.

Programmes need to be financially sustainable, taking into consideration changes in prevalence and potential pressure to extend their reach. This is particularly important since inadequate antiretroviral therapy programmes carry the risk that drug-resistant disease can develop.

Although it is relatively early days for the three antiretroviral therapy programmes, they seem to be meeting the essential prerequisites listed by the WEF's Global Health Initiative.

Care and support

Antiretroviral therapy provision is also very much part of the bigger picture of care and support in these companies. One challenge is to support employees who are HIV-positive (but not yet at the stage of needing drugs) in keeping their immune system strong and protecting themselves against infections. BHP Billiton and Eskom have wellness programmes for all employees, which obviously benefit people living with HIV. The programmes provide advice on diet, exercise, safe sex, etc. Anglo American's wellness programmes are only for HIV-positive employees.

³⁴ *The role of the business sector in scaling up access to antiretroviral therapy*. New York, Global Business Coalition on HIV/AIDS, June 2003.

Key to effectiveness and success

The three South African companies agreed that the following are key to the success of HIV and AIDS workplace programmes:

- Leadership from the top;
- Partnership across a wide range of private and public sector stakeholders;
- Consultation and collaboration with workforce and labour organizations;
- Careful management of the programme, including monitoring and evaluation, and sustainable procurement and provision of drugs;
- The importance of going beyond the workplace into the communities in which the companies operate. Business cannot work ‘as an island of privilege’; it needs to recruit from within its communities and to recognize its corporate responsibility to them. (All the companies studied are active in their communities in a range of projects and measures that will undoubtedly benefit the whole country as the South African Government rolls out its antiretroviral therapy programme).

Challenges

As the three antiretroviral therapy programmes are relatively new, it is very early to write about successes. However, there are specific indicators of success that may be due to antiretroviral provision; both Anglo American and BHP Billiton report relatively high rates of treatment adherence and few serious adverse effects.

But there are still many challenges. One is cooperation with the workforce and labour organizations. Despite reassurances of confidentiality and anonymity, some trade unions have been resistant to prevalence and other surveys being carried out.

Each company reported that, despite years of HIV-prevention programmes, awareness-raising and peer education, within the workforce there are still high levels of stigma and discrimination against people living with HIV. This certainly hinders the provision of counselling and testing services (considered essential to any programme’s success). In a few cases, stigma and discrimination are preventing people living with HIV from coming forward to receive antiretroviral therapy. At Eskom, Roos said there have been several people who have “preferred to go home and die.” In some cases, low take-up has been a problem for the company partly because people have ill-founded fears about the toxicity of antiretroviral drugs.

Meanwhile, a recent report (*The Economist*, 27 February 2004) on the nationwide programme of access to antiretroviral therapy in Botswana revealed that fewer people are coming forward for treatment than expected because of the stigma attached to HIV and AIDS. This is despite the country’s very high prevalence.

There is considerable work to do (and not just by the companies involved) in educating people about antiretroviral therapy. Brink said that all stakeholders involved need to understand and communicate the fact that people with HIV or AIDS urgently need access to antiretroviral therapy. He says it is also a priority to reach those living with HIV who may feel well, even though they are at the stage when they would benefit from taking antiretroviral drugs. Anglo American personnel are considering using industrial theatre to promote the antiretroviral therapy programme to employees. Conversely, it is important to convey the message that not everyone who is HIV-positive needs antiretroviral therapy; it is a treatment for people at a particular clinical stage of the illness.

The work of the Treatment Action Campaign (TAC) project of Ulwazi in South Africa's Khayelitsha community offers an example of how to prepare a community to accept treatment.³⁵ The involvement of people living with HIV can be an important factor in such a programme's success. Through the GIPA project, Eskom has been working for several years with individuals and groups of people living with HIV, although not specifically on antiretroviral therapy provision. Anglo American is involving TAC members as treatment supporters for employees on antiretroviral therapy. These partnerships with people living with HIV have to depend to some extent on the strength of their networks in countries. This does vary considerably from country to country and region to region.

A major issue is whether to provide antiretroviral therapy to employees only, or also to their partners and families. Anglo American has decided to treat only its employees and has been criticized for this. However, over time Brink and his colleagues are planning to reach employees' families through community initiatives. Both BHP Billiton and Eskom do provide treatment to dependents.

Another issue that needs to be addressed is how to sustain antiretroviral therapy when an employee is made redundant or chooses to leave the company's employment. This has yet to be fully resolved by the three companies, but finding a solution is vital in terms of ensuring treatment adherence and avoiding patients developing resistance to the drugs.

³⁵ *Antiretroviral Therapy in Primary Health Care: South African experience*. Geneva, World Health Organization, 2003.

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Other resources

International Labour Organization: www.ilo.org/aids

Global Business Coalition on HIV/AIDS: www.businessfightsaids.org

World Economic Forum: www.weforum.org

International Confederation of Free Trade Unions: www.icftu.org

International Organisation of Employers: www.ioe-emp.org

The Futures Group International: www.tfgi.com

Asian Business Coalition on AIDS: www.abcon aids.org

The South African Business Coalition on HIV/AIDS: www.sacob.co.za

Centers for Disease Control and Prevention: www.hivatwork.org

World Bank: www.worldbank.org

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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Access to treatment in the private-sector workplace; the provision of antiretroviral therapy by three companies in South Africa

Antiretroviral therapy (ART) is having a huge impact on the lives of those who have access to it. For them, AIDS has become a manageable condition rather than a death sentence. However, for the vast majority of people living with HIV, nothing has changed because neither they nor their countries' health-care systems can afford to pay for antiretroviral therapy.

One source of hope comes from the business sector. The workplace—both private and public—provides many opportunities for extending access to treatment, through occupational health schemes and health insurance schemes. A number of companies now have experience in providing antiretroviral therapy for their employees (and, in some cases, also for dependants). Given the impact of the epidemic, there is a clear economic advantage for companies in offering employees access to treatment and in demonstrating a strong corporate responsibility.

After a brief description of the important components of workplace programmes on HIV/AIDS, this case study features three companies in South Africa that are providing antiretroviral therapy to their employees: AngloAmerican, BHP Billiton and Eskom. Detailed descriptions are given of the companies' antiretroviral therapy and care-and-support programmes, with an analysis of their differing approaches and shared challenges.

Public health provision should be strengthened, not undermined, by the contribution of the private sector to HIV and AIDS treatment. The companies profiled in this report are working with government, communities and civil society to extend treatment nationwide, through various projects and programmes and by setting an example of sustainable access to treatment and care.



Joint United Nations Programme on HIV/AIDS

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