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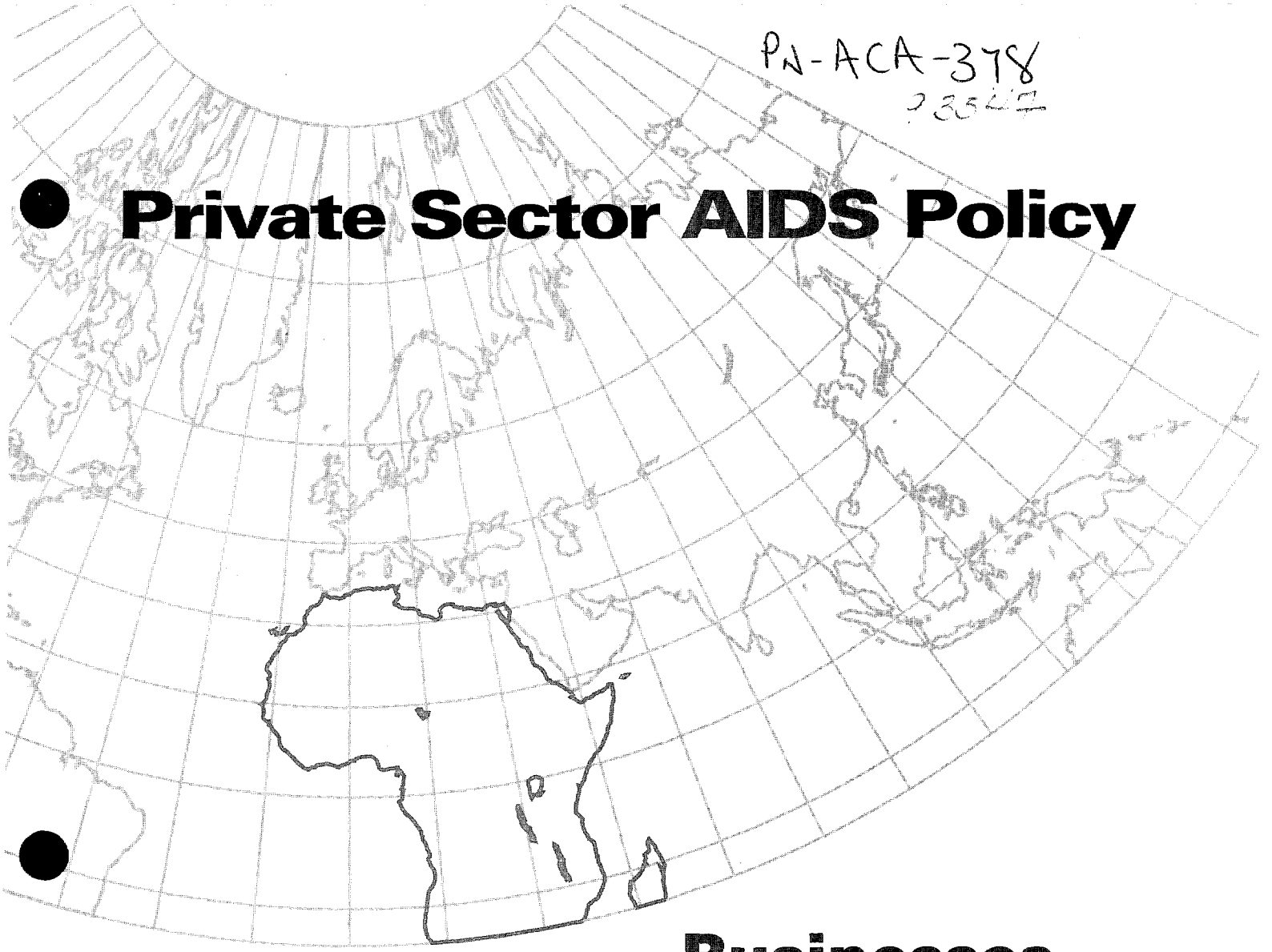
Private Sector AIDS Policy



Businesses Managing HIV/AIDS

A Guide for Managers

AIDSCAP

USAID

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INTRODUCTION

MODULE 1

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The HIV/AIDS crisis poses one of the greatest challenges ever faced by African businesses. The epidemic threatens the health and stability of the workforce and the vitality of the marketplace. HIV/AIDS must not be allowed to compromise the development gains won through hard economic, social, and political struggle.

Some businesses have already put in place HIV/AIDS prevention programs, as seen in the many excellent examples of programs in Botswana, Zimbabwe, and elsewhere. Many more companies are now considering how best to respond to the AIDS threat and seek to learn from the experiences of their colleagues in the region and beyond. When it comes to AIDS, there are no competitors: businesses must learn from—and work with—each other to fight the spread of HIV.

This Guide is a valuable tool to businesses in preparing their workplace policy and program responses to HIV/AIDS. Each module is written with the questions and concerns of managers (and workers' groups) in mind. Rather than simply presenting guidelines, this Guide provides business-based rationale for recommendations, encourages the generation of options, and offers a process for HIV/AIDS policy and program formulation.

A companion collection, the *African Workplace Profiles*, will also prove useful to businesses. It is a collection of 17 business studies from four different African countries, describing the impact of the disease on each company and illustrating the various ways in which businesses are responding to HIV/AIDS.

With foresight, commitment, and the prudent use of resources, the impact and spread of AIDS can be reduced. This Guide can help shape and implement an effective HIV/AIDS prevention program for the workplace.

Honorable Herbert M. Murerwa
Minister of Industry & Commerce
Harare, Zimbabwe

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Over the past eight years, Family Health International has helped design and implement over 100 HIV/AIDS prevention programs for the workplace. Many of the lessons learned from those experiences are incorporated into this *Manager's Guide*.

Among the lessons we have gained relating to HIV/AIDS prevention in the workplace are:

- Businesses can best protect their profits and staff from the impact of HIV/AIDS by offering prevention interventions which are supported by appropriate policies that define the responsibilities and rights of both management and employees.

- HIV/AIDS prevention programs and policies can fit into existing workplace structures without adding a major administrative or financial burden.

- Employees are anxious for AIDS prevention information and respond positively to management leadership on HIV/AIDS prevention.

- Adoption of HIV/AIDS prevention policies and programs allows businesses to participate proactively in countering the epidemic.

HIV/AIDS has already claimed some of the best entrepreneurs, managers, technical specialists, and other workers in large parts of Africa. The loss of these people has been devastating to families and communities. It has also made it more difficult for businesses to productively function in an ever-more competitive environment. All business sectors and all levels of employees are vulnerable to the impact of HIV/AIDS.

Businesses alone can not end the spread of HIV/AIDS. However, businesses are in key positions to help inform and influence employee attitudes and sexual behavior. The workplace provides a structured environment for sharing information, for reinforcing notions of acceptable behavior, and for implementing prevention interventions. The information in this *Manager's Guide* provides guidance on developing those interventions, as well as on creating policies that fit the needs of each business. In short, this *Manager's Guide* will aid businesses to deal with HIV/AIDS in the workplace.

Peter Lamptey, MD
Senior Vice President of AIDS Programs, Family Health International
and Director, AIDS Control and Prevention (AIDSCAP) Project

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INTRODUCTION

The *Manager's Guide* is a "how-to" manual that describes a step-by-step approach to planning and implementing HIV/AIDS prevention programs and policies for businesses. It is designed to help managers understand the impact of HIV/AIDS on business and to give guidance on how to minimize that impact through the development and implementation of appropriate policies and ongoing employee prevention programs.

The *Manager's Guide* is one component of the Private Sector AIDS Policy (PSAP) materials developed for the private sector by Family Health International/AIDSCAP. The PSAP materials will inform businesses about the seriousness of the threat of HIV/AIDS to company productivity and profitability. With the materials in this Guide, managers can respond effectively to the risks HIV/AIDS poses to their operations. The PSAP materials encourage businesses to manage HIV/AIDS in the workplace by developing and implementing rational corporate policies and prevention programs.

Who Can Use the *Manager's Guide*?

The *Manager's Guide* is designed especially for use by private sector, for-profit businesses. However, many other large-scale organizations are likely to find it useful. Many governmental bodies and parastatal enterprises (private/public joint ventures) will find that the HIV/AIDS policy recommendations and prevention strategies are appropriate for their organizations as well. Non-governmental organizations (NGOs) may be interested in communicating and advocating the policy and prevention guidelines to organizations with which they work.[1] Users of the *Manager's Guide* are encouraged to adapt the materials as appropriate for their organizations.

The *Manager's Guide* is written for senior management with responsibilities toward employee health and productivity. Thus, the managing director, and the financial, medical and human resources directors are all considered appropriate users of the Guide. In many instances, other staff will be involved in planning HIV/AIDS policies and programs, and the Guide will assist them in their work.

The *Manager's Guide* is designed for companies of different sizes. Some smaller firms may not have the staff to develop an in-house response to HIV/AIDS. In those cases, they are encouraged to seek

[1] NGOs and training institutions may find the companion volume, *Facilitator's Guide*, particularly useful. This guide provides instructions on how to conduct presentations and workshops for organizations on HIV/AIDS policy and program design.

outside assistance from other organizations with expertise in setting up HIV/AIDS prevention programs.

All companies may not be able to provide all of these components directly. Mid- to large-size firms (300+ employees) are likely to have medical and personnel staff and resources to manage a comprehensive prevention program. It is possible that smaller organizations may not operate their own clinic, provide STD services, or have staff who could offer counseling services. Even in these cases, however, alternative arrangements may be possible. For example, companies may work out cost-reimbursement arrangements with local clinics to provide STD services, or several companies can pool resources to hire counselors.

Another possibility is that some companies may prefer to contract the services of outside organizations to help operate their workplace HIV/AIDS prevention program. Should a company choose to do this, managers will still need to be conversant with HIV/AIDS policy issues, demonstrate and communicate to employees their commitment to HIV/AIDS prevention, and monitor the program. Again, this Guide provides sufficient information for managers to converse in confidence with any outside organization they may contract to assist in developing or implementing HIV/AIDS prevention programs or company policies.

Increasingly, there are public and private organizations that can provide all or some prevention services to businesses. Some examples of organizations that are likely to offer assistance are health-related NGOs (particularly those involved in HIV/AIDS, family planning activities, and women's reproductive health issues), the Red Cross, unions, employer's federations, and national AIDS control programs (NACPs).

How to Use the *Manager's Guide*

The *Manager's Guide* is meant to be a basic reference tool for business managers and for others involved in developing HIV/AIDS prevention programs and policies for the workplace. The six modules of the *Manager's Guide* provide background information on the HIV/AIDS epidemic, take users through an assessment of the economic costs of HIV/AIDS to a company, and outline a process for developing workplace prevention programs and policies.

The six modules will be of varying interest to different readers. It is not expected that users will read directly through the *Manager's Guide* in one sitting, but will use the different modules as needed. It is best to see the *Manager's Guide* as a reference tool, to be consulted both for background information on the epidemic and its influence on the workplace and for its detailed guidelines on specific aspects of HIV/AIDS in the workplace.

The *Manager's Guide* is set out in a way that assumes that users will be planning HIV/AIDS programs and policies. Background information leads into internal organizing for planning. Economic analyses can be

used to make rationale decisions about the costs and benefits of HIV/AIDS prevention. Finally, guidelines are offered for developing workplace policies and prevention programs. Obviously, users will adapt the materials, and their sequence, to fit their specific organizational needs and processes.

By presenting the materials in separate modules, users can readily turn to the sections of immediate interest. Also, the structure allows for inclusion of new or additional materials.

I. WHY IS HIV/AIDS A BUSINESS ISSUE?

Disease prevention and health promotion are not commonly thought to be business concerns. These concerns usually have been the responsibility of public health officials, medical doctors, nurses, and other health professionals. But in recent years, the HIV/AIDS epidemic has forced public and private sector leaders to reexamine the role of businesses in disease prevention and health promotion. This reexamination has come about because HIV/AIDS is affecting businesses in profound and costly ways.

According to the Joint United Nations Programme on HIV/AIDS, as of early 1996, over 20 million adults were estimated to be infected with HIV globally, and, at present rates, 30 to 40 million people will be living with HIV by the year 2000. As of early 1996, an estimated 1.5 million children had been infected with HIV. Over 5 million people already have died of AIDS, 3 million of those in sub-Saharan Africa. Although the African continent has been hardest hit so far (over 13 million HIV-infected adults), Asia is expected to surpass Africa in the number of new HIV infections in the next decade. As the World Health Organization, the World Bank, and other organizations have observed, up to 90 percent of HIV/AIDS infections are among adults in their prime working years.

AIDS not only causes illness, disability, and death to employees and severe economic and emotional disruptions to their families, it also increases the cost of doing business. Employers face a greater burden of health care, death benefits, pensions, and other costs. AIDS causes decreased productivity as workers are absent due to illness or away from work to care for sick relatives. Costs rise as experienced workers with valuable training and skills become ill and unable to work; this causes disruptions in production and increases training and labor costs. Furthermore, as more people become ill and die from AIDS, there will be fewer people with resources to purchase goods and services.

As an example of the severity of the problem, one business in Zambia had nearly a fourfold increase in AIDS-related deaths of employees under the age of 45 between 1989 and 1992. WHO estimates that in the 1990s the loss of potential productive years of Ugandan workers between the ages of 20 and 49 will triple (from about 12 percent

A ZIMBABWE MINING COMPANY REPORTED THAT HIV/AIDS RESULTED IN...

- Loss of experienced personnel
- Increased expenditure to hire and train replacements
- Increased absenteeism
- Increased labor turnover
- Decreased productivity
- Shrinkage of pool of available hires
- Increased health care costs, including growing health staff, medical insurance, life insurance premiums, and disability payments.

in 1989) because of AIDS. In cities in both Zambia and Uganda, between a quarter and a third of pregnant women are infected with the AIDS virus. In Abidjan, Côte d'Ivoire, the prevalence of infection with the AIDS virus, at about 1 percent in 1986, climbed to over 10 percent of the adult population as of 1991. In Nairobi, Kenya, the HIV rate was estimated at 14 percent in 1992 and is expected to grow to 24 percent by the year 2005, if unchecked. Infection rates in some populations in Botswana, Zimbabwe, and Malawi are even higher.

The prevalence of HIV/AIDS within a business is usually the same as that for the surrounding community, though it can vary. Businesses that employ workers who frequently travel or live away from their partners and families (e.g., transport, mining, tourism companies) are likely to have a higher rate of HIV infection among their workforce. On the other hand, it is difficult to identify particular types of businesses that would have inherently lower levels of risk among their workforce compared to the surrounding community. Thus, most businesses need to consider how to reduce their exposure.

There is growing evidence of the effectiveness of prevention efforts. Those programs have included: regular education sessions for employees, access to sexually transmitted disease (STD) services, and condom distribution. For example, such a program resulted in more than a 75 percent decline in STD cases at two companies in Zimbabwe (STDs not only are a cause of employee illness and absenteeism, but increase the risk of HIV transmission). In Uganda, studies of four programs found that condom use increased significantly after a prevention program was initiated. In Botswana, one small company managed to introduce a comprehensive program and now reports a stable rate of absenteeism despite rapidly rising HIV rates in the country. Management of another Botswana business with a prevention program reports a dramatic decline in STD cases at its clinic.

The AIDS epidemic has spread throughout Africa, and its impact is increasingly felt by businesses across the continent. Even in countries with low HIV prevalence rates, some companies are already beginning to brace for the impact. For example, one Senegalese company doctor reports that he knows some workers are infected and worries about the likely impact. The company benefits package is quite comprehensive and all employees—skilled and unskilled—thus represent a significant financial investment. Because some workers have misconceptions about the risk HIV-infected coworkers pose, there could be work disruptions if workers find out there are HIV-infected persons among them. Plans are underway to establish a company-wide prevention program.

II. WHAT IS A WORKPLACE HIV/AIDS PREVENTION PROGRAM?

Workplace HIV/AIDS programs range from in-house prevention education, to service delivery, to support for community prevention efforts. The most effective workplace prevention program will consist of a comprehensive and coordinated set of components. The *Manager's Guide* recommends that the following components be included:

- Policies and practices that are clearly defined, understood, and consistently followed;
- Formal and informal education activities for all staff;
- Condom distribution systems that make condoms readily and consistently available;
- Sexually transmitted disease (STD) diagnosis and treatment;
- Counseling and support services for employees and families.

Though it may be possible to operate a successful prevention program that does not include all of these components, they all should be given serious consideration before any of them are excluded. The experience of a number of workplace programs in Uganda, Tanzania, Zimbabwe, and other countries suggests that the effectiveness of programs may be jeopardized unless sufficient attention is devoted to these complementary components. For example, company education programs will raise worker awareness and motivation to adopt safer sexual practices. However, unless condoms are easily available to and affordable for employees, they will not be able to make these behavioral changes. Similarly, if an organization does not have a policy of medical confidentiality, workers may not be willing to use clinical services for STD treatment or ask medical staff questions about HIV transmission that could change their risk behavior.

Two factors cut across each of these components of HIV/AIDS programs. First, the needs of women, as employees and as partners of male employees, may be different than those of men. HIV rates for women in many parts of Africa are higher than for men. Most women become infected through their husbands or steady male partner. Women have limited influence over the sexual behavior of men, and communication between men and women about sexual issues is usually minimal. As a result of these factors, women may have greater interest in or need for support services and specialized education activities. The second factor is supporting HIV/AIDS prevention beyond the workplace

gates. Prevention can be emphasized at work, but employees also exist within communities. Their behavior and the messages they convey to friends and neighbors will influence the behavior of others. Likewise, a company's public stand on HIV/AIDS will be known in the communities where employees live and where services and/or products are available.

There are sound reasons for each prevention component:

1. Policies and practices that are clearly defined, understood, and consistently followed.

Policies are the foundation of a workplace HIV/AIDS prevention program. A HIV/AIDS policy defines a company's position and practices as they relate to HIV/AIDS, whether an employee is, or is believed to be, HIV-infected. HIV/AIDS policies establish consistency of practice for the business. Policies set standards of behavior expected of all employees and set the standards for communication about HIV/AIDS. Policies let employees know where to go for assistance and instruct supervisors and managers on how to manage HIV/AIDS in their work groups.

2. Formal and informal education and prevention activities for all staff.

HIV/AIDS education and training activities in the workplace are designed to educate workers about HIV/AIDS and encourage changes in behavior that will reduce the spread of HIV. Depending on how they are structured, formal sessions may take as little as 30 minutes and as long as a couple of hours to cover factual information about HIV/AIDS, about its transmission, and about safer sex alternatives. It is recommended that such presentations be made to all employees during regular work hours and be offered approximately every other month.

Informal education and training approaches are often conducted by coworkers who have been specially trained as "peer educators." Informal, small group, and one-on-one interactions are used to discuss HIV/AIDS,

BOTSWANA MEAT COMMISSION

Community HIV rate: 16.2-17.8%
Known HIV-infected workers: 18+

Company Response:
BMC began an HIV/AIDS prevention program for its 1,500 employees in 1991, including:

- Ongoing HIV/AIDS formal and informal education sessions for all workers. Workers attend one-hour lectures, watch videos, and participate in health talks.
- Condoms are available from dispensers in toilets, changing rooms, and shower rooms. They are also given out at the clinic.
- Workers and their partners are treated for STDs and counseled about them at the company clinic.
- Prevention and counseling is offered to employees and their families by clinic staff.
- BMC's policies are clear about HIV/AIDS: Applicants and workers undergo physical exams but are not tested for HIV. Employees with HIV/AIDS are provided the same medical and other benefits as any other employee with a disability. HIV-infected workers are given less strenuous jobs until they are no longer able to work.

Company Costs: Minimal. Condoms are provided by the Ministry of Health, the clinic staff are already contracted, and worker education sessions are generally scheduled around normal breaks and slow production periods.

Company Payoffs: Management reports dramatically increased condom use and declining STD cases. Consistent condom use and low STD rates greatly reduce HIV transmission risk, health-related absenteeism, and medical costs.

teach safer sex practices, answer questions, discuss fears, distribute pamphlets and other materials, and generally foster an environment of greater awareness and understanding about the disease.

3. Condom distribution systems that make condoms readily and consistently available.

Most HIV/AIDS education activities include condom promotion as a part of their safe sex message. If condoms are not widely available in the community at reasonable cost, condom distribution in the workplace is an important component of a comprehensive prevention program. Though this may seem to be a sensitive issue at first, experience shows that employees appreciate and support condom distribution in their workplaces. For example, at one Kenyan company where condom dispensers were installed, the discontent first voiced by a few workers has been replaced with overwhelming support from the majority of workers. The *Manager's Guide* discusses education about condom use and condom distribution in Modules 4 and 5 as part of the development of a HIV/AIDS prevention program.

4. Sexually transmitted disease (STD) diagnosis and treatment.

Many employees suffer debilitating illnesses that increase absenteeism and reduce productivity as a result of undiagnosed or untreated STDs. Not only are STDs injurious in their own right, but they also greatly increase the possibility of transmitting the AIDS virus during unprotected sex. Thus STD diagnosis and treatment become part of a comprehensive workplace HIV/AIDS prevention program. STD diagnosis and treatment are discussed in more detail in the *Manager's Guide* in Modules 4 and 5, as part of the development of an HIV/AIDS prevention program.

5. Counseling and support services for employees and their families.

Counseling and support services for concerned workers and for HIV-infected workers and their families are usually part of a comprehensive workplace HIV/AIDS program. Not only are these services beneficial to the physical and mental welfare of employees and their families, but they increase the probability of sustained behavior changes that will help prevent the transmission of the AIDS virus. *Voluntary, informed, and confidential* HIV testing may be one service offered employees and their partners. Counseling, voluntary testing, support services, and related issues are discussed in the *Manager's Guide* in Modules 4 and 5 as part of developing a HIV/AIDS prevention program.

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Companies which provide the comprehensive and coordinated set of prevention components described above—or at least ensure that these components are accessible to all their employees in the surrounding community—will establish workplace HIV/AIDS programs that are strong, cost-effective, and sustainable. One of the best examples of a company's commitment to such a program is Barclays Bank of Zambia (see their HIV/AIDS policy statement, Appendix 1).

III. THE BASICS OF HIV/AIDS

This section provides basic information on HIV/AIDS. It is intended to provide an explanation of the primary facts of HIV/AIDS. Also, see the glossary of terms in Appendix 8.

1. What is the difference between AIDS and HIV?

AIDS stands for *Acquired Immunodeficiency Syndrome*, a disease in which the body's immune system breaks down due to an infection with a virus called the *Human Immunodeficiency Virus*, or HIV. In other words, HIV (a virus) causes AIDS (one or more serious illnesses). No one will develop AIDS unless he or she has been infected with HIV. By preventing HIV infection, AIDS can be prevented.

If HIV enters the blood stream, one may become infected with HIV. A person who is infected with HIV can infect others, even if no symptoms are present. The breakdown of the immune system by HIV occurs over years. The immune system fights off infections and certain other diseases. Because the immune system fails, a person with AIDS develops a variety of life-threatening illnesses. The onset of AIDS is signaled by the beginning of these health problems and illnesses. In some people these illnesses may develop within a couple of years of infection. Others stay healthy for as long as 10 years or more before symptoms appear. One cannot tell by looking at someone whether he or she is infected with HIV. An infected person can appear completely healthy.

In addition to appearing well, a person may not test positive for HIV infection for several weeks, or even months, after having become infected. This period during which an HIV-infected person does not test positive is referred to as the "window period." During this period, a person can transmit HIV to others in an unprotected encounter.

"HIV/AIDS" is a common and professional way of referring to the range of issues associated with HIV infection and AIDS-related illnesses. Thus, this Guide will refer to HIV/AIDS programs, HIV/AIDS policies, and people with HIV/AIDS.

2. How is HIV transmitted?

A person can become infected with HIV by exchanging bodily fluids with an infected person. Specifically, infection with HIV can occur in the following ways:

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- Having *unprotected* sexual intercourse—vaginal, anal, and possibly oral—with an infected person;

- Sharing drug needles or other skin-piercing instruments contaminated with HIV;

- Through blood transfusions with HIV-contaminated blood; and

- Women infected with HIV can pass the virus to their fetuses during pregnancy or during birth. They can also pass it on when breast feeding.

Because of biological differences, women are generally more vulnerable than men to becoming HIV-infected during unprotected sexual intercourse. Again, for biological reasons, it is believed that young women run a higher risk of HIV infection from unprotected sexual intercourse than do men. However, both males and females are at serious risk of contracting HIV from an infected partner during unprotected sexual intercourse, and this risk increases substantially if either person has a sexually transmitted disease (STD).

3. How is HIV/AIDS *not* transmitted?

HIV infection does not just happen. You *cannot* simply "catch" it like a cold or the flu. Unlike cold or flu viruses, HIV is *not* spread by coughs or sneezes.

HIV is *not* passed through everyday contact with people at work, home, school, or anywhere else. One will *not* get HIV from clothes, telephones, toilets. It *cannot* be passed on by things like spoons, cups, or other objects that someone infected with the virus has used. One *cannot* get it from everyday contact with an infected person. Transmission of HIV requires exchange of bodily fluids containing the virus; none of these types of normal daily, non-intimate interactions involves such an exchange.

HIV *cannot* be contracted from a mosquito bite. HIV will *not* live in a mosquito, and it is *not* transmitted through a mosquito's salivary glands like other diseases such as malaria or yellow fever. One *cannot* get it from bed bugs, lice, flies, or other insects, either.

HIV is *not* transmitted through sweat, tears, or sneezes.

4. Preventing HIV transmission

HIV transmission is the result of specific behaviors; avoiding these behaviors will prevent HIV/AIDS. To reduce the risk of sexual transmission:

- Postpone the age of initiating sexual activity;

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- Abstain from sexual intercourse when not with one's regular partner; and

- Properly use a latex condom.

Eliminating contact with blood through the use of protective materials (e.g., latex gloves) during workplace accidents will reduce the risk of transmitting HIV, hepatitis, and other blood-borne pathogens. Most public health authorities can provide detailed information on how to implement appropriate procedures for workplace accidents.

Ideally, needles, surgical knives and other skin-piercing instruments should be used only once and for only one person. However, if one-time use is not practical, instruments should be properly sterilized between each use and/or before they are used on another person.

If at all possible, donated blood should be screened for HIV before being given to another person.

Sharing needles while taking intravenous drugs carries the risk of transmitting HIV through the blood left on the needle.

Reported rates of mother-to-fetus/infant transmission vary from 20 to 45 percent. Scientific studies indicate that the drug AZT may reduce the probability of a HIV-infected woman transmitting the virus to her fetus. However, AZT is expensive and not widely available. Thus, if there is reason to believe that either partner may be HIV-infected, it is prudent to encourage a voluntary HIV test and counseling for each before conceiving a child. The two most important means to prevent mother-to-fetus/infant transmission are:

- Preventing HIV infection in women of reproductive age; and

- Making contraception voluntarily available to HIV-infected women.

5. Getting more facts about HIV/AIDS

It is very common for people to feel unsure of the facts about HIV/AIDS. It takes time, thought, information, asking questions, getting answers, and patience. A doctor, nurse, or someone from a community organization who works with HIV/AIDS may be able to provide more information.

IV. WHAT ABOUT THE LEGAL ISSUES?

Though few African governments have established labor laws specific to HIV/AIDS, many existing labor regulations are applicable. For example, Senegalese labor codes specify employer responsibilities as far as sick leave, non-work-related accidents, health coverage, severance for sick employees, and termination indemnity are

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concerned. These codes pertain fully to employees with HIV infection and AIDS-related illnesses.

Because laws vary greatly from country to country, this *Manager's Guide* does not provide legal advice. Companies are encouraged to examine relevant laws in their jurisdiction and, if needed, to seek the advice of legal counsel.

V. FORMAT OF THE *MANAGER'S GUIDE*

This manual provides a step-by-step approach to develop or expand a comprehensive workplace HIV/AIDS prevention program. Each of the six modules is presented in sequence. Though the manual provides a balanced progression for establishing a comprehensive program, each module is written so that, if desired, it may be used independently of the others.

Module 2: Representation, Leadership, and Support from Top Management

Module 2 discusses the advantages of using a team approach in establishing HIV/AIDS policies and prevention programs and how to build a team. The importance of leadership and how to develop and use it effectively are also presented. Additionally, this module outlines the necessary supports and approvals needed to develop an HIV/AIDS program.

Module 3: Determining the Costs of HIV/AIDS and of an HIV/AIDS Program

Module 3 discusses the potential costs of HIV/AIDS to a business and the corresponding costs of maintaining a prevention program. Connected with this Module, in Appendices 9 and 10, are spreadsheets for a detailed examination of both sets of costs.

Module 4: Developing Workplace HIV/AIDS Policies

This module clarifies different kinds of HIV/AIDS policies and how policies reflect company practices. It describes basic principles and rationale to incorporate into policies, provides a series of steps to develop policies, and suggests ways to implement formulated policies.

Module 5: Developing a HIV/AIDS Prevention Program

Module 5 describes the steps necessary to create and implement comprehensive HIV/AIDS prevention and education activities.

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Module 6: Appendices

The appendices provide examples of existing company policies and other supplemental materials that can be used in designing programs. A companion Guide, *African Workplace Profiles*, provides further illustrations of business responses to the disease.

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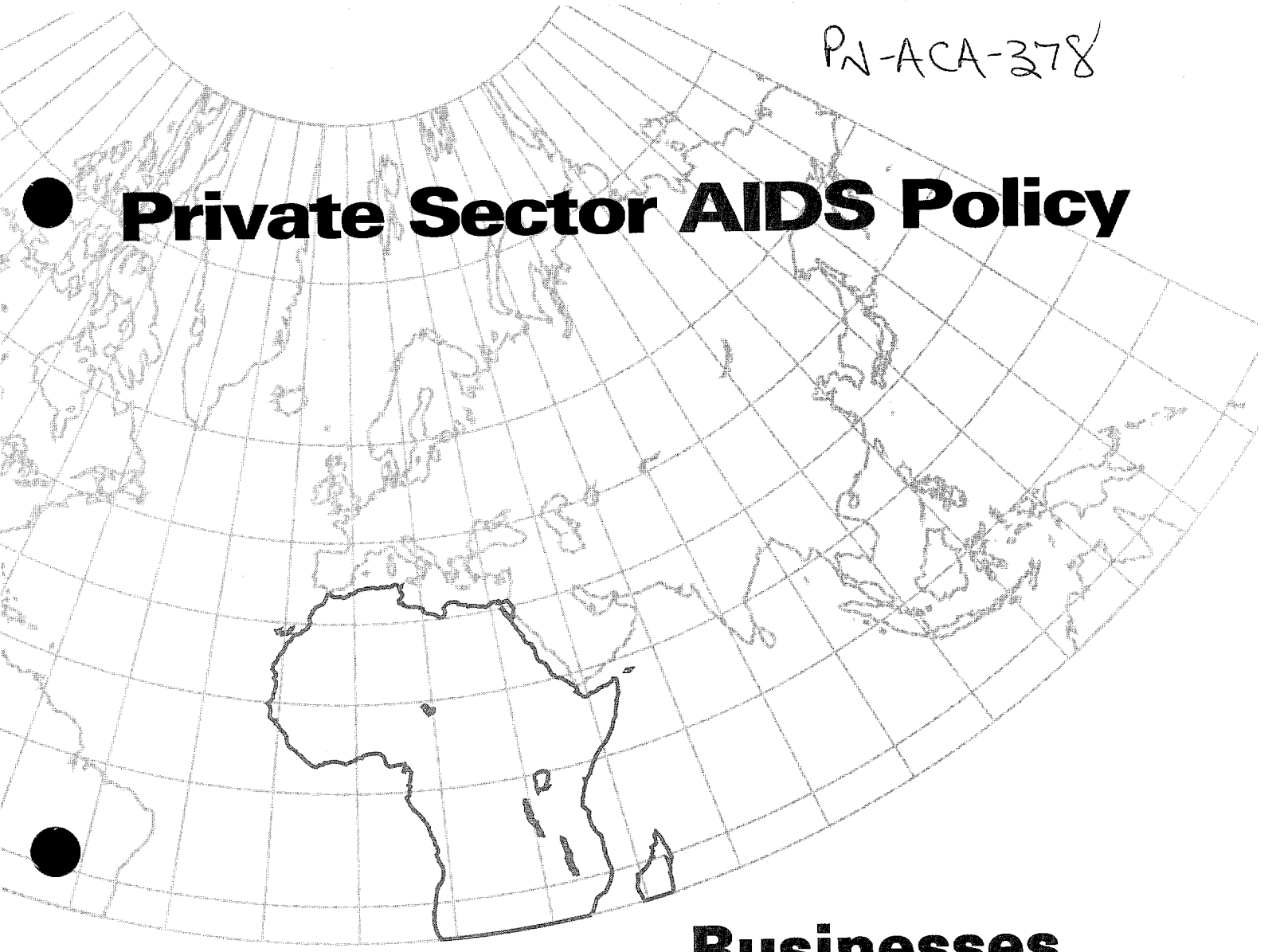
Private Sector AIDS Policy



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Developed by Family Health International's AIDSCAP Project (No. 936-5972.31-4692046) as part of the **Private Sector AIDS Policy Presentation** (PSAP) under USAID contracts HRN-5972-Q-00-4002-00 and HRN-5972-C-00-4001-00 Funding provided by the United States Agency for International Development.

REPRESENTATION, LEADERSHIP, AND SUPPORT FROM TOP MANAGEMENT

MODULE 2

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REPRESENTATION, LEADERSHIP, AND SUPPORT FROM TOP MANAGEMENT

I. INTRODUCTION

Successful HIV/AIDS prevention planning includes people who represent various aspects of the workplace, are committed to the issue, and are able to sell decisions to others.

Step 1: Organize a HIV/AIDS prevention planning committee

Many businesses have designated committees to develop and implement HIV/AIDS policies and prevention programs for their employees. Identifying the appropriate people to represent the diverse interests and needs of the workforce is the first step in the planning process. It is important to keep the committee small enough to be easily managed, yet large enough to be representative. As a committee is formed, it may be helpful to keep the following points in mind:

- **Include key people who represent the various interests of the business.**
  Rationale: The needs of divergent work areas and the ways policies and programs affect these work areas can be different. Differences can be taken into account, and policies can be developed that work for all areas of the business.

- **Include women on the planning committee.**
  Rationale: Women should be included on the committee, as it is important that potentially differing perspectives, interests, and concerns of women about HIV/AIDS be fully incorporated into the planning and program response of the organization.

- **Include representatives from all appropriate departments and levels, including workers with HIV/AIDS.**
  Rationale: By being aware of the needs and concerns of people at all levels of the workforce, HIV/AIDS policies will serve everyone properly. So that the policy development process can include the needs of all employees, it is appropriate to include both workers

and managers on the committee. If there are employees who are HIV-infected who are willing to let their condition be known to others, they can be very helpful committee members. They, better than anyone else, can inform the committee of the capacities and concerns of people with HIV/AIDS.

- **If workers are unionized, including union representatives early in the process may be beneficial.**
  Rationale: Union-management relationships can sometimes be adversarial. Union-management conflicts around HIV/AIDS can be minimized by including union participation early. In addition, unions can be very effective communicators with employees and can be an important conduit of communication about HIV/AIDS.

- **Include people who are committed to the issues and able to sell the committee's decisions to others.**
  Rationale: Just because someone represents a significant part of the workplace does not necessarily mean that he or she would be effective on the committee. A strong committee encourages participation from people who recognize the value of addressing HIV/AIDS at work. Equally important is including people who are liked and respected, as they can build outside support for the committee's decisions.

- **Keep the committee size manageable.**
  Rationale: Ideally, the committee will be large enough to represent the business and various interests within it, yet small enough to get the job done. Determine the size that is right for the business—usually between four and ten people.

- **Leave time for disagreement and problem resolution among the members of the committee.**
  Rationale: With any group of people, there can be disagreements. HIV/AIDS can be a confusing, controversial, and sensitive subject. Establish, at the beginning, that some disagreement is likely and build in time for disagreement to be resolved. If participants know up-front that there is room for differing points of view and time for working through problems, resolution will be more easily reached.

BOTSWANA DIAMOND VALUING COMPANY

Company size: 525 employees

Recognizing the great risk BDVC faces from losing its skilled workforce, the company began planning for an HIV/AIDS prevention program in 1992.

BDVC took a team approach, with key players in the training and personnel departments taking the first steps to establish an AIDS-in-the-workplace program with top management support. Over 20 peer educators have been trained, and an AIDS coordinator hired to oversee the program. Program success is attributed to the commitment and effective team work between the AIDS coordinator, personnel, training, and peer educators.

Management acknowledges that prevention program development has advanced without HIV/AIDS policy development. In order to avoid future problems that may arise from vague policies on HIV/AIDS, the company is developing official policies.

Step 2: Identify leadership within the committee

Leadership is essential to effective workplace HIV/AIDS prevention programs. An individual motivated to initiate and stay with the effort provides the leadership necessary over time to develop a successful program. Sometimes, leaders are top executives, and sometimes, they are not. Leaders are team players who will not lose sight of the program's goals and the strategies necessary to achieve them.

Step 3: Get support from top management

For a HIV/AIDS prevention program to succeed, it is critical to have visible support from top management, preferably from the beginning and from the most senior officer, or owner, of the business. If the initiative does not originate from the top, one of the first tasks is to justify to management the business need for a HIV/AIDS prevention program.

Experience indicates that, as in any business matter, top managers are primarily concerned about costs. They are not just concerned about the costs of a HIV/AIDS prevention program, but the costs that HIV/AIDS might have on the business in other ways as well. Thus, it may take some homework to build a case for support from the top.

Several modules of this manual provide information on how to build a case for top management support. In Module 1, the section, "Why Is HIV/AIDS a Business Issue?" can help answer questions managers may have about why HIV/AIDS is a business concern. Module 3, "Determining the Costs of HIV/AIDS and of a HIV/AIDS Program," explains how to estimate the economic impact of HIV/AIDS and how to project the costs of operating a workplace HIV/AIDS prevention program. It may also be helpful to find out if other businesses in the area have developed HIV/AIDS programs and to share information about what worked, what did not work, and why. Compile this information and any other relevant data and present it to top management, as one would any other business issue.

At this preparation stage, develop a checklist of the internal approval steps that will be required to create a HIV/AIDS prevention plan and policies. In some businesses, it may be

THE ECONOMIC IMPACT OF HIV/AIDS

- HIV/AIDS causes illness, disability, and death to employees, resulting in severe socioeconomic disruptions to businesses, employees and their families, and clients and suppliers.
- HIV/AIDS increases the cost of doing business, in terms of health care, death benefits, pensions, recruitment, training, and other costs.
- HIV/AIDS results in decreased productivity and disruptions in production as workers require additional time off due to illness or time needed to care for sick relatives. Costs rise as experienced workers with valuable training and skills become ill and unable to work.
- As the prevalence of HIV/AIDS increases, there are fewer people with resources to purchase products and services.

appropriate to get top management approval at various intervals as the program is being developed. Identify a process that will work best for the business and try to anticipate and receive the approvals necessary to move forward.

II. TRAPS AND PITFALLS TO AVOID[1]

Even if management support has been won and management has the best of intentions, it is possible to make strategic mistakes in planning a workplace HIV/AIDS response. In the process of developing and implementing comprehensive workplace HIV policies, businesses should guard against common policy or strategy pitfalls.

Pitfall Number One: Failing to involve representatives from all levels of the organization in policy planning and implementation—line workers and top management.

If HIV/AIDS policy planning does not include the perspectives of both the workers affected by policy and the managers who have the power to implement policy, the process will be marked by frustration and confusion, and the result will be only partially successful. The policy planning committee should both reflect the diversity of the organization and have enough vested authority to investigate problems, craft solutions, and shepherd proposals through the corporate decision-making process with some reasonable chance of successful action.

Pitfall Number Two: Allowing HIV/AIDS policy-making to be cast as a "labor vs. management" debate.

An example should help illustrate. One large business that had meat-packing operations as part of its holdings developed a HIV/AIDS policy addressing worksite infection control. This enterprise was also characterized by lukewarm relations between labor and management, and, unfortunately, management did not adequately consult with worker representatives about its HIV/AIDS policy. Workers reacted to the policy announcement by asserting that "management is not telling the whole truth" about HIV/AIDS in the workplace, and the policy initiative got muddled in all ensuing debates. In fact, the union ended up taking the issue to court (where their case was dismissed), and labor/management polarization was only heightened.

Pitfall Number Three: Failing to allocate the financial and personnel resources required to develop and implement HIV/AIDS policies.

Developing and implementing HIV/AIDS policies in the workplace will require time and, ultimately, money. Freeing staff time for participating

[1] This section is adapted from Earl C. Pike's *We Are All Living With AIDS: How You Can Set Policies and Guidelines for the Workplace*, Minneapolis, MN: Fairview Press, 1993.

in the planning process, acquiring materials, and attending employee education activities all carry a price tag.

The cost of HIV/AIDS policy development and implementation is rarely excessive, usually is well within the capabilities of most concerns, and always has to be measured against the costs of not doing anything.

Pitfall Number Four: Adopting policy without offering employee education about HIV/AIDS; offering employee education without good policy to back it up.

Some corporations have provided employees with good information about HIV/AIDS but have failed to support that education with policy. Informing workers that "there is no reason to treat people with HIV/AIDS differently" in the workplace but neglecting to undergird that information with anti-discrimination policy will not help eliminate discrimination in business settings. And if HIV/AIDS discrimination is prohibited without educating employees about the wisdom of that prohibition, anti-discrimination efforts will be undermined. HIV/AIDS policy and employee education go hand-in-hand.

Pitfall Number Five: Failing to take into account the needs of certain operations, or regional differences between operations.

Business concerns with multiple sites and operations cannot expect that a single approach—or even a single statement of policy on specific HIV/AIDS topics, such as infection control—will work at every site, for each operation. There are regional variations in style that must be taken into account when doing employee education. And policy makers will find that there are country-to-country variations on some legal matters, such as confidentiality and regulations about HIV testing, that will need to be incorporated into policy.

Pitfall Number Six: Approaching HIV/AIDS in the workplace as a "one-time" issue rather than an ongoing concern requiring continual monitoring.

One CEO, when asked what the corporation had done about HIV/AIDS, confidently replied, "Oh, we've taken care of all that. We wrote the policy and had education for all employees back in 1988." An examination of the business' outdated policy on HIV/AIDS revealed some errors of fact and terminology, in addition to policy positions that were no longer legally tenable. In other words, the policy, while sincerely articulated, had become worthless over time. One has to ask whether employees who participated in HIV/AIDS education so many years ago still remember the facts, and whether new employees are learning anything about HIV/AIDS.

In all matters related to HIV/AIDS, the shifting landscape of law, health care management, and research requires continual monitoring.

Business leaders not only need to survey current events in the world of HIV/AIDS, but translate, when necessary, those events into revised corporate policy. The task is ongoing.

And if a business provides employee education about HIV/AIDS, that education should also be regularly scheduled. Not only are regular updates for all employees appropriate, but consideration should be given to employee turnover and ways the corporation can bring new workers up to speed on corporate policy and the essential facts about HIV/AIDS.

Pitfall Number Seven: Approaching HIV/AIDS policy and employee education from a purely "scientific," detached position.

Some early education about HIV/AIDS stuck to the "scientific angle," attempting to carefully usher audiences through the complex science of HIV/AIDS. While understanding the facts is important, HIV/AIDS educators soon learned that facts alone are not enough. Education and policy have to address the range of emotional responses that attend this disease and help individuals sort through personal feelings, values, and beliefs to arrive at understanding, awareness, and compassion.

Some businesses have recruited company medical personnel to deliver "science of HIV/AIDS" lectures to employees. As long as the information is comprehensible to the audience, it can be useful. But it is just as important to hear from people with HIV/AIDS—how the illness has affected their lives, what supports they need—and individuals affected by HIV/AIDS: friends and family members. And it is equally important to allow dialogue, to engage people, and to permit the free and open expression of feelings. Education that does not include such elements will only have limited effectiveness in the long run.

III. DEVELOPING AN ACTION PLAN

It is recommended that the team responsible for establishing the organization's HIV/AIDS approach develop an action plan and timetable early in the planning process. The various components of the *Manager's Guide* can be easily linked and sequenced to create a comprehensive planning tool. This planning tool will help provide the team with a systematic approach, aid in distributing tasks among the team members, and track the organization's progress in developing interventions. The following page relates the modules in the *Manager's Guide* to the steps that can go into an action plan for establishing a HIV/AIDS policy and prevention program.

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Action Plan[2]

Activities	*Related Module*	*Timetable*
1. Organize a HIV/AIDS Prevention Planning Team, develop plan of action, timetable, assign tasks	Module 2	Beginning
2. Assess the potential economic impact of HIV/AIDS	Module 3	Weeks 2–4
3. Information gathering and initial planning on a HIV/AIDS policy: learn about HIV/AIDS, review manual, review existing company policies, develop checklists	Module 4	Weeks 2–4
4. Write HIV/AIDS policy, obtain management approval, begin communicating/implementing policy	Module 4	Weeks 4–8
5. Identify internal and external resources to assist in prevention program development and/or implementation	Module 5	Weeks 6–8
6. Assess workplace and community situation, select prevention components of program	Module 5	Weeks 8–12
7. Draft budget and obtain management approval	Module 5	Weeks 12–16
8. Implement prevention activities	Module 5	Week 16+

[2] An actual action plan could be further detailed with specific sub-steps/activities, identification of persons responsible for their accomplishment, and resources necessary for each activity.

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Private Sector AIDS Policy

Businesses Managing HIV/AIDS

A Guide for Managers

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DETERMINING THE IMPACT OF HIV/AIDS AND THE COST OF A PREVENTION PROGRAM TO A WORKPLACE

MODULE 3

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DETERMINING THE IMPACT OF HIV/AIDS AND THE COST OF A PREVENTION PROGRAM TO A WORKPLACE

I. INTRODUCTION

One of the most important issues facing management in addressing HIV/AIDS at the workplace is the financial risk presented by the disease. The materials in this Module provide guidance on determining, for individual businesses, the costs of HIV/AIDS and the benefits to be gained from prevention programs.

Measuring social benefits is never easy. In the case of HIV/AIDS prevention, defining benefits will depend on (1) the quality and comprehensiveness of the program, and (2) the existence of other programs in the community. For the purposes of this *Manager's Guide*, the "benefit" of a workplace prevention program is defined as the estimated value of the impact (of HIV/AIDS and STDs) averted by the workplace program. Though this may not satisfy all managers, estimates prepared by AIDSCAP/FHI for a number of companies in sub-Saharan Africa indicate that the financial impact of HIV/AIDS and STDs on an organization exceeds the cost of operating a prevention program. Furthermore, even if the long-term benefits are difficult to estimate, the costs of running a comprehensive HIV/AIDS and STDs prevention and management program, about US$15–25 per employee annually in a lower-income country, are more easily determined.[1]

A comprehensive prevention program is ideal, but may be beyond the capacity of companies to afford or implement. A minimum program will include a solid education component that provides employees with regular information about HIV/AIDS, sources of STDs, and counseling and other services within the community, maintains access to condoms, and defines clearly developed policies. The cost of running such a basic program is likely to be about US$5 per employee annually. These costs

[1] This estimate includes the costs of staff time and resource inputs for prevention education and training, condom distribution, STD management, and counseling and support services. It does not include the costs of medical care for AIDS-symptomatic employees.

are rough estimates. Each company will want to determine potential program costs to reflect their business operations and national conditions. Company contributions to HIV/AIDS prevention can extend beyond the workplace without added or high costs. For example, sponsorship of World AIDS Day events may fit in with a company's community relations strategy. In the process, sponsorship increases the social acceptability of HIV/AIDS prevention.

Two spreadsheets are available for use with this module of the *Manager's Guide*. The spreadsheet in Appendix 9 can be used to determine the potential economic impact of HIV/AIDS on business operations. The spreadsheet in Appendix 10 can be used to determine the cost of developing a HIV/AIDS prevention program in the workplace.

Both spreadsheets are sufficiently detailed to account for the range of costs a business is likely to encounter. Each spreadsheet includes instructions and technical notes. *It is strongly recommended that copies be made of the spreadsheet templates before they are filled out so that they may be used over again*. The spreadsheets are also on a computer disk (in Lotus 1-2-3©), which is a part of the *Manager's Guide* package.

II. CALCULATING THE IMPACT OF AIDS IN THE WORKPLACE

There are several broad categories of data used in determining the economic impact of HIV/AIDS (and other STDs) in the workplace. Those categories include:

- Number of employees and average salaries
- Labor turnover
- Training
- Reduced productivity
- Funeral attendance
- Absenteeism
- Recruitment
- Annual health costs
- Burial costs/death benefits

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In addition, it is useful to divide employees by appropriate categories, such as:

- Secretarial or support staff
- Manual laborers
- Supervising managers
- Technical professionals
- Senior managers

Many organizations will find that it takes several hours of their financial unit's time to collect the necessary data to complete the spreadsheets.

III. THE IMPACT OF HIV/AIDS AND THE COSTS OF A PREVENTION PROGRAM: AN EXAMPLE FROM KENYA

Data collected from several companies in Kenya in 1994 provide a means to illustrate the potential impact of HIV/AIDS on business profitability and the costs of a prevention program. The case example that follows represents a composite of several companies. The data were drawn from several large companies in Kenya and illustrate how the results from the impact and cost spreadsheets can inform business decision-making. For reasons of completeness of the data and to preserve the anonymity of individual companies, the data were combined to create a general scenario.

Estimates of the number of people infected by HIV/AIDS and STDs were obtained using the epidemiological data available in Kenya. HIV prevalence rates in Nairobi were 14 percent in 1995. STD rates were estimated at 10 percent and AIDS rates at 1.2 percent. Based on these prevalence rates, the number of people in the organization living with HIV/AIDS and STDs was estimated.

To determine the total cost of HIV/AIDS and STDs to the organization, the cost of each employee category was calculated. These costs (assuming that AIDS affected employees at all levels to an equal extent) included burial and health care costs, recruitment, reduced revenue, and absenteeism. The total cost was then divided by the total number of employees in the organization to determine the per employee costs of HIV/AIDS and STDs to the organization.

As the summary table of the impact spreadsheet indicates, health care costs (11.8 percent), absenteeism (61.1 percent in total), funeral attendance (9.7 percent), and training costs (6.4 percent) are significantly

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affected by HIV/AIDS and STDs. Based on the 1995 prevalence rates, the cost of HIV/AIDS and STDs to this composite company would be US$48,057, or US$44 per employee, annually.

The costs will rise dramatically as the epidemic continues and the number of people living with HIV/AIDS or other STDs grows. By the year 2000, the HIV rate in urban Kenya is projected to rise to 24 percent, the AIDS rate to 3 percent, and STD rates within the country to 20 percent—in the absence of a stronger prevention program. Based on these epidemiologic projections, the financial impact of HIV/AIDS and STDs to the composite company annually will exceed US$170,000, or about $156 per employee. If nothing is done to mitigate the impact of the disease on the organization, the financial impact could rise to US$221,270, or US$203 per employee by the year 2005.

TABLE 1: ESTIMATED ECONOMIC IMPACT OF HIV/AIDS ON BUSINESSES IN KENYA

Year	1995	2000	2005
Urban HIV Prevalence Rate	14.0	24.0	28.0
Urban AIDS Prevalence Rate	1.3	3.0	6.0
Urban STDs Prevalence Rate	10.0	20.0	27.0
HIV/AIDS/STDs Financial Impact to Average Company	US$48,057	US$170,040	US$221,270
HIV/AIDS/STDs Financial Impact per Employee	US$44	US$156	US$203

Source: AIDSCAP/FHI data synthesized from five companies in Kenya, 1994.

Again using data derived from several companies to create a composite example, the costs of operating a comprehensive prevention program in the first year is estimated to be US$26,100, or about US$24 per employee.[2] After the initial investment in training and some capital equipment, recurrent operating costs would be US$18,110, or about US$16 per employee. By putting a prevention program in place now, the financial impact on the organization will be affected less over the long run.

[2] To calculate the cost of a prevention program, all the resources needed to implement such a program were taken into account. This includes the wage costs of educators, counselors, peer educators, and clinicians and the cost of condoms, and condom vending machines. It was assumed in this example, that only one educator would be needed for every 100 workers (the organization is encouraged to use different numbers depending on the prevailing conditions of the organization). Also, it is assumed that most of the time used for education programs will occur during employee breaks.

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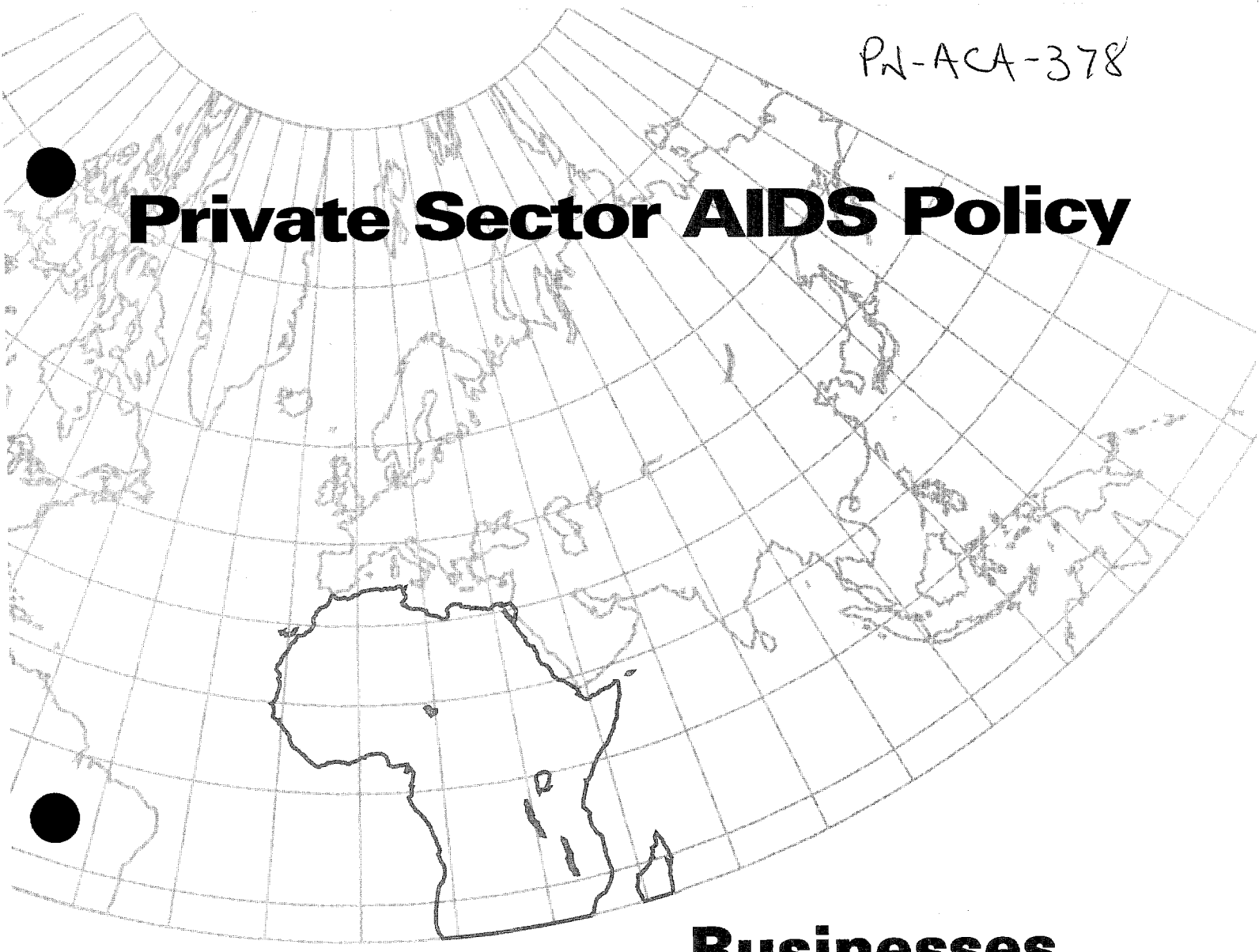
Private Sector AIDS Policy



Businesses Managing HIV/AIDS

A Guide for Managers

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DEVELOPING WORKPLACE HIV/AIDS POLICIES

MODULE

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DEVELOPING WORKPLACE HIV/AIDS POLICIES

I. THE VALUE OF HIV/AIDS POLICIES

A HIV/AIDS policy defines an organization's position and practices for preventing the transmission of HIV and for handling cases of HIV infection among employees. Businesses experienced in addressing HIV/AIDS suggest that it is useful to have a written policy stating the company's position and procedures to guide managers and employees. HIV/AIDS policies can be many pages long or can be as short as a few paragraphs. Usually the length of the policy depends on whether it simply outlines broad policy guidelines or provides detailed instructions and procedures on how the policy is to be enacted.

1. A HIV/AIDS policy:

- Sets a foundation for a HIV/AIDS prevention program;
- Offers a framework for consistency of practice within a business;
- Expresses the standards of behavior expected of all employees;
- Lets all employees know what assistance is available and where to go for it.;
- Instructs supervisors and managers on how to manage HIV/AIDS in their work groups; and
- Assures consistency with any relevant local and national statutes.

Some companies initiate HIV/AIDS prevention activities before establishing clear policies on how to deal with HIV/AIDS in the workplace. Though this is certainly one option, it is not recommended. After all, the process of establishing a prevention program will require that a number of policy decisions be made, even if a policy is not formally written. For example, when management agrees to have some workers trained as peer educators, they are agreeing to pay employees to learn and practice duties that are outside their original work

responsibilities. Because these types of decisions are made as part of establishing a program, it will be useful to include the parameters of the prevention program in the policies developed. Thus, it is recommended that a written policy be produced.

2. The benefit of written policies

Some businesses, especially smaller ones, do not have formal written policies. Instead, these businesses follow unwritten business practices that are established over time. Eventually, the result is standard practices that guide managers and employees and lead to consistent, predictable, desired results. However, because standard practices come about only through repeated experience, they are not established in time to lead to desired results the first few times an issue comes up. And the first few times a business has to deal with HIV/AIDS can often be the most difficult, with the results unpredictable. Thus, a major value of developing written policies concerning HIV/AIDS, as opposed to letting an unwritten practice develop over time, is that one can control or plan the results before an incident occurs.

Another value of written policies over unwritten practice is that policies provide the framework for dealing with HIV/AIDS in ways that are best for the business. Written HIV/AIDS policies provide clarity and certainty about a subject many people find confusing and uncertain.

3. Life-threatening illness policies

Some businesses choose not to have an HIV/AIDS-specific policy to emphasize that HIV/AIDS will be treated like any other illness. These businesses include HIV/AIDS within general policies on life-threatening illnesses and disabilities, such as cancer and tuberculosis, treating HIV/AIDS no differently from other major illnesses. Some businesses prefer this approach because it affirms their concern about all major life-threatening illnesses and disabilities without singling any out.

4. HIV/AIDS-specific policies

Other businesses wish to reinforce that they have thought about and planned carefully for HIV/AIDS, and thus, develop policies that refer specifically to HIV/AIDS. Though corporate *responses* should be similar to those of other serious illnesses, HIV/AIDS is a unique disease: it is always fatal, often carries a great social stigma, has a disproportionate effect on working-age adults, and, in some regions, affects a very high proportion of the population. This approach acknowledges that HIV/AIDS is a major health issue and highlights the employer's commitment to addressing it in appropriate, responsible ways. These policies acknowledge the potential impact of HIV/AIDS on the workplace and offer rational cost-effective responses to that impact.

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5. Policies that extend beyond the gates

Companies may be affected as much by the health and welfare of their suppliers and customers as by that of their own employees. For example, long distance truck drivers are usually identified as people at high risk of HIV infection because of the long periods of time away from home and their access to sex workers. Illness-related turnover of drivers in transport companies may well affect the arrival of needed supplies or delivery of orders.

Companies can help reduce the impact of HIV/AIDS beyond their immediate employees by discussing with clients and suppliers their HIV/AIDS policies and programs. Networking among businesses can strengthen the overall HIV/AIDS prevention efforts. Sponsorship of community HIV/AIDS awareness activities not only contributes to corporate credibility, but adds to changing social norms and beliefs.

II. BASIC PRINCIPLES

Successful HIV/AIDS policies used by businesses around the world share a number of basic principles. These principles are recommended by international organizations such as WHO and the International Labour Office (ILO), and by many business groups in Africa, Europe, North America, Latin America, and Asia. These principles have been used by WHO, ILO, and the Red Cross to prepare a set of workplace guidelines on HIV/AIDS (Appendix 2). Another complementary set of principles, called the Ten Principles for the Workplace, adopted or modified by many businesses globally, was developed by the Citizens Commission on AIDS of New York City and Northern New Jersey, U.S.A. (Appendix 3).

Examples of business coalitions adopting these types of basic principles include the Federation of Kenyan Employers, the U.K.-based Business Exchange on AIDS & Development (BEAD), the U.S. National Leadership Coalition on AIDS, and the Thailand Business Coalition. Many corporations in Africa—large and small—have adopted policies consistent with these basic principles, such as Barclays Bank of Kenya, Muhoroni Sugar of Kenya, the Port Authority of Dakar, the Botswana Meat Commission, and Rio Tinto Zimbabwe. Multinational corporations following these policies include such firms as Unilever, IBM, Northwest Airlines, Xerox, and Levi Strauss.

The business merits of the Ten Principles are not necessarily self-evident to companies that have not had an opportunity to discuss them in depth. The *Manager's Guide* offers a brief rationale for each of them:

1. People with HIV/AIDS are entitled to the same rights, benefits, and opportunities as people with other serious or life-threatening illnesses.

Rationale: Good business practices strive for consistency. This principle encourages consistency when dealing with anyone with a

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serious or life-threatening illness. There are no medical or other reasons to treat people with HIV/AIDS differently from anyone else with a serious or life-threatening illness. As with the other principles, abiding by this recommendation will help establish a loyal, productive, and satisfied workforce.

2. Employment practices related to HIV/AIDS will, at a minimum, comply with national, regional, and local laws and regulations.

Rationale: Businesses are expected to comply with national, regional, and local laws and regulations governing the relationship between employers and workers. These laws provide the minimum baseline for a business response to HIV/AIDS. Businesses cannot legally do less than the law requires, and often find that it benefits them to do more.

3. Employment policies should be based on the scientific and epidemiological evidence that people with HIV/AIDS do not pose a risk of transmitting HIV to coworkers through ordinary workplace contact.

Rationale: Good business practices are based on sound, established facts. The scientific and epidemiological facts are that people with HIV/AIDS do not pose a risk of transmission of the virus to coworkers through ordinary workplace contact.

4. The highest levels of management, union, and other worker leadership should endorse non-discriminatory employment policies and educational programs about HIV/AIDS.

Rationale: There is no basis for discriminatory employment practices for workers with HIV/AIDS. People living with HIV/AIDS do not pose a risk to coworkers in ordinary workplace contact. Thus, there is no reason to treat them differently from any other worker with a serious or life-threatening illness or disability. Employment practices are best based upon an employee's ability to do the job, not on his/her health status or disability. Senior managers, union, and other worker representatives should be encouraged to use their positions of leadership to set the standard of non-discrimination at the workplace.

Workplace leaders are also in a unique position to promote HIV/AIDS education and prevention. The only way to stop HIV/AIDS is through education and prevention, and endorsement

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of workplace programs by business and labor leaders can have a strong influence on the effectiveness of these programs.

5. Employers, unions, and other worker representatives should communicate their support of these policies to employees in simple, clear, and unambiguous terms.

Rationale: Communication of clear messages that support the company's HIV/AIDS policies reinforce established business practice, assure consistent implementation and administration of policy, and reinforce desired worker behavior. This ensures the smooth flow of production and avoids costly disruption due to unexpected negative responses to HIV/AIDS in the workplace.

6. Employers should provide employees with sensitive and up-to-date training about HIV/AIDS risk reduction in their personal lives.

Rationale: Successful HIV/AIDS prevention programs focus on risk reduction in one's personal life by discouraging unsafe behaviors and encouraging safe behaviors. Thus, it is in the best interests of both employees and employers to offer clear, up-to-date education and prevention programs that will reduce the risk of HIV/AIDS transmission.

7. Employers have a duty to protect the confidentiality of employees' medical information.

Rationale: Employees with HIV/AIDS frequently encounter harsh discrimination when their medical condition is revealed to coworkers or employers who know little about HIV/AIDS. Provisions assuring confidentiality and privacy of workers' medical information help guarantee that discrimination will not occur. Discrimination in the workplace is inconsistent with good business practice and can cause disruption. Thus, protecting the confidentiality of employees' medical information makes good business sense.

8. To prevent work disruption and rejection by coworkers of an employee with HIV/AIDS, employers and workers' representatives should undertake education for all employees before such an incident occurs, and as needed thereafter.

Rationale: Uninformed coworkers, not knowing in advance what was expected of them, often respond in unpredictable, disruptive, and

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cruel ways to workers with HIV/AIDS. These unanticipated and costly incidents can be avoided by providing education and prevention programs early and regularly for all workers.

9. Employers should not require HIV screening as part of pre-employment or general workplace physical examinations.

Rationale: HIV screening cannot guarantee a workplace free of HIV/AIDS. A worker could test negative today and positive tomorrow, because an individual can be infected with HIV for up to six months before the test identifies HIV antibodies in the blood. In addition, a worker could become infected after the test was performed, making the test result irrelevant. Employees and applicants usually resent mandatory HIV screening; morale and, in turn, productivity are undermined. Finally, even if employees become HIV-infected, they are likely to be productive for several years to come. Rather than devoting business resources to the costly and, ultimately, uncertain process of HIV testing, it is better to concentrate these resources on preventing transmission with measures that are scientifically effective and readily available.

10. In special occupational settings where workers are regularly exposed to human blood or blood products, such as health care facilities, there may be potential risk of exposure to HIV. In such settings, employers should provide ongoing education, training, and necessary equipment to reinforce appropriate infection control procedures and ensure that they are implemented.

Rationale: Although there is no risk of HIV transmission in normal workplace settings,

THE MANAGEMENT PHILOSOPHY REGARDING HIV/AIDS OF ONE ZIMBABWE COMPANY

- Employees with AIDS and other life threatening illnesses should be allowed to contine work at the required level of efficiency until they are no longer able to work.
- AIDS is not spread by casual contact, so it is considered safe to work with or alongside an employee with the disease.
- Company physicians, after consultation with the employee's personal physician, will determine suitability of work.
- Information entrusted to company physicians will be treated in a confidential manner.
- Employees with life-threatening illnesses are eligible for significant medical benefits under the company medical plan.
- The Personnel Department will assist employees in understanding the provisions of medical coverage and assist them in obtaining those benefits.
- The Company will provide health education programs about AIDS so that employees and their families can obtain factual information on the disease.

there are special types of work settings that do pose a risk of possible HIV transmission, and employees in those settings must be protected. Work tasks in those workplaces need to be assessed for potential risk. Health and safety procedures must clearly specify infection control procedures and provide necessary protective equipment to minimize the potential for contagion. All workers in these settings should receive comprehensive and periodic training in the necessary infection control procedures. It is worth noting that the measures taken in such settings to prevent HIV transmission will also prevent the transmission of other more contagious blood-borne diseases such as hepatitis.

III. DEVELOPING HIV/AIDS POLICIES

The process of developing a business HIV/AIDS policy is similar to developing any other business policy. What steps are needed to develop policies?

- Define and understand the issue.
- Formulate options for addressing the issue.
- Select an option.
- Implement the selected option.

What follows is a series of steps for developing an HIV/AIDS policy incorporating the four elements above. This is one approach; each organization should decide the best way to establish its own business policy on HIV/AIDS. The steps that follow refer to tasks to be completed by a planning committee. The term is a short way to refer to a representative group from within an organization, as discussed in Module 2.

A. Information gathering and initial planning

Step 1: Learn about HIV/AIDS

Many people who are given the responsibility to develop a business HIV/AIDS program are relatively new to the issues. It is not necessary to be a HIV/AIDS expert to develop an

HIV/AIDS POLICY DEVELOPMENT STEPS

A. Information gathering and planning
   1. Learn about HIV/AIDS
   2. Review this Guide
   3. Review existing policies
   4. Develop checklists
   5. Work through checklists
   6. Develop rationale
B. Write the HIV/AIDS policy
   1. Summary rationale
   2. Policy statements
   3. Workplace guidelines
   4. HIV/AIDS prevention activities
C. Approve policy
   1. Write final draft
   2. Reach committee agreement
   3. Obtain top management approval and support
D. Implement policy
   1. Identify messenger(s)
   2. Determine sequence and type of communication

excellent program, but it does require an understanding of the basics of HIV/AIDS.

One option is to identify someone in the area who is very knowledgeable about HIV/AIDS—such as a doctor or nurse from a community organization who works with HIV/AIDS—and have that person conduct a workshop for staff who are developing the program. There are other options as well. As often happens in Botswana, Kenya, and elsewhere, NACPs and various community organizations regularly offer workshops for business people. Staff can use these opportunities to raise concerns and ask questions until they are confident about their knowledge of HIV/AIDS.

Step 2: Review this Guide

The HIV/AIDS prevention planners should review this manual and meet to discuss the steps needed to develop a policy and program for the business. The procedures can, of course, be adapted and modified over time, if necessary. The input of each planner will be enhanced by being completely clear on the steps chosen for developing the HIV/AIDS prevention response. Not all committee members may have equal familiarity with the company's policies and procedures. Relevant input from the organization's human resources/personnel staff may be needed for those who are less familiar with the policies and procedures. This way, everyone on the committee can participate as equals in the planning process.

Step 3: Review existing policies

This consists of two parts. First, reviewing the organization's existing policies and procedures will promote consistency between the new and old policies. Many employers find it useful to relate their HIV/AIDS policy to other policies that are established already, such as those about employee benefits. Second, reviewing the policies of other companies that already have well thought-out HIV/AIDS policies may provide useful guidance to the committee. Appendix 1 contains several sample policies that have proven effective to other businesses.

Step 4: Develop checklists

There are many issues to consider in developing a strong and useful business HIV/AIDS policy. These issues can be generally broken down into two areas. One area includes the *planning steps* necessary to create a prevention program. The other area includes the *policy topics* that should be addressed. At this point it may be useful to draw up a checklist for each area.

To develop an *HIV/AIDS policy topic checklist*, it may be helpful to establish a set of criteria for identifying and evaluating the relevance of the topics. The following list of criteria can be modified as desired:

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- The existing organizational policy provides sufficient guidance.
- The issue or concern has already been raised.
- Other organizations have adopted the policy.
- The policy would meet a broad range of needs.
- The policy is clear and unambiguous.
- Organization and employee rights and responsibilities are represented and/or specified.
- The policy addresses or fulfills national laws and policies.

An illustrative *policy planning checklist* and a *policy topics checklist* are provided below. Use the checklists as guides for developing policy.

Step 5: Work through the checklists

To prepare for writing the organization's HIV/AIDS policy, the committee will need to work through the items on the checklists. The pace at which the committee progresses will depend, in part, on the complexity of existing and proposed policies and on how much previous experience the committee has in policy development. If it is a complex situation, the committee may want to take the following steps. Assign specific items on the policy topics checklist to committee members most able to research them. Agree to a plan of action and a timetable (perhaps weekly) when the committee will meet to discuss the findings and to make decisions about how to proceed. Before and during these meetings, it may be helpful to keep these questions in mind:

- What are the main issues that should be considered in deciding whether or not the particular policy should be adopted?
- Are there other factors that should be considered in making the decision?
- Is there precedent or an existing procedure for making a decision on the policy? What is the best way to make a decision on the issue or policy?
- How can the policy be drafted to best state the company's position?

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Step 6: Develop the rationale

As the organization's position is formulated or clarified on various issues, it may be helpful to the committee to draft a clear rationale for each policy recommendation. This can then be used in the written company policy. For example, from the checklist above, the committee may choose to support a policy of not testing employees or applicants for HIV. The following rationale could be used to explain the policy decision:

Rationale: People with HIV/AIDS do not pose a risk of HIV transmission to coworkers through ordinary workplace contact. Thus, there are no medical or other reasons to treat people with HIV/AIDS differently from anyone else with a serious or life-threatening illness. HIV screening to avoid or exclude employees is not practical or cost-effective. Skilled workers with HIV/AIDS who perform their jobs well are contributing to the success of the business. To arbitrarily replace productive employees who are HIV-positive would incur unnecessary expenditures, including the costs of replacement hiring and training. Thus, hiring, promotion, and termination practices will be based on a worker's ability to do the job and on-job performance.

POLICY PLANNING GUIDE

- ☐ Get management support.
- ☐ Organize an HIV/AIDS prevention planning team.
- ☐ Create a plan of action, a timetable, and assign tasks.
- ☐ Write policy and guidelines on HIV/AIDS.
- ☐ Develop a communication plan.
- ☐ Develop an implementation plan.

Policy Topics Checklist

- ☐ Will the policy be HIV/AIDS-specific or address all life-threatening illnesses?
- ☐ What worker HIV/AIDS prevention education and other prevention services will be provided?
- ☐ Specify hiring, promotion, and termination practices.
- ☐ Ensure compliance with the law.
- ☐ Assure medical confidentiality and privacy.
- ☐ Establish policy to prevent discrimination.
- ☐ Provide accommodations for employees with disabilities.
- ☐ Address coworker concerns.
- ☐ Are policy changes required to ensure prevention coverage to families/ partners?

B. Write the HIV/AIDS policy

After the committee has researched, discussed, and reached a decision on each of the issues from the checklist, it is time to lay out the components of the policy in written form. It may again be helpful to refer to Appendix 1 for sample policies in helping to draft the company's policy. This *Guide* presents a structure for an comprehensive HIV/AIDS policy that has been found to be effective for many companies. It includes four parts:

1. A summary rationale for the adoption of an HIV/AIDS policy
2. General policy statements that set forth the organization's position on workplace-related HIV/AIDS issues
3. Specific guidelines to managers and employees about how they are to handle HIV/AIDS in the workplace

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4. Delineation of the HIV/AIDS prevention and program activities supported by the organization

Part 1: Summary rationale

The first part provides the broad rationale for a HIV/AIDS policy and links it to other established policies and practices. A HIV/AIDS policy should be presented in a context that is understandable and acceptable to both managers and workers.

One way to tie familiar, acceptable company practices into a written policy is to introduce it by saying:

We take care of our own, and it is in this tradition that we developed our policy and program on HIV/AIDS.

Some businesses have chosen to present their HIV/AIDS policies as the appropriate actions of responsible employers. In this context, employers may say:

The HIV/AIDS epidemic is everyone's concern, and we are developing our policy and program so that we are prepared to deal with the epidemic responsibly and knowledgeably, and in a businesslike way.

Many other businesses have chosen to address HIV/AIDS as a health and safety issue. Such businesses may say:

We are committed to providing a healthy and safe work environment for all employees. The HIV/AIDS policy and program in this company are intended to assure that everyone can learn how to prevent the spread of HIV and be confident about health and safety in the workplace.

Part 2: Policy statements

The second part usually includes general policy statements that set forth the company's position on HIV/AIDS and/or life-threatening illnesses. This section identifies and highlights the major issues and states, generally, what the policy is about.

Many companies have adopted or modified the following language to establish a life-threatening illness policy that includes HIV/AIDS:

The Company does not discriminate against a qualified individual with a disability with regard to job applications, hiring, advancement, discharge, compensation, training, or other terms, conditions, or privileges of employment.

Further, the Company recognizes that employees with life-threatening illnesses—including but not limited to heart disease, multiple sclerosis, cancer, HIV disease—and other disabilities may wish to and be able to engage in as many of their normal pursuits as their conditions allow, including work.

Employees are encouraged to be sensitive to the fact that continued employment for a person with a life-threatening illness or disability provides self-supporting income and other benefits, may be therapeutically important, may assist in the remission or recovery process, and may help to prolong his/her life.

The Company seeks to accommodate employees with life-threatening illnesses or disabilities as long as they are able to meet acceptable performance standards, and medical evidence indicates that their conditions are not a threat to themselves or others.

While accommodating employees with life-threatening illnesses and disabilities, the Company recognizes its obligation to provide a safe work environment for all employees and customers. Every precaution should be taken to ensure that an employee's condition does not present a health and/or safety threat to other employees or customers.

The second part of the policy should include the company's positions on each of the issues (from the *policy topics checklist*) that is to be included in the policy. The series of paragraphs describing the business rationale of each issue on the checklist can be used to draft this part of the policy.

Part 3: Workplace guidelines

The third part of a HIV/AIDS policy usually contains guidance or instructions for managers and workers that clarify what is expected of them. This part of the policy expands on the issues identified in the general statements that begin the policy, stating how the policy should be carried out and providing step-by-step procedures and guidelines.

A number of businesses have adopted or modified the following to draft the guidelines section of their HIV/AIDS policy:

Managers should:

Remember that an employee's health condition is personal and confidential, and reasonable precautions should be taken to protect information regarding an employee's health condition.

Contact Human Resources if you believe that you or other employees need information about terminal illness or a specific life-threatening illness, or if you need further guidance in managing a situation that involves an employee with a life-threatening illness.

Contact Human Resources if you have any concerns about the possible contagious nature of an employee's illness.

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If warranted, make reasonable accommodation for employees with life-threatening illnesses consistent with the business needs of the department or division.

Make a reasonable attempt to transfer employees with life-threatening illnesses who request a transfer because they are experiencing undue stress.

Be sensitive and responsive to coworkers' concerns, and emphasize employee education available through Human Resources.

No special consideration will be given beyond normal transfer requests for employees who feel threatened by a coworker life-threatening illness.

Be sensitive to the fact that continued employment for a person with a life-threatening illness provides self-supporting income and other benefits, may be therapeutically important, may assist in the remission or recovery process, and may help to prolong an employee's life.

Encourage employees to seek appropriate medical treatment and counseling services. Information on these services can be requested through Human Resources.

Again, use the series of paragraphs describing the business rationale of each issue on the *policy topics checklist* to describe how each issue is to be handled. This will make clear to managers, supervisors, and workers what is expected of them and what they can expect in return.

Part 4: HIV/AIDS prevention activities

A fourth part of a comprehensive HIV/AIDS policy should explain the HIV/AIDS prevention activities and programs offered by the organization. Although virtually all companies with a HIV/AIDS policy statement include the first three parts, this final part is not always included. Although the planning group and management need to determine what is most appropriate, the *Manager's Guide* recommends the inclusion of this part because it demonstrates the organization's commitment to preventing HIV/AIDS within the workforce.

If no prevention program exists, organizations are urged to initiate prevention activities in the workplace as soon as is practical (Module 5 describes how to do this in more detail). Policy formulation should not stand in the way of establishing a prevention program. Thus, it is preferable to exclude or delay adoption of this fourth part than to delay the operation of prevention activities.

Assuming there is support for this fourth part, HIV/AIDS prevention activities and programs described in the policy may include:

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- **Formal and informal prevention education and training activities for all staff.**
  Formal and informal HIV/AIDS education and training include programs or activities conducted in the workplace that educate employees about HIV/AIDS. These programs can bring about changes in behavior that will reduce the spread of HIV/AIDS among employees and their families.

- **Distribution systems that make condoms readily and consistently available.**
  Condom use is an essential factor in the prevention of HIV/AIDS and easy access to condoms among employees is an effective part of workplace HIV/AIDS prevention programs. Thus, this policy could include a section about where and how condoms are available to employees.

- **Sexually transmitted disease (STD) diagnosis and treatment.**
  Many employees suffer debilitating illnesses that increase absenteeism and reduce productivity as a result of undiagnosed or untreated STDs. Not only are STDs injurious in their own right, but they also greatly increase the possibility of transmitting HIV during unprotected sex. Thus, access to STD diagnosis and treatment services is usually part of a comprehensive workplace HIV/AIDS prevention program.

- **Counseling and support services for employees and their families.**
  Counseling and support services for concerned employees and for HIV-positive workers and their families can be an effective component of a comprehensive workplace HIV/AIDS program. Counseling and support help sustain the physical and mental well-being of employees and their families. These services also help minimize disruption and maximize productivity when a worker or family member is sick. Finally, with the help of counseling and support services, employees with HIV/AIDS are more likely to remain healthy and work longer, reducing health care costs and sustaining productivity. Counseling and support services increase the probability of sustained behavior change and help prevent the transmission of the AIDS virus among employees and their families.

Incorporating each of these prevention components into a company policy might be done as follows:

In order to inform employees about HIV/AIDS and to encourage employees to practice behaviors that are known to reduce the risk of HIV

transmission, the Company will offer a regular program of education about HIV/AIDS. Employees will receive formal prevention training sessions and have access to informal peer educators.

Condoms are an effective barrier to sexually transmitted diseases (STDs) and HIV transmission. Thus, to provide easy access to condoms for employees and partners who wish to use them, the Company will make condoms available at reasonable cost in the restrooms and clinic.

Untreated STDs are injurious and increase the risk of HIV transmission. In order to reduce the number of cases of STDs and improve the general welfare of employees and their families, the Company will provide confidential diagnosis and treatment for STDs at the medical clinic (and/or community clinic) at no cost. Employees with repeated cases of STD will be counseled about the risks associated with unsafe sexual practices.

Counseling and support services help employees and their families cope with social, emotional, and other concerns associated with HIV/AIDS and to sustain behavioral changes that reduce the risk of HIV transmission. Confidential counseling and support services may be requested by employees and their families at the clinic or Human Resources Department, or from peer educators.

C. Approve Policy

The final phase in writing a HIV/AIDS policy requires tying together the various parts of the policy, getting agreement from committee members on the final draft, and winning senior management approval and support.

Step 1: Write the final draft

At this point, all the components of the draft company policy are ready to be put together into one document. Organize the components of the policy in the four-part structure described above, or in another logical, easy-to-follow arrangement. Then, from those components, write a draft of the policy using language that is easy to read and understand. Appendix 1 provides an example of what a HIV/AIDS company policy might look like.

It may be useful to consider the following questions to ensure that the final draft is complete: Have all items on the *policy topics checklist* been addressed sufficiently? Have the basic principles discussed above been reviewed and included as desired by the organization? Is there a written rationale to explain each recommended policy component, and are they consistent with each other? Is the policy consistent with other policies and practices of the company and with national policies and laws?

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Step 2: Reach committee agreement

The committee should review the draft—either individually or together—and revise it to accommodate the comments and suggestions of the committee members. In this way, the final draft policy will be a document about which the entire committee is confident. Acceptance of the final draft by all committee members becomes the first step in implementing the policy throughout the business.

Step 3: Obtain top management approval and support

The likelihood of receiving top management support of the final draft can be increased by gaining periodic approvals during the development of the policy. Management involvement—both as part of the committee and in the review process—also increases the probability of having strong and vocal senior management support for the policy.

Keep in mind that, as in any business matter, senior managers are concerned about costs. They are likely to be concerned not only about the costs of a HIV/AIDS prevention program, but about the costs that HIV/AIDS may have on the business in other ways as well. Thus, the committee will likely need to justify its request for management support, and several modules of this *Manager's Guide* can help build a case for support. The Introduction, "Why Is HIV/AIDS a Business Issue?" can help the committee prepare justification for a HIV/AIDS prevention program. The module, "Determining the Cost of a HIV/AIDS Program," offers a method for estimating the impact of HIV/AIDS and the costs of a prevention program. A thoroughly prepared explanation for each component of the policy—including a sound business justification—will facilitate the process of gaining management support.

D. Implement Policy

Once approved, an organization's HIV/AIDS policy is implemented in acceptable, practical ways throughout the business. The organization should plan implementation of the policy in such a way that it becomes the foundation of the entire HIV/AIDS program. The way in which the policy is introduced will set the tone for future communications about HIV/AIDS in the company and will introduce the other programs and activities to follow.

Implementation of the HIV/AIDS policy calls for a thoughtfully planned communication strategy so that the policy will be as carefully implemented as it was developed. As is the case with other aspects of business planning, the organization's structure, size, and style will determine the best ways to communicate about HIV/AIDS. One approach to introducing an HIV/AIDS policy follows.

Step 1: Identify messenger(s)

Introduce the policy from the highest levels of management, preferably by the most senior person in the business, such as the general manager,

managing director, or other principal officer. When the policy is introduced by a senior leader, it is most likely to be heard throughout the workplace and to be seen as an important message.

The initial message throughout the workplace should be presented in such a way that all employees can learn at the same time about the company's general position on HIV/AIDS. Be aware of how employees have responded to communications and communication channels in the past, and choose what will work best for this kind of policy issue. The initial communication should also contain some statements about HIV/AIDS education and prevention programs to follow.

Step 2: Determine the sequence and type of communication

Supervisors and Managers

After the general company-wide communication introducing the HIV/AIDS policy and programs, there are specific people who need to receive more information about the policy and what is expected of them. Plan the sequence of communication in such a way as to include people first whose job functions require more information: staff people and key managers who would be called upon to participate in handling an actual case of HIV/AIDS in a work group, or in advising supervisors and managers how to handle an actual case. Whoever is likely to be called upon for information, advice, or a decision needs to be included so that they are prepared to respond appropriately. They will need information about how to administer the policy and what their roles and responsibilities are. They will, of course, also need basic education about HIV/AIDS.

Workers

Next, determine how and when to communicate the policy to workers, and the level of detail that communication should contain. If the initial company-wide communication introducing the policy contains information about the HIV/AIDS education and prevention programs to follow, it may be better to wait until these programs begin to explain the policy in greater depth. Though workers do not usually need to know much about the administration of a policy (contrary to supervisors and managers), they do need to know how the policy affects them. Thus, the content of the communication about policy will be different with non-supervisory staff than it will be with supervisors and managers.

IV. CONCLUSION

Development of a HIV/AIDS policy helps a business deal with HIV/AIDS consistently, responsibly, and cost-effectively. Most people in the organization—from senior management to workers at all levels—will appreciate the clarity and direction that the policy provides.

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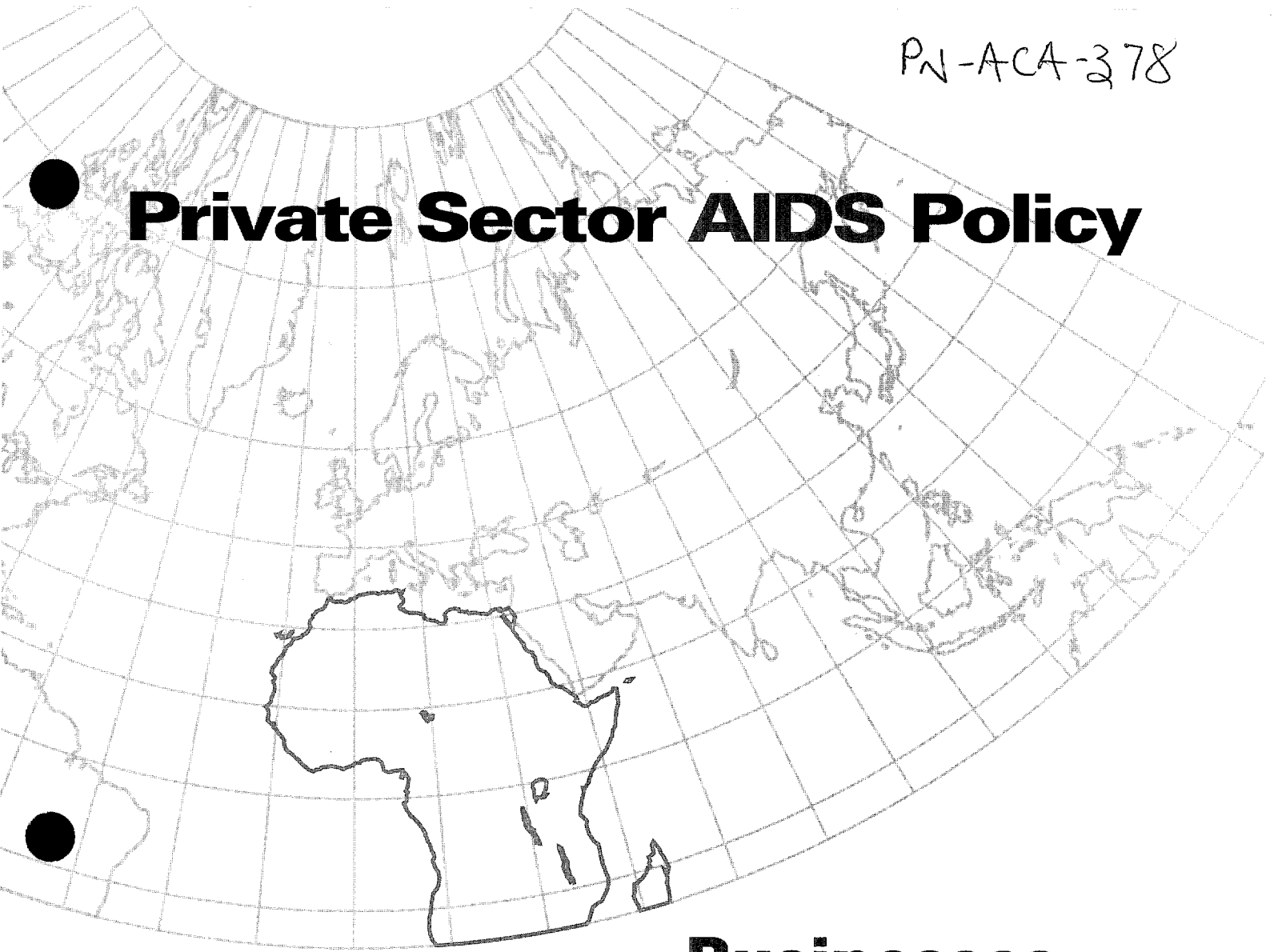
Businesses often find that developing a HIV/AIDS policy takes less time than expected, and that it is an informative and valuable experience. The biggest benefit is the knowledge that the organization is prepared to deal effectively with what is potentially a serious business problem. HIV/AIDS is a difficult subject to address, and often, it seems easier to dismiss it. However, HIV/AIDS can cause difficult, unpleasant, and expensive disruptions to a business caught unprepared. The development of a HIV/AIDS policy, in fact, demonstrates an organization's commitment to its own success and to the well-being of its workforce. By taking a responsible stand on HIV/AIDS, an organization joins the ranks of businesses that are successfully confronting the HIV/AIDS epidemic.

PN-ACA-378

Private Sector AIDS Policy



Businesses Managing HIV/AIDS

A Guide for Managers

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AIDSCAP

USAID

DEVELOPING A HIV/AIDS PREVENTION PROGRAM

MODULE 5

Developed by Family Health International's AIDSCAP Project (No. 936-5972.31-4692046) as part of the **Private Sector AIDS Policy Presentation** (PSAP) under USAID contracts HRN-5972-Q-00-4002-00 and HRN-5972-C-00-4001-00 Funding provided by the United States Agency for International Development.

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DEVELOPING A HIV/AIDS PREVENTION PROGRAM

HIV/AIDS prevention programs seek to inform employees, promote changes in behavior that will reduce the spread of HIV/AIDS, and provide services to reinforce behavior changes. Effective HIV/AIDS prevention interventions are not one-time events, but a variety of coordinated activities and services that are ongoing. As discussed in the Introduction of the *Manager's Guide*, the four recommended prevention components are formal and informal education, condom distribution, sexually transmitted disease (STD) diagnosis and treatment, and counseling and support services for employees and their families.

The prevention program is the core of an organization's response to HIV/AIDS. These prevention activities will, in turn, be informed and sustained by well-designed policies. If an organization is in the initial stages of designing a program, it is recommended that the planning committee complete the preparation of a HIV/AIDS policy before developing prevention activities. Completing the policy first provides the organization with a great deal of information about HIV/AIDS and can serve as the foundation for the prevention program. However, if establishing a policy is likely to be a prolonged effort, any existing or new prevention activities should *not* be delayed.

I. PRELIMINARY PLANNING

HIV/AIDS prevention activities are formed through a set of planning steps. These steps can be applied to each of the four recommended prevention components. Though some adaptation may be necessary, the preliminary planning phase for prevention programming is much like the process outlined in Module 4 for policy development. The basic steps are:

- Learn about HIV/AIDS;
- Review this manual and prevention program alternatives;
- Review existing prevention activities in the organization;
- Develop a *prevention program planning checklist* for creating the prevention program; and

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- Work through the checklist.

Developing a prevention program, like formulating policy, requires strong management support. If policy formation preceded prevention planning, this support probably already exists. If management support is still uncertain, Module 3 and Module 4 offer some strategies for gaining this commitment. Regular contact, reporting, and involvement of management in prevention activities will also be important to maintaining management support.

Module 2 also provides information on the value of forming a HIV/AIDS planning committee. It is advisable to continue working with the same committee members, committee approach, and leadership while you develop the company's HIV/AIDS prevention activities. This will bring about consistency of planning with a group of people already knowledgeable about and invested in the process. After completing the planning process for policy, the committee members know more about the subject and understand the ways in which the business can move forward to develop HIV/AIDS prevention activities.

The committee will probably need to devote a good portion of its time, initially, to planning the prevention activities, setting timetables, and assigning tasks. As in preparing the policy, it may be helpful to divide up tasks among the committee members. Each sub-group could be assigned one of the four HIV/AIDS prevention program areas to develop.

Depending on the resources and capabilities of the organization, some businesses may choose to seek outside help to plan or operate their prevention programs. For example, some organizations without medical staff may elect to contract medical services in the community to provide STD services. Or, organizations may be able to find professionals to conduct formal HIV/AIDS education sessions and/or counseling services for employees. Even if an organization decides to contract out for most or all of its prevention services, it is still important to learn about HIV/AIDS prevention, select service providers, effectively communicate the importance of HIV/AIDS prevention to employees and management's commitment to prevention, and monitor the program.

Section 2 below briefly discusses how to identify internal and external resources. Once this planning and resource identification is done, it will be necessary to plan a budget for prevention interventions. In fact, projections of costs should be woven throughout the preliminary planning process of developing HIV/AIDS prevention activities. Module 3 provides instructions to estimate, in advance, the costs of a HIV/AIDS prevention program. This information can then be used to develop a program budget. Preparing a budget will be useful in working with management as well as marshaling the resources for the prevention activities.

1. Components of a prevention program

Module 1.III. of this *Manager's Guide* lays out a recommended framework for an HIV/AIDS program. In summary, this framework includes:

- Clearly delineated and consistent policies.
- Formal and informal education activities for all staff.
- Condom distribution systems that make condoms readily and consistently available.
- STD diagnosis and treatment.
- Counseling and support services for employees and their families.

A well-designed HIV/AIDS prevention program usually consists of a comprehensive set of components. In the preliminary planning stage, it is useful to clarify the relationships between each of the components and how they will be coordinated. For example, formal and informal education activities should reinforce STD services by explaining the importance of prompt STD diagnosis and indicating where employees can go for treatment. The relationships among each of the four program areas and their coordination will be discussed in more detail in later sections of this module. Keep in mind that while it is possible to develop a workplace program that does not include all of these components, experience in other workplace settings indicates that the most effective programs ensure that these complementary components are readily available to employees, either in the workplace or in the surrounding community.

The experience of the Rio Tinto mining company in Zimbabwe demonstrates the complementarity of components and the benefits that may accrue from establishing a comprehensive prevention program. As the

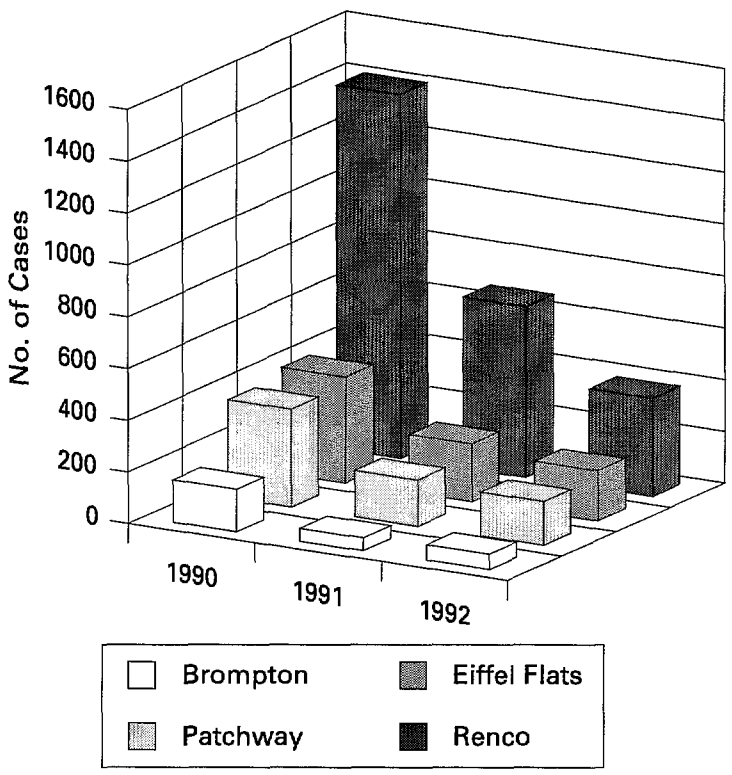
HIV/AIDS PREVENTION PROGRAM PLANNING CHECKLIST

- Get management support
- Plan how to sustain management support
- Organize a HIV/AIDS prevention planning committee
- Create a plan of action, and a timetable, and assign tasks to team members
- Divide the group into prevention component sub-groups
- Identify leaders of the sub-groups
- Identify internal and external resources to assist in program development and/or implementation
- Assess workplace/surrounding community situation and select prevention components for workplace program
- Draft a budget for the prevention program and obtain management approval
- Implement prevention activities

following graphs show, the number of STD cases treated at the company's four clinics declined between 47 and 78 percent between 1990 and 1992. This was after the introduction of a HIV/AIDS prevention campaign within the company in 1990 and a 63 percent increase in condoms distributed during the same two-year period.

The collection of *African Workplace Profiles* provides other examples of how some companies have established comprehensive prevention programs. The business studies of Muhoroni Sugar in Kenya, Eastern Highland Plantations in Zimbabwe, and Botswana Meat Commission are good examples of effective programs.

STDs Treated at Rio Tinto Zimbabwe Clinics 1990–1992



Source: Rio Tinto Zimbabwe Ltd; from *Work Against AIDS,* ActionAid and AMREF, with permission.

2. Accessing prevention resources and assistance

Different businesses are at different stages of prevention program development. Some companies have already begun addressing HIV/AIDS in the workplace. For example, some businesses may already distribute condoms as part of an existing family planning program, or already offer STD services, or hold formal HIV prevention education sessions. Other businesses may be dealing with HIV/AIDS for the first time and have few or no prevention program components in place. Whatever the experience, it is important for each business to identify the prevention resources and assistance available within the organization.

Once internal resources and capabilities have been identified, the organization is in a better position to assess what external resources may be needed. Many businesses will find that they need external assistance. Fortunately, a growing number of organizations have experience in one or more prevention areas and can provide technical assistance. Some of the traditional sources of assistance include ministries of health, the National AIDS Control Program, public health offices, and health clinics. In addition to these organizations, there are also business-oriented groups such as business coalitions, employers' federations, and workers' associations (e.g., unions). There are also nongovernmental organizations (NGOs) like the Red Cross and other local groups. These

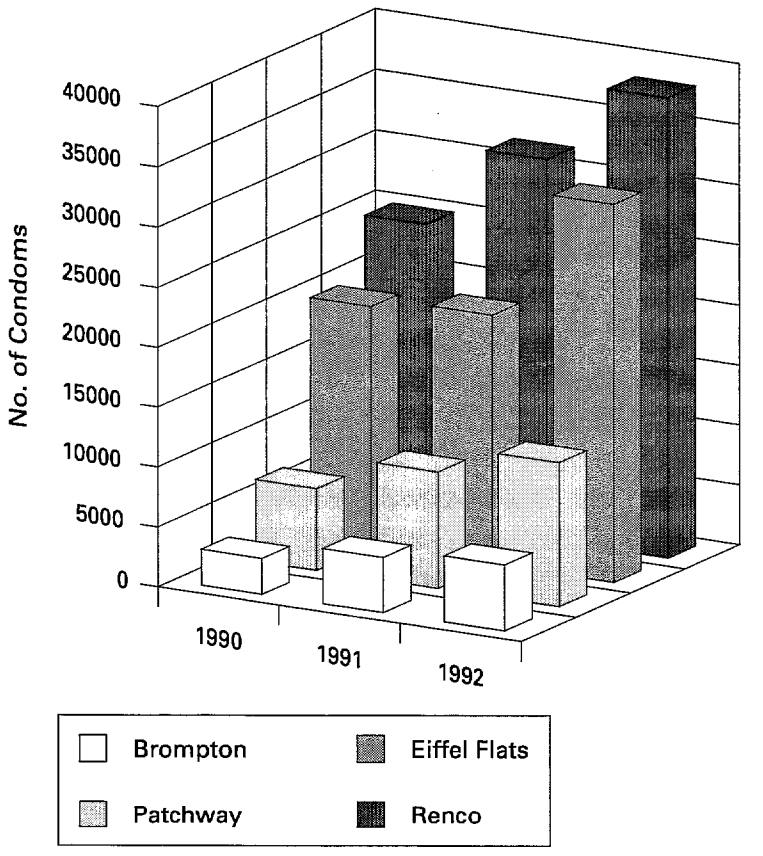
business groups and NGOs often have highly skilled staff who can respond quickly and flexibly to business requests for technical assistance in HIV/AIDS prevention programming.

II. DEVELOP THE ACTIVITIES FOR EACH OF THE FOUR PROGRAM AREAS

A. Formal and informal education activities for all staff

HIV/AIDS education programs are activities in the workplace that inform employees about HIV/AIDS and seek to motivate changes in behavior that will reduce the spread of HIV/AIDS. An organization's formal and informal HIV/AIDS education activities are the base upon which the other three prevention program areas are built.

Condoms Distributed at Rio Tinto Zimbabwe Clinics 1990–1992



Source: Rio Tinto Zimbabwe Ltd; from *Work Against AIDS,* ActionAid and AMREF, with permission.

Step 1: Learn about the target audience

Though it may seem obvious, people's knowledge, communication, and interaction styles may vary, depending on their cultural background, birthplace, sex, age, and a host of other factors. Understanding and adapting communication messages to fit with people's backgrounds, knowledge, and styles is important to effectively reach people with these messages. In the case of workplace programs, this generally includes workers, their partners, and their families. Part of the process of developing education programs is targeting the audience: identifying different groups of people to be reached and developing communication messages appropriate to each group. For example, discussions about HIV/AIDS are likely to address the very personal issues of sex and sexuality. These personal issues are often communicated differently in different parts of the same society.

Sometimes the best way to find out what is understandable and acceptable to a group of employees is to ask them directly. This is one good reason to include workers on the planning committee. Planning several pilot sessions before launching the program helps test the

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appropriateness of the activities and materials while they are still being developed. Ask for feedback from workers about use of language and sensitivity to their cultural values after they have participated in preliminary activities and have reviewed the materials. It is essential to be sure that the messages in the company's education and prevention programs are suitable to the people for whom they are intended.

The box below lists some of the most important issues to be learned about workers and their families to ensure that prevention activities are well targeted. If the organization's prevention planners cannot do this kind of assessment, seek help from health educators or other specialists.

TARGET AUDIENCE(S) ISSUES

- What target audience members know about HIV/AIDS and what, if any, preventive behaviors they practice.
- What information will help them change behaviors or continue safer sex practices.
- When and where the target audience gets information, especially about sexual/family topics.
- How they perceive of peer and social norms around sexual behaviors and HIV/AIDS prevention.
- How target audience members communicate with each other, where and when they meet, and who makes up their immediate social network.
- What they perceive as their risk of becoming infected with HIV/AIDS and STDs.
- Whom they see as credible and influential sources of information about sexual/ family topics.

Step 2: Identify subject-matter resources

Although a HIV/AIDS prevention planning committee may be able to plan formal and informal education activities appropriate for a business, they may not have the knowledge necessary to develop the specific content material needed for the activities. While developing the activities, the committee should seek assistance and advice from experienced people and organizations. The same consultation and advice will also be useful when developing the activities and services for the other three program areas.

During the planning phase of developing the organization's HIV/AIDS policy, the committee will have likely identified people with useful skills. In many cases, there are existing resources that national and local organizations already doing HIV/AIDS prevention work can offer. They will probably have education materials and program designs that can be adapted to particular workplaces with minimal effort and at low cost. Many organizations have medical or personnel staff who can serve both as assistants to the planning committee and as formal health educators for the workplace program.

Step 3: Use peer education

In addition to more formally trained health professionals and educators (e.g., medical clinic staff) who may conduct formal education activities, training employees as peer educators for informal education work is also effective.

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Peers are people in the workplace similar to one another in age, background, experience, and interests. People are more likely to listen to and follow advice from their peers. Peers also have greater influence on each other than non-peers, a significant factor in changing behaviors. With specific training and support, peer educators (workers) can effectively carry out a range of HIV/AIDS education and other prevention activities with their coworkers in work groups.

Peer educators can often communicate issues of importance to employees, lead large group meetings, and distribute pamphlets, brochures, and condoms. If properly trained, peer educators also may be able to conduct support groups with coworkers. Appendix 4 provides more information on the selection and training of peer educators. Frequently, organizations seek the assistance of health-related NGOs to assist them in the initial training of peer educators and to provide follow-up monitoring and training as needed.

Step 4: Identify the essential issues to be included in the HIV/AIDS education activities

HIV/AIDS education activities use a variety of forms and approaches (see Step 5 below) so that a broad range of issues can be addressed. Whatever approach is used, there are specific core issues that should be included to keep the activities focused and coordinated. A list of the core issues and a rationale for their inclusion is offered in Appendix 5.

Briefly, the core issues to convey in education programs are:

- The company's policy or position on HIV/AIDS and procedures for handling HIV/AIDS-related problems or concerns;
- How HIV/AIDS is and is not transmitted;
- Why there is no risk of casual transmission of HIV/AIDS;
- How to prevent the spread of HIV;
- How to respond to a coworker with HIV/AIDS;
- How to assess personal risk and formulate behavior change plans;
- Benefits available to employees and family members with HIV/AIDS;
- Confidentiality and privacy requirements; and
- Where to go for help and for additional information.

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Step 5: Identify and select the range of activities to be offered

HIV/AIDS education and prevention activities should take a variety of forms and approaches so that a broad range of issues can be covered and, over time, systematically reinforced. For example, some should be aimed at awareness and sensitivity-raising toward persons living with HIV, while others should focus primarily on prevention education and skill building. By using a variety of complementary approaches in the company's HIV/AIDS prevention activities, the messages being delivered will be positively reinforced. The range of activities for HIV/AIDS education include:

- Formal lectures.
  Lectures can be used for delivering basic information to large groups of people at the same time. Lectures can be an effective way to present policy issues or basic information on HIV/AIDS, and should be as participatory as possible.

- Work group training sessions or informal small group discussions.
  Work group training sessions bring people within the same unit, department, category of employee, or other affinity group together to focus on an issue or activity. Such sessions make it possible to involve a group of peers in personalized discussion of HIV/AIDS using limited manpower.

- Videotape presentations.
  Video presentations are useful for promoting discussion in small groups. Videotape presentations about HIV/AIDS featuring well known or recognizable people also lend strong credibility to a topic that is often dismissed as controversial and confusing.

- Posters.
  Posters placed strategically throughout the workplace can provide reminders of the existence of HIV/AIDS, offer prevention education messages, and draw workers' attention to the company's policies and programs.

- Brochures and pamphlets.
  Brochures and pamphlets can convey many kinds of messages about HIV/AIDS and are an effective way to reinforce prevention education activities. Brochures and pamphlets reach a large audience when employees take them home and into their communities.

The maximum impact of a workplace prevention program will be achieved by using complementary education and prevention activities.

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The content of lectures, discussions, or other small group activities may range from basic information about HIV/AIDS to the specifics of safer sexual practices. Materials such as posters, brochures, or pamphlets may range from written messages describing the risks of contracting HIV/AIDS to graphics and cartoons providing important information to people who cannot read. All of these activities overlap and, in conjunction with one another, work to strengthen the organization's HIV/AIDS prevention program.

Step 6: Plan the content of HIV/AIDS education activities

To develop the content of the HIV/AIDS education activities or modules, one must decide on the particular message to be conveyed in each activity or module. To do this, determine the purpose of each module and then focus the content for it accordingly. In addition to the information in Step 5 above, Appendix 6 offers an illustrative example of how an organization might plan its HIV/AIDS education modules and the content of each.

Step 7: Schedule the education activities

Decisions must be made about a number of practical scheduling issues in order to smoothly and effectively implement an organization's HIV/AIDS education activities. The checklist identifies some of these issues. Answer these questions and add additional ones to the checklist until the planning committee is confident that all aspects of the HIV/AIDS education and prevention activities are properly timed and scheduled. Appendix 7 lists each of these questions and provides some suggestions for discussion around each of them.

Step 8: Introduce HIV/AIDS education and prevention activities

The introduction of HIV/AIDS education activities will involve:

- Introducing the peer educators (or the people who will facilitate worker education activities).
- Describing the activities, how employees can participate in them, and how the activities will be coordinated with normal work requirements.

EDUCATION PROGRAM SCHEDULING CHECKLIST

☐ How long will the worker education and prevention activity sessions be?
- — One hour?
- — Two hours?

☐ How frequently will the same work group be provided with new activities?

☐ When will worker education sessions be scheduled?
- — Before work?
- — During work hours?
- — During lunch time and/or other breaks?
- — After work?

☐ Are sessions mandatory or voluntary?
- — Where will sessions be conducted?
- — Is transportation needed?
- — Is privacy available?

☐ How are worker sessions coordinated with production needs?

- Describing other prevention program areas of the organization (e.g., condom distribution, STD management, and counseling and support services).

In addition to using already established modes of communication, it is useful to consider other forms of communication to inform workers and to launch the HIV/AIDS education and prevention activities. Consider a series of training sessions along with the development of posters, brochures, pamphlets, and other materials. These should describe the components of the education program (e.g., peer educators), the various activities offered, how employees can participate in them, how the activities will be coordinated with normal work requirements, and the other workplace prevention program components.

B. Distribution systems that make condoms readily and consistently available

A second component of a workplace prevention program is usually a condom distribution system that makes condoms readily and consistently available to employees. Regular and correct condom use is an essential factor in the prevention of HIV/AIDS and STDs. A major focus of the worker education and prevention sessions is likely to be on the importance of correct condom use.

Unless the company is certain that condoms are readily, reliably, and affordably available in the surrounding community, the organization will probably want to provide employees with condoms. In fact, many companies will probably find that they have already begun distributing condoms as part of a program of family planning and/or STD management.

If the organization is planning a condom distribution program for the first time, or if it is considering modifying the program as part of expanding prevention activities, it may be helpful to consider the following:

1. Rationale for condom distribution in the workplace

Some employers dispute the role of business in condom distribution to workers, because an employee's private sexual life takes place away from work. This is true, but it's also true that employees' private lives have an impact on work as well. As discussed in Module 1, workers' private sexual behaviors can have a significant cost impact on business. It makes good business sense and is cost-effective to invest in ways that can help employees prevent the transmission of HIV/AIDS in their private lives.

Condom distribution to employees supports and reinforces HIV/AIDS education and prevention activities. When employees are encouraged in their worker sessions to talk about how to use condoms,

and the discussions are backed up by the distribution of condoms, workers are more likely to learn to use them and to change their behavior toward safer sexual practices.

2. Choosing condom distribution systems

Condom distribution systems are ways of making condoms easily available to employees at low or no cost. There are different ways to accomplish this. The organization can procure condoms in bulk and provide an ample supply to each peer educator for distribution during worker sessions. Sometimes, local health authorities, NGOs, or the national AIDS control program provide condoms at no charge to companies. In this way, employees will be supplied with condoms while condom use is being discussed.

In addition to providing supplies of condoms to peer educators, place supplies of condoms at convenient locations around the work site so that employees become familiar with them and can take them as they wish. Installing condom dispensing machines

CONDOM PROGRAM PLANNING CHECKLIST

Step:	Examples:
☐ Identify topic experts	a. Company physician b. Condom marketing/distribution specialist c. Company social worker or health education professional
☐ Identify and select range of activities	a. Lectures—includes: – Reasons for consistent condom use – How to use a condom correctly – Lubricants – Condom negotiation skills b. Peer group sessions—includes: – Condom negotiation – Role playing
☐ Select modes of condom distribution	a. Condom vending machines b. "Unlimited" mass supply (e.g., in restrooms) c. Health clinic d. Paycheck envelope
☐ Select most appropriate methods of promoting the program	a. Posters at various locations b. Letter in paycheck envelope c. Lunch room promotional talks d. Peer educators e. Company newsletter f. All staff lectures

so that employees can purchase condoms easily and conveniently is particularly effective. The cost of condoms from a dispensing machine should be carefully set to acknowledge their value, but not exceed employee purchasing capacity. Because condoms are related to sexual behavior, some workers may be embarrassed to ask for them, so condoms should be available directly to workers.

3. Paying for the condom program

The bulk procurement and distribution of condoms is a relatively inexpensive and prudent business investment. Just as one would try to find sources for any necessary business equipment or supplies, seek out available suppliers and negotiate the most advantageous arrangement. Frequently, local public health authorities, the National AIDS Control Programme, or NGOs that provide health and family planning assistance can help an organization procure condoms.

A supplier of condoms may also be able to provide condom dispensing machines. The cost of bulk purchases of condoms and the purchase or rental of dispensing machines can then be included in the organization's HIV/AIDS prevention budget. It may be possible to set the charge to purchase condoms from dispensing machines to cover the cost of the condoms (and possibly the machine). Remember however, that unless condoms are affordable, employees may not purchase them. In some cases, this may mean that condoms should be provided free to employees.

4. Developing a condom program planning checklist

As with many of the other program areas, a planning checklist may be helpful in creating and managing prevention activities. A successful condom distribution program requires employee knowledge about the proper use of condoms, motivation to use them, and adequate access to them. Thus, a workplace condom program will probably integrate education activities and distribution methods. An example of a integrative condom program planning checklist is provided.

C. Sexually transmitted diseases management

STDs are one of the most common health problems among workers. In many African countries, STDs are among the top five reasons for health service consultations. The presence of an STD also greatly increases the possibility of transmitting the HIV/AIDS virus during sexual intercourse. STD diagnosis and treatment are medical issues and are not usually seen as directly related to business functions. However, there is a strong relationship between worker health and high productivity.

STD services, whether internally or externally provided, should be covered in the same way as other company-sponsored health services. The cost of diagnosis and treatment for a worker with an STD is often

less than one day's wages, and the worker remains productive. Should a worker's STD be ignored, absenteeism and the resulting impact on productivity, medical fees, and other expenses can be many times more costly than diagnosis and treatment.

STD management services includes information that encourages employees (and their partners) to learn about STDs and avoid their transmission, and offers access to medical services for the diagnosis and treatment of STDs. To provide STD services, a workplace clinic will need medically trained personnel, some testing procedures and equipment, and, perhaps most important, adequate supplies of pharmaceuticals.

A company with a medical clinic on-site should offer STD services for several reasons. First, the willingness of the business to treat STDs demonstrates the commitment of the organization to deal professionally (e.g., confidentially and without stigma) with intimate sexual matters. Second, in some settings, the company clinic is the only—or most convenient—medical service in the immediate vicinity. Third, some employees find the cost of outside services to be prohibitive and avoid treatment, or seek less expensive and inappropriate treatment.

Just as confidentiality and privacy are essential aspects of an organization's HIV/AIDS policy, workers' medical information about STDs also must remain confidential and private. Effective STD management requires a non-judgmental and discreet approach. Blaming, judging, or stigmatizing employees (or others) with STDs is likely to discourage people from seeking diagnosis or treatment.

Despite an organization's best efforts to provide STD services discreetly, employees sometimes prefer to have STDs treated outside of the company setting, where they may feel they have greater privacy. One approach to meeting the need for STD services, while acknowledging employee concerns about privacy, is to make treatment for uncomplicated STD cases available at the workplace clinic and to refer more complicated cases to full-service clinics. The organization will need to make arrangements with external provider(s) to pay for these services.

Undiagnosed STDs hurt employees, their productivity, and frequently those with whom they have sexual contact. STD services will

STD MANAGEMENT PLANNING CHECKLIST

- ☐ Identify clinic personnel for training
- ☐ Decide on management guidelines from the Ministry of Health or World Health Organization
- ☐ Procure necessary pharmaceutical supplies
- ☐ Develop record procedures to ensure confidentiality and overall program monitoring
- ☐ Develop partner notification protocol
- ☐ Ensure links with outreach/peer workers and prevention activities
- ☐ Advertise services

need to be provided not only to the employee, but to the partner(s) of the employee. Unless the employee's partner is treated as well, the probability of reinfection is very high. The organization will need to carefully consider how to ensure that partners are notified and treated. Often, there are legal as well as ethical considerations to partner notification. Local medical authorities can provide guidance if the proper procedures are not already known.

An STD management planning checklist can help in establishing STD services. As the accompanying checklist indicates, an STD management program has several elements, including integration with prevention education activities, medical detection and treatment services, pharmaceutical acquisition, and partner notification procedures.

D. Counseling, testing, and support services for employees and their families

The last program area to develop for a HIV/AIDS education and prevention program is counseling and support services for employees and their families. Counseling and support services for employees and their families reinforce other prevention activities and can be important for creating and maintaining desired behavior change. They provide personal and individual reinforcement for behavior change outside the formal and informal group activities offered.

1. Counseling and HIV testing

Though businesses are strongly discouraged from requiring mandatory HIV testing of employees or applicants, some employers may choose to provide *voluntary, informed, and confidential* testing for employees and their partners as a part of the employee education program. If HIV testing is conducted, it is essential that those who are tested receive pre- and post-test counseling to discuss the nature of the test and its implications, and to address the concerns and questions that arise from the test process and results. *Voluntary* means that the person is not coerced or manipulated into having the test; *informed* means that the individual understands what the test is, how it works, and what the consequences of the results are; and *confidential* means that the results of an individual's HIV test will not be shared with anyone else without their full consent. If test results are released to public or other authorities, the names of those tested are withheld.

There is growing evidence that voluntary HIV testing, along with counseling, is an important educational tool in HIV/AIDS prevention. Individuals who seek to know their HIV status are usually motivated to learn more about the disease and about how they can protect themselves and their sexual partners. As part of its educational program, a company can consider paying for voluntary and confidential testing of employees by outside service providers.

2. Steps to developing counseling and support services

The steps outlined below will assist in identifying, developing, and coordinating counseling and support services for employees and their families.

Step 1: Define the counseling and support services for employees and their families

Counseling and support services for workers and their families are personal interactions that undergird the HIV/AIDS prevention activities. Counseling and support services reinforce condom use, encourage STD diagnosis and treatment, help maintain the smooth flow of work, keep diagnosed workers productive longer, and ultimately save money. The specific goals of prevention counseling are usually to:

- Encourage people to initiate and sustain behavior change;
- Help people obtain referrals to additional medical, preventive psycho-social, or other care and services; and
- Provide a safe opportunity for people to learn their HIV-status (this assumes voluntary, confidential HIV testing is provided).

Some counseling and support services for employees and their families are often built in to the activities and services of the HIV/AIDS education and prevention program. Peer educators provide counseling and support while they are facilitating work group sessions or informal small group discussions. One aspect of STD diagnosis and treatment services includes counseling for workers and their families around STD and HIV/AIDS transmission, and the importance of condom use.

In addition to the group activities above, counseling and support services are sessions for employees or family members that focus on personal feelings, problems, beliefs, or responses to HIV/AIDS and other related issues, such as sex, intimacy, or condom use. These sessions are conducted by trained facilitators. In these sessions, employees can explore their questions and concerns about HIV/AIDS in a safe and understanding environment and discuss their own personal and sexual behavior.

Step 2: Plan counseling and support services for employees and their families

One of the weakest resource areas presently in workplace programs is the lack of skilled counselors. Peer educators may be able to offer some basic referral assistance. However, because of confidentiality issues and the level of counseling skills required to be an effective counselor, peer educators are not generally good candidates to offer more in-depth

support services. Some organizations do have medical and/or human resources staff trained at offering counseling assistance who could also be trained in HIV/AIDS-related counseling. Alternatively, they may be able to refer employees seeking counseling or support to other organizations offering these services. Sometimes hospitals, church groups, NGO medical clinics, or other AIDS-related service organizations offer counseling.

If a business can offer its own counseling and support services, it will be useful to set up a schedule of specific hours during the week when employees and family members can make appointments or drop-in for counseling and support. It is also appropriate and useful to schedule hours after work for these services.

Step 3: Paying for these services

The cost of counseling and support services should be built into the overall costs of the HIV/AIDS education and prevention program (see Module 3). Keep in mind that these services for employees and their families have the potential for paying for themselves over time, out of savings that otherwise would have been spent on worker HIV/AIDS-related costs.

Step 4: Publicize counseling and support services for employees and their families

Information about all of the HIV/AIDS education and prevention activities should be woven into all communications about the program. Every education and prevention activity offered to employees should encourage them to make use of counseling and support services. The services can be advertised through posters, brochures, and pamphlets. Communications that weave together all of these activities and services will attract workers and lead to the desired goal of HIV/AIDS prevention.

III. CONCLUSION

You have now completed a step-by-step process for developing your organization's HIV/AIDS education and prevention activities in a responsible and cost-effective way. HIV/AIDS education and prevention activities will assist workers and their families in preventing the spread of HIV/AIDS. The business will derive the benefits of reduced costs, stable productivity, and a healthier workforce. Most people in the organization, from senior management to workers and their families, will appreciate and benefit from the depth and extent of the HIV/AIDS prevention activities and support services.

PN-ACA-378

Private Sector AIDS Policy

Businesses Managing HIV/AIDS

A Guide for Managers

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AIDSCAP

USAID

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APPENDICES

MODULE 6

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APPENDIX 1
SELECT COMPANY HIV/AIDS POLICIES

The following statements of company HIV/AIDS policies provides examples of how several firms have responded to the epidemic. In each case, the company has felt it appropriate and important to lay out for all employees its intent. Usually, companies have found it useful to include some explanation of rationale for the policies.

The policies included here follow the wording used by each company, unless otherwise noted.

Barclays Bank of Zambia, "Business Response to AIDS." Condensed from a Presentation by A. L. Keembe, Personnel Director on 11 March 1993.

I. Introduction

Zambia like most other countries in the region, is regarded as a high-risk country for the deadly disease of AIDS. The magnitude of this worldwide epidemic continues to escalate at an alarming rate whilst a cure continues to elude the medical fraternity.

At Barclays Bank we understand and acknowledge that:

- HIV/AIDS afflicts all age groups. It is prevalent among school leavers and the middle-to-upper age groups. The peak is among the 30 to 39 year-olds. These are sexually active people and in the prime of their lives.

- Our business is concentrated in the "infamous" provinces (line of rail and Eastern Province). Over 95 percent of our staff live and work in these provinces. The level of exposure to HIV/AIDS infection cannot be underestimated.

- Business in Zambia, like in most countries in the sub-region, operates in an environment of relative uncertainty.

II. Impact of AIDS on Barclays Bank

An accurate assessment of the existence of AIDS in Barclays Bank is impossible. We are not medical specialists, infected staff will not admit they are afflicted with the virus, and information on the dead (115 since 1987) often lacks medical authenticity. Causes of death are often stated as TB, pneumonia, or "unknown."

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We are, however, prepared to conjecture on the basis of certain facts which tend to confirm our general view that HIV/AIDS-related cases exist in the Bank:

- Ministry of Health figures include Barclays Bank staff—we are part of Zambian society.
- Our age distribution shows that Barclays Bank labour force is generally young-to-upper middle aged (91 percent are below 46 years of age). This productive group is sexually active—hence vulnerable.
- Our statistics show a concentration of staff deaths in the younger age groups. 86 percent of the deceased staff were below 46.
- The death rate has risen from 0.4 percent in 1987 to 2.2 percent in 1992.

We believe that these are not coincidences—they are serious indications that AIDS-related diseases exist in the Bank. Though we do not know what portion is accountable by HIV/AIDS, we do know that it is having a serious effect on the Bank and staff concerned:

- Ex-gratia payments linked to basic salaries of deceased staff affect profit levels. In 1991 K6.8 million (approximately US$43,520) was paid for 28 deceased staff. In 1992 we paid K24.6 million (US$157,440) for 38 deaths. Subsequent years will be worse.
- In the event of death of an employee or spouse the Bank pays funeral grants and provides a coffin and transport (often hired). These costs are escalating.
- Some costs are not readily quantifiable. For instance, we have observed an upswing in absenteeism due to ill-health of staff or family members.
- As expected, staff morale suffers in an environment of ever-increasing sickness and death. The question: *Who next?* Those diagnosed with HIV/AIDS decline in performance and absenteeism over time.

III. Barclays Response to HIV/AIDS

AIDS is a national problem at every employer's doorstep, even if it is difficult to measure the impact. The threat of AIDS and the problems arising from it cannot be left to government and nongovernmental organizations alone. At Barclays Bank, we are committed to the dire need

to control the spread of AIDS and discrimination against people with HIV infection. In this endeavor, we list below our responses.

An HIV/AIDS Personnel Policy is in place emphasizing that:

- *The only medical criterion for recruitment and termination of employment is fitness to work. HIV infection does not, in itself, constitute a lack of fitness to work. Pre- and post-recruitment HIV screening is therefore not required.*

- *Staff affected by, or perceived to be affected by, HIV/AIDS must be protected from stigmatization and discrimination. They must enjoy health and social protection in the same manner as other employees suffering from other serious illnesses.*

- *We conduct HIV/AIDS campaigns through information and education:*

- *Our training courses, management staff meetings, and conferences include lectures, videos, and other literature on AIDS.*

- *Through our in-house magazine (Eagle Press), we provide updated information to enable staff and their families to protect themselves from HIV infection and to cope with the presence of AIDS.*

- *Our preventive health measures which focus on changing attitudes and behaviour include provision of condoms. Access is free, simple, and discreet. We provide condoms at Bank premises (in the restrooms).*

- *In a spirit of understanding and compassion for people with AIDS, we provide for special care and support (e.g., home-care visits and counseling). The Bank has a health counsellor who is a non-medical staff member.*

- *We continue to provide financial/material support for organizations involved in HIV/AIDS prevention campaigns.*

The way forward is to accept that AIDS is a national problem at every employer's doorstep—it is a management problem.

• • •

HIV/AIDS Policy of Africa Business, Inc. (ABI)[1]

Rationale:

ABI is committed to providing a healthy and safe work environment for all employees. After checking the facts and getting as much information

[1] This illustrative policy, of a fictitious company, is drawn from the policy statements of a number of actual companies.

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as possible from the most reliable authorities, we are developing an HIV/AIDS policy and prevention program so that all employees can learn how to prevent the spread of HIV and be confident about health and safety in the workplace.

Practice:

The Company does not discriminate against a qualified individual with a disability with regard to job applications, hiring, advancement, discharge, compensation, training, or other terms, conditions, or privileges of employment.

Further, the Company recognizes that employees with life-threatening illnesses—including but not limited to heart disease, multiple sclerosis, cancer, HIV disease—and other disabilities may wish to and be able to engage in as many of their normal pursuits as their conditions allow, including work.

Employees are encouraged to be sensitive to the fact that continued employment for a person with a life-threatening illness or disability provides self-supporting income and other benefits, may be therapeutically important, may assist in the remission or recovery process, and may help to prolong his/her life.

The Company seeks to accommodate employees with life-threatening illnesses or disabilities as long as they are able to meet acceptable performance standards, and medical evidence indicates that their conditions are not a threat to themselves or others.

While accommodating employees with life-threatening illnesses and disabilities, the Company recognizes its obligation to provide a safe work environment for all employees and customers. Every precaution should be taken to ensure that an employee's condition does not present a health and/or safety threat to other employees or customers.

Procedures for Management:

1. An employee's health condition is personal and confidential, and reasonable precautions should be taken to protect information regarding an employee's health condition.
2. Contact Human Resources [Personnel] if you believe that you or other employees need information about terminal illness, or a specific life-threatening illness, or if you need further guidance in managing a situation that involves an employee with a life-threatening illness.
3. Contact Human Resources if you have any concerns about the possible contagious nature of an employee's illness.
4. If warranted, make reasonable accommodation for employees with life-threatening illnesses consistent with the business needs of the department or division.
5. Make a reasonable attempt to transfer employees with life-threatening illnesses who request a transfer because they are experiencing undue stress.

6. Be sensitive and responsive to coworkers' concerns, and emphasize employee education available through Human Resources.
7. No special consideration will be given beyond normal transfer requests for employees who feel threatened by a coworker life-threatening illness.
8. Be sensitive to the fact that continued employment for a person with a life-threatening illness provides self-supporting income and other benefits, may be therapeutically important, may assist in the remission or recovery process, and may help to prolong his/her life.
9. Encourage employees to seek appropriate medical treatment and counseling services. Information on these services can be requested through Human Resources.

Prevention Services:

In order to educate employees about HIV/AIDS and to encourage employees to practice behaviors that are known to reduce the risk of HIV transmission, the Company will offer a regular program of education about HIV/AIDS. Employees will receive formal prevention training sessions and have access to informal peer educators.

Condoms can be an effective barrier to sexually transmitted diseases (STD) and HIV transmission. Thus, to provide easy and affordable access to condoms for employees and partners who wish to use them, the Company will make condoms available at a reasonable cost in the toilets and clinic.

Untreated STDs are injurious and increase the risk of HIV transmission. In order to reduce the number of cases of STD and improve the general welfare of employees and their families, the Company will provide confidential diagnosis and treatment for STDs at the medical clinic (and/or community clinic) at no cost. Employees with repeated cases of STD will be counseled about the risks associated with unsafe sexual practices.

Counseling and support services help employees and their families to cope with social, emotional, and other concerns associated with HIV/AIDS and to sustain behavioral changes that reduce the risk of HIV transmission. Confidential counseling and support services may be requested by employees and their families at the clinic, human resources/personnel department, or from peer educators.

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Shell Petroleum Development Company[2]

Principles

1. *Awareness*

In accordance with its HSE objectives, SPDC strives to provide a safe and healthy working environment for employees. The Company

[2] As specified in the *AIDS and the Workplace: What You Need to Know About AIDS* brochures distributed to employees of Shell Petroleum Development Company (SPDC) of Nigeria.

recognizes the worldwide spread of AIDS and the devastating effects of the disease on the lives of individuals and their families, and its impact on organisational effectiveness.

Realizing the above, the Company will institute and sustain AIDS awareness and prevention campaigns by actively providing information and facilities to staff and their families on the various aspects of AIDS, with the objective of the maximum containment of the spread of the disease.

2. ***Non-discrimination***

In accordance with WHO fundamental guidelines for policy formulation, while also responding to AIDS and the workplace:

- Employees with HIV infection who are healthy will be treated the same as any other employees

- Employees who are ill and HIV-infected (such as workers with AIDS) will be treated the same way as any other employee with an illness.

Medical assessment of prospective recruits will continue to be on the basis of expected physical and mental fitness to work, without their being required to undergo HIV screening.

However, ill health from AIDS, like any other serious illness, may lead to medical advice not to promote/transfer an employee in the interest of their health.

3. ***Support***

The company will offer support and counselling to staff who are HIV positive and/or have developed AIDS. Staff may request to have their blood tested. Strict medical confidentiality will be preserved.

Employees with HIV/AIDS will continue to receive medical treatment and care, in Company facilities or third party institutions, and will remain in employment while they are fit for work. If an employee should develop aggravated AIDS symptoms then, following established review processes, the normal practice of release from employment on medical grounds will be considered.

Employees with HIV/AIDS will be eligible for the same employees' benefits as other employees.

4. ***Protection***

The company will ensure that in its medical facilities every precaution is taken to prevent the transmission or spread of the HIV virus to patients and its own medical staff. To enhance the protection of medical staff all patients shall be deemed to be HIV positive as regards the application of precautionary measures.

Testing for AIDS will not be done routinely on staff except in respect of:

(a) All blood meant for transfusion;
(b) Screening for the purposes of obtaining an overseas Work Permit or Visa (where this is a requirement);
(c) On medical indication.

In all cases strict medical confidentiality will be adhered to.

Company Medical Officers will ensure that designated specialists and third party hospitals/clinics used for referral of staff meet satisfactory clinical standards and hygiene.

Staff travelling in areas where blood supplies, sterility of needles, etc., cannot be guaranteed (e.g. outside the Company main bases) will, on request, be provided with appropriate emergency AIDS prevention kits.

5. ***Work place behaviour***

Since in normal circumstances AIDS is not an infectious risk, staff are expected to cooperate to share a workplace with a colleague who is HIV positive.

6. ***Review***

In view of the continuing spread of AIDS, and the changing knowledge of its behaviour, the Company will from time to time review its policy in order to comply with public health regulations and the most appropriate means of sustaining a healthy and safe working environment.

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RJR Nabisco Management Statement on AIDS[3]

RJR Nabisco treats AIDS and HIV infection as disabilities in accordance with our policy on Equal Employment Opportunity (EEO) and the requirements of the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973. In addition to the provisions of the company's EEO policy on non-discrimination and reasonable accommodation for disability, the following guidelines are intended to assist managers in maintaining a work environment that is responsive to the workplace issues created by AIDS and HIV infection and the concerns of employees who may request management assistance:

- RJR Nabisco recognizes that a supportive and caring response from managers and coworkers is an important factor in maintaining the quality of life for an employee with AIDS or HIV infection. Managers should be sensitive to the special needs of employees and assist them by demonstrating personal support,

[3] A multinational conglomerate producing a range of food and other products and services.

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referring them to counseling services and arranging for benefits counseling as necessary. Studies show that the support of others in the workplace can be therapeutic for the employee with AIDS or HIV infection and may help to prolong the employee's life.

- **AIDS does not present a risk to the health or safety of coworkers or customers.** On the basis of current medical and scientific evidence, RJR Nabisco recognizes that AIDS is a life-threatening illness that is not transmitted through casual personal contact under normal working conditions.

- **Co-workers will be expected to continue working relationships with any employee who has AIDS or HIV infection.** Managers are encouraged to contact the Personnel Department for assistance in providing employees with general information about AIDS and HIV infection. Any employee who is unduly concerned about contracting AIDS may be further assisted through individual counseling.

- **An employee's health condition is private and confidential.** An employee with AIDS or HIV infection is under no obligation to disclose his/her condition to a manager or any other employee of RJR Nabisco. Managers are expected to take careful precautions to protect the confidentiality of information regarding any employee's health condition, including an employee with AIDS or HIV infection.

- **An employee with AIDS or HIV infection is expected to meet the same performance requirements applicable to other employees, with reasonable accommodation if necessary.** If an employee becomes disabled from performing the work involved, managers will make reasonable accommodation, as with any other employee with a disability, to enable the employee to meet established performance criteria. Reasonable accommodation may include, but is not limited to, flexible or part-time work schedules, leave of absence, work restructuring or job reassignment.

RJR Nabisco is following the process of medical research on AIDS and HIV infection. If any significant developments occur, these guidelines will be modified accordingly.

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Northwestern Mutual Life

Communicable Diseases and/or Life-Threatening Illnesses

Northwestern Mutual recognizes that employees with life-threatening illnesses, including but not limited to AIDS, cancer and heart disease, may wish to continue to engage in as many of their normal pursuits as their condition allows, including work. As long as these employees are able to meet acceptable performance standards, and medical evidence indicates that their conditions are not a threat to themselves or others, managers should be sensitive to their conditions and needs and ensure that they are treated consistently with other employees.

At the same time, Northwestern Mutual is committed to all employees to provide a safe work environment. Every precaution will be taken to ensure that the health and/or safety of Northwestern Mutual employees and guests is not threatened.

The Employee Relations Division and Health Clinic of the Human Resources Department shall be resources for management and employee education, referral to agencies and organizations which offer supportive services for life-threatening illnesses, and benefit consultation to assist employees and their managers in effectively managing health, leave and other benefits.

Procedure

Upon learning that an employee has contracted a communicable disease or a life-threatening illness, contact the Employee Relations Division or Health Clinic of the Human Resources Department. Further:

1. Managers should remember than an employee's health condition is personal and confidential. Northwestern is always careful to keep medical information about its employees confidential and managers should also take reasonable precautions to protect information regarding an employee's health condition.
2. Managers should be sensitive to the fact that continued employment for an employee with a life-threatening illness may sometimes be therapeutically important in the remission or recovery process, or may help to prolong that employee's life. If able to work, provide the employee with usual work assignments. The Health Clinic will determine if a statement is needed from the employee's attending physician that continued presence at work will pose no threat to the employee or co-workers.
3. If warranted, reasonable accommodation for employees with life-threatening illnesses, consistent with the business needs of the division, should be made. Reasonable attempts shall be made to transfer employees with life-threatening illnesses who request a transfer and are experiencing undue emotional stress.

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4. Managers should keep open and candid communications with the individual including forthright discussions on such matters as personal hygiene/hand washing.
5. If the employee is unable to work, he/she will be eligible for disability leave on the same basis as for any other disability.
6. To control medical and group disability income costs, hospice and home care will be encouraged.
7. Employees should be encouraged to seek assistance from established community support groups for medical treatment and counseling services. Information on these services can be requested through Employee Relations or Health Clinic.
8. Education and/or counseling (e.g., bereavement) will be provided as appropriate, for co-workers.

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DAKA[4]

Life Threatening Illnesses

DAKA is sensitive to associates with disabling and life threatening illnesses. Because of the seriousness and sensitivity of disabling and fatal diseases, such as and not limited to, certain cancers and HIV (human immunodeficiency virus), DAKA will treat any inflicted associate with the same dignity and compassion as any DAKA associate who suffers permanent disability from any cause.

We will not knowingly permit any associate with a life threatening illness to be discriminated against nor terminated solely because of their illness or disability.

HIV/AIDS is not a food borne illness nor can it be transmitted in the workplace through casual contact such as sneezing, coughing, breathing the same air, sharing eating utensils, or using the same rest room facilities. Periodically, education via newsletter articles, guidelines, educational videos, and awareness sessions will be made available through DAKA's Home Office and designated AIDS Program Representative.

Strictest confidentially will be maintained when a DAKA associate advises of his/her life threatening condition. All information regarding the person's history, diagnosis and other medical information will not be shared with any other associate.

Associates who have contracted a life threatening disease may seek help or information confidentiality through the Human Resources Department. Associates who need help and/or information regarding HIV/AIDS may contact the AIDS Program Representative confidentially, to provide individuals with an in-depth an clear

[4] A food service, hospitality industry company.

understanding of their illness or concerns, and referral to agencies and organizations that offer supportive services for life threatening illnesses.

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Fuel Service Industries Ltd. (FSI)[5]

"DRAFT POLICY ON LIFE THREATENING DISEASES & DISABILITIES"

Preamble

FSI is committed to a policy of non-discriminatory employment practices and the creation of a work environment which will maximize employee potential. The company believes that employees with life threatening diseases (LTD) and disabilities such as Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Cancer, Cardiovascular disease, etc. should be allowed, if they so wish, to continue productively contributing to the company for as long as their health permits. Such individuals have the right to continue working as long as they can carry out their jobs satisfactorily (with a reasonable degree of accommodation) and as long as the best available medical advice confirms that continued employment is not detrimental to the health of the employee, his/her co-workers, or external customers.

The following guidelines will apply in dealing with such situations.

Recruitment & Staffing

The company reserves the right to recruit and maintain staff, applying the criteria of fitness for employment.

The determination of an individual's fitness for employment will be the prerogative of the company's medical adviser in consultation with the company.

Security of Employment

The company will endeavor to accommodate employees with LTDs as long as they are able to perform their basic job function as certified by the company's medical adviser and provided that medical evidence confirms that their continued employment does not present a threat to themselves or others with whom they work.

Testing

The company will not require current employees to undergo testing for HIV infection or any other LTDs, nor prospective employees to submit to any specific test other than as may be required as part of a medical

[5] Fictitious name for the Caribbean operations of a multinational oil-production company.

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examination to determine medical fitness pursuant to the medical fitness criteria for employment with the company.

Relationship with Co-Workers/Customers

In the case of HIV/AIDS the best medical advice currently available confirms that normal work and social contact which does not involve the exchange of bodily fluids is safe. An employee with HIV infection or AIDS therefore does not constitute a risk to the health or safety of co-workers or external customers. Employees are encouraged to recognize that continued employment of a colleague with an LTD, chronic illness or disability is often beneficial and that they should be sensitive to the needs of such persons.

Through continuous education and counseling the company will attempt to promote proper attitude among its employees towards a colleague who is ill.

The company will not entertain requests for job transfers or any other form of accommodation on the basis of the LTD illness of another employee.

Confidentiality

Information about an employee's health is regarded as confidential. An individual with a life threatening illness is under no obligation to disclose the information to the company except where disclosure is pertinent to the performance of the individual's job.

Medical information about an employee provided to the company on a confidential basis may not be disclosed to others without specific written consent of the employee concerned, or where the illness is infectious or contagious.

Medical Care & Absence From Work

The cost for the treatment of any LTD, disability or chronic illness will be covered to the extent of the provisions available under the company's medical insurance scheme. Absence from work will be provided for under the prevailing provisions.

APPENDIX 2
WHO/ILO GUIDELINES ON HIV/AIDS AND THE WORKPLACE[6]

Persons Applying for Employment

Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be required. Screening of this kind refers to direct methods (HIV testing), indirect methods (assessment of risk behaviours), and questions about HIV tests already taken. Pre-employment HIV/AIDS screening for insurance or other purposes raises serious concerns about discrimination and merits close and further scrutiny.

Persons in Employment

1. **HIV/AIDS screening:** HIV/AIDS screening, whether direct, indirect, or asking questions about tests already taken, should not be required.
2. **Confidentiality:** Confidentiality regarding all medical information, including HIV/AIDS status, must be maintained.
3. **Informing the employer:** There should be no obligation for the employee to inform the employer regarding his/her HIV/AIDS status.
4. **Protection of employee:** Persons in the workplace affected by, or perceived to be affected by HIV/AIDS, must be protected from stigmatization and discrimination by co-workers, unions, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.
5. **Access to services:** Employees and their families should have access to information and educational programmes on HIV/AIDS as well as to relevant counselling and appropriate referral.
6. **Benefits:** HIV-infected employees should not be discriminated against, and should have access to standard social security benefits and occupationally related benefits.
7. **Reasonable changes in working arrangements:** HIV infection itself is not associated with any limitation in fitness to work. If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made.
8. **Continuation of employment:** HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as medically fit for available, appropriate work.
9. **First aid:** In any situation requiring first aid in the workplace, precautions need to be taken to reduce the risk of transmitting blood-borne infections, including hepatitis B. These standard precautions will be equally effective against HIV transmission.

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[6] World Health Organization/International Labour Office/League of Red Cross and Red Crescent Societies, *Guidelines on AIDS and first aid in the workplace*, WHO AIDS Series No. 7, 1990.

APPENDIX 3
TEN PRINCIPLES FOR THE WORKPLACE[7]

1. People with AIDS or HIV (Human Immunodeficiency Virus) infection are entitled to the same rights and opportunities as people with other serious or life-threatening illnesses.
2. Employment policies must, at a minimum, comply with federal, state, and local laws and regulations.
3. Employment policies should be based on the scientific and epidemiological evidence that people with AIDS or HIV infection do not pose a risk of transmission of the virus to coworkers through ordinary workplace contact.
4. The highest levels of management and union leadership should unequivocally endorse nondiscriminatory employment policies and educational programs about AIDS.
5. Employers and unions should communicate their support of these policies in simple, clear, and unambiguous terms.
6. Employers should provide employees with sensitive, accurate, and up-to-date education about risk reduction in their personal lives.
7. Employers have a duty to protect the confidentiality of employees' medical information.
8. To prevent work disruption and rejection by coworkers of an employee with AIDS or HIV infection, employers and unions should undertake education for all employees before such an incident occurs and as needed thereafter.
9. Employers should not require HIV screening as part of general pre-employment or workplace physical examinations.
10. In those special occupational settings where there may be a potential risk of exposure to HIV (for example, in health care, where workers may be exposed to blood or blood products), employers should provide specific, ongoing education and training, as well as the necessary equipment, to reinforce appropriate infection control procedures and ensure that they are implemented.

[7] The Ten Principles were developed in 1988 by the Citizens Commission for AIDS for New York City and Northern New Jersey (USA), to help employers and unions address the ethical, legal, and emotional aspects of creating HIV/AIDS workplace policies and prevention programs. At the time of their release, 30 organizations endorsed them. Since then, over 400 businesses, government agencies, labor groups, and other organizations in the U.S. and internationally have adopted them as part of their response to AIDS. Over three and a half million employees are covered by the Ten Principles.

APPENDIX 4
PEER EDUCATORS

How Are Peer Educators Identified?

Select peer educators from work groups and social groups at work where peer education will be used. Develop selection criteria for choosing people to be peer educators and have the HIV/AIDS prevention planning committee make the selections. In the selection criteria, identify qualities that would be appropriate to peer educators in your business. Employees who make good peer educators are responsible, reliable, well-liked, and respected by their coworkers and by others in the company. Effective peer educators are usually good workers and natural leaders who are trusted and popular among other employees. These individuals stand out among their peers, and yet, they are very much a part of their peer groups. In addition, peer educators should have an interest and desire to work on the prevention of HIV/AIDS.

You may want to use a selection criteria rating scale, like the one below, for rating each peer educator candidate. Identify the selection criteria appropriate for your business. Then, use the rating scale by placing a check mark in the numbered column that most closely fits your assessment of the candidate's qualifications. Employees with the highest scores in each selection criterion would probably be the best candidates.

SELECTION CRITERIA RATING SCALE

1 = not acceptable
2 = below average
3 = average
4 = above average
5 = exceptional

PEER EDUCATOR CANDIDATE's NAME: _____

Criteria/Score	1	2	3	4	5
Responsible/Reliable					
Well-liked					
Respected					
Leader					
Trusted					

You may want to begin identifying peer educator candidates during the policy development phase. If so, add it to the checklist for planning the company's HIV/AIDS policy. Some members of the HIV/AIDS prevention planning committee may make good peer educators as they have

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demonstrated sensitivity, knowledge, and commitment to the subject. In addition, members of the planning committee may have identified other appropriate peer educator candidates while developing the policy on HIV/AIDS.

You may decide to use the launch of the company's policy as a time and place to begin identifying peer educator candidates. One effective way to identify peer educators is to have workers nominate coworkers from within their work groups to be peer educators. A significant advantage to this approach is that if employees know that they have input into the process and feel themselves to be part it from the beginning, they will ultimately be more responsive to the program. This can have a powerful effect on behavior change.

As employees, peer educators must feel able and willing to take time for these added responsibilities. In turn, peer educators should be paid for the time they devote to this work, as they are paid for their other work responsibilities. Usually a peer educator supervisor or manager should be involved so that work schedules and supervision can be appropriately coordinated.

How Are Peer Educators Trained?

Peer educator training requires between two and five days of specialized instruction so that participants can learn the necessary skills and content material required for education and prevention activities. To conduct your peer education training, you will need to identify and engage an experienced HIV/AIDS trainer with specific skills in peer education.

Training for peer educators should be based on what they need to know to carry out the planned education and prevention activities. Small group discussions with the identified peer educators will reveal the knowledge and skills they already have and help plan your educational activities.

Training should focus on:

- Understanding roles and expectations
- Building knowledge on
  - The basics of HIV/AIDS and sexually transmitted diseases (STDs)
  - Relationship between HIV/AIDS and STDs
  - Company policy
  - Condom use, availability, and distribution
  - Where to go for assistance
- Learning about community norms and attitudes about sex and sexuality

- Understanding values about sexuality and relationships, and learning to talk confidently about sex and sexuality among their peers
- Developing facilitator skills for working with peers
- Practicing facilitator skills

What If Peer Education Is Not Right For My Business?

Peer education is considered the most effective way to provide employees with HIV/AIDS education and prevention, but it is not the only way these activities can be accomplished. Smaller businesses or other organizations may decide that an individual or a small group of people should be responsible for conducting the company's formal and informal HIV/AIDS education and prevention activities. If this is the decision at your company, it is still essential that the people identified as HIV/AIDS educators receive adequate training.

Some businesses have chosen to train staff members from the personnel department to be HIV/AIDS Resource People for the company. Other businesses have left HIV/AIDS programming to their medical staff. These approaches can be effective if done thoughtfully and with the right training. In any case, you will need to identify and engage an experienced HIV/AIDS trainer to provide these individuals with the necessary skills and content material required for your company's education and prevention activities.

If you choose to have the company doctor or other medical staff conduct formal and informal education and prevention activities, it is important to realize that few of these people have ever had training or experience facilitating small groups of workers around issues of sex, sexuality, condom use, and behavior change. It is incorrect to assume that because HIV/AIDS is a medical issue, medical professionals can facilitate your prevention programs. On the contrary, whoever is assigned the responsibility for providing HIV/AIDS education and prevention activities must be properly and specifically trained.

What About Training Costs?

The costs of training a group of peer educators is not necessarily more than the cost of training one or two professionals from your personnel or medical department. It is also more cost-effective to train a group of peer workers than it is to train just one or two staff people. In most situations, it will cost no more to train 15 or 20 peer educators than it will to train one or two other individuals, because the hourly cost of the subject-matter expert remains the same. Fifteen or twenty peer educators comprise one average-size class for one instructor, keeping the cost per student low by distributing the cost among all the students and

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producing a wise investment. Furthermore, because of work demands, job turnover, and other work-related factors, some trained individuals will be unable to make use of the skills for which they were trained. Thus, training a group of peer educators is a cost-effective, practical way to ensure that your business will have strong, sustained HIV/AIDS education and prevention programs.

APPENDIX 5
CORE ISSUES FOR BUSINESS HIV/AIDS POLICIES AND THEIR RATIONALE

The company's policy or position on HIV/AIDS and procedures for handling HIV/AIDS-related problems or concerns.

Rationale: Setting all education and prevention activities in the context of your company's policy or position on HIV/AIDS reinforces consistency of practice for management and consistency of desired behavior for employees. This message, repeated over time, makes clear to all workers the company's position on HIV/AIDS and lets everyone know, in advance, what is expected of them.

How HIV/AIDS is and is not transmitted.

Rationale: Repeating this information in every HIV/AIDS education and prevention activity reinforces knowledge and begins to form the basis for behavior change. The more an individual hears and understands how HIV/AIDS is and is not transmitted, the more likely that individual will be to avoid infection.

Why there is no risk of casual transmission of HIV/AIDS.

Rationale: This message helps employees understand that the transmission of HIV/AIDS is through specific behaviors and does not happen casually. It also reinforces the fact that working beside someone who has HIV/AIDS does not pose a risk of infection and encourages the desired responses to a coworker with HIV/AIDS.

How to prevent the spread of HIV.

Rationale: This message is the basis of HIV/AIDS prevention. The more a person knows how to prevent transmission, the more likely that person will behave in ways that will prevent transmission. This means open discussion of the importance and use of condoms, condom availability, and explaining your company's system of condom distribution.

How to respond to a coworker with HIV/AIDS.

Rationale: You will reinforce consistency of desired behavior and practice around HIV/AIDS by reiterating in all HIV/AIDS

education or prevention activities how the company wants workers to respond to someone with HIV/AIDS.

Benefits available to employees and family members with HIV/AIDS.

Rationale: You can minimize unexpected, unwanted, potentially costly surprises and trouble when workers understand what is expected of them and what they can expect from their employer. Thus, in addition to employees needing to know how they are expected to behave, they need to know what the company will provide to them if they contract HIV/AIDS.

Confidentiality and privacy requirements.

Rationale: Employees with HIV/AIDS often encounter harsh discrimination when their medical conditions are revealed. Provisions assuring confidentiality and privacy of workers' medical information help safeguard that inappropriate discrimination will not occur. Discrimination in the workplace is inconsistent with good business practice and often causes disruption. Thus, messages about the importance of confidentiality and privacy of employees' medical information should be included in all HIV/AIDS education or prevention activities.

Where to go for help and for additional information.

Rationale: HIV/AIDS can be confusing and troublesome and can raise many questions over time. All education and prevention activities should encourage employees to openly discuss HIV/AIDS, ask questions, and try to understand as much as possible. Workers often have pressing questions or want more information at times other than when they are attending an HIV/AIDS education or prevention activity. When a question goes unanswered, an individual is likely to assume an answer, which may or may not be correct, and then behave on that assumption. Thus employees may make costly, inappropriate decisions at work based on incorrect assumptions. Identify an individual or group within your business where employees can go or call for assistance and more information.

These core issues, repeated in all of the company's education and prevention activities keep the issues of HIV/AIDS in your workplace clearly framed by your policy. This ensures ongoing consistency between your HIV/AIDS policy, practices, and education and prevention activities.

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APPENDIX 6
EXAMPLE OF PREVENTION MODULES AND CONTENT PLAN

First Year Module and Content Plan for HIV/AIDS Prevention
The ABC Company (500 employees)

Module 1

Large Group/Formal Lecture:

Over a period of two months, in groups of 50 employees each, there will be an initial series of eight lectures conducted in the company canteen or meeting hall so that every worker can learn about our company's HIV/AIDS policy and procedures.

Content:
The content of this module includes the following:

- The company's policy and position on HIV/AIDS, and procedures for handling HIV/AIDS-related concerns
- How HIV/AIDS is and is not transmitted
- Why there is no risk of casual transmission of HIV/AIDS
- How to prevent the spread of HIV
- How to respond to a coworker with HIV/AIDS
- Benefits available to employees and family members with HIV/AIDS
- Confidentiality and privacy requirements
- Where to go for help and for additional information

Module 2

Work Group Training Sessions:

All employees are divided up into groups of 10 to 15 people each. Each group is composed of people who regularly work with each other. Peer educators provide one work group training session (30–60 minutes) each week for these workers. Over the next year work group training sessions will be conducted sequentially in three phases.

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Content of Phase 1:

The content of this phase includes a brief summary of the essential issues every HIV/AIDS education and prevention activity needs to include (see Appendix 5 above). The content focus of the sessions in Phase 1 is on how HIV/AIDS is and is not transmitted.

Content of Phase 2:

The content of this phase also covers a brief summary of the essential issues every HIV/AIDS education and prevention activity should include. The primary content focus covers how to prevent the spread of HIV/AIDS, safer sexual practices, and the use of condoms.

Content of Phase 3:

The content of this phase briefly reviews the essential issues every HIV/AIDS activity needs to include and the primary focus is on the relationship between STD and HIV/AIDS, the importance of STD diagnosis and treatment, and further discussion on preventing the spread of HIV/AIDS, safer sexual practices, and the use of condoms.

Module 3

Videotape Presentations:

Over the period of two months a series of one-hour management meetings are conducted with ten managers in each meeting using a videotape presentation followed by a facilitated discussion, so that all managers experience an HIV/AIDS education and prevention session.

Content:

"It Ain't Easy," a videotape on workplace HIV/AIDS issues in Uganda will be presented, followed by a discussion about the company's policy, practices, and HIV/AIDS prevention activities (other videotapes will be shown in the future).

Module 4

Informal Small Group Discussions:

The peer educators are trained to facilitate informal small group discussions with employees. These discussions take place during rest or meal breaks, before and after work, or at other non-work times when workers gather.

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Content:

The content of informal small group discussions focus on any aspect of HIV/AIDS education and prevention ranging from the issues identified in Appendix 5 above to more personal concerns around safer sex practices, condoms, family issues, and STDs.

Module 5

Posters:

The company has purchased HIV/AIDS prevention posters from the National AIDS Program Office. The posters provide a variety of messages that are compatible with your company's position on HIV/AIDS. The posters are prominently displayed in locations where they are seen by employees.

Content:

The posters use few or no words and convey HIV/AIDS education messages through easy to understand graphics or cartoons.

Module 6

Brochures and Pamphlets:

The company has purchased a series of HIV/AIDS awareness, education, and prevention brochures and pamphlets for distribution to workers. Brochures and pamphlets are distributed during the presentations of the other modules and as workers ask for them.

Content:

The content of brochures and pamphlets vary and include messages about transmission, safer sex, STDs, and other related issues around HIV/AIDS prevention. Some materials are in written form for distribution to people who are able to read, and some, in a simple graphic or cartoon format for those who cannot read.

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The above example of a module and content plan shows how HIV/AIDS prevention modules and activities overlap and, in conjunction with one another, work to strengthen the prevention program. Over time, the various modules and activities reinforce employee knowledge and understanding and lead to reduced risk behavior.

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APPENDIX 7
PROGRAM DEVELOPMENT DISCUSSION QUESTIONS

How long will your worker education and prevention activity sessions be?

One hour?
Two hours?

Discussion: Worker education and prevention activities should be at least an hour in length. Less than one hour does not leave enough time for adequate information presentation, discussion, and questions and answers. Facilitated small group interactive activities for employees probably should not be longer than two hours, as by then, workers may begin to experience "information overload." Formal lecture programs should be no more than one hour, as without interaction, one begins to lose worker attention.

How frequently will the same work group be provided with another activity?

Discussion: The frequency of worker activities should be regular enough so that the last session is still fresh in employees' minds and they can begin the next session without having to repeat the previous session. This encourages one session building on another leading to desired reinforcement. Thus, there should be no more than a few weeks between sessions. Clearly, this decision has to be made in conjunction with the employees, supervisors, the needs of production, and when sessions can be done.

When will worker education and prevention activity sessions be done?

Before work?
During work hours?
During lunch and/or other breaks?
After work?

Discussion: HIV/AIDS education activities are usually more effective when they are able to be done during working hours. Sessions conducted during work hours reinforce the reality of the company's commitment to preventing HIV/AIDS, and they ensure maximum worker participation. The primary issue is to determine how much time and with what regularity small groups of employees can meet during work hours. This decision will depend upon the needs and expectations of production, work schedules, costs, management, and other practical business considerations.

How many employees in each session?

Discussion: As discussed earlier, large group lectures with as many as 50 or more employees in attendance should be used only for communicating straight-forward, general information, such as company policy and procedures. Other worker sessions should be small in size. Each session should be small enough to allow for and encourage interaction so that each person has time to talk and participate in the process, but large enough to build group dynamics. It is through group dynamics—listening, talking, and struggling with the issues—that the material of the sessions becomes integrated and participants begin to move toward behavior change. Another determinant of worker group size is the comfort of the peer educator or facilitator. Some people work better with small groups while others work better with larger groups. Worker session size probably should be no less than six people and no more than 12 or 15 people.

Are sessions mandatory or voluntary?

Discussion: Maximum benefit of the education and prevention programs will be achieved if all workers participate in them. If they are conducted during work hours, it is appropriate to make worker participation part of the usual work schedule and mandatory. However, some people might initially resist participating in something that they do not see yet as relevant to their work. To avoid this minor resistance, it is better not to use the word mandatory, structure the sessions so that they include small groups of people from the same work groups, and conduct them at times when these people are normally together. Sessions conducted outside of work hours should be voluntary, and some employees will not participate as they will have commitments elsewhere. In any case, employees should be encouraged to attend all sessions so that everyone participates in HIV/AIDS prevention.

Where will sessions be conducted?

Is transportation needed?
Is privacy available?

Discussion: Worker sessions should be conducted in places that are conveniently located and, preferably, afford some privacy. If possible, find locations in the workplace for the sessions that are close to where employees normally work. In this way, they will identify the HIV/AIDS education and prevention activities as an integral part of their jobs. This will encourage workers to be more

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open and to talk more freely about HIV/AIDS on the job, which helps reinforce the learning that takes place in employee sessions. Because HIV/AIDS issues can be experienced as awkward and difficult, the locations of the sessions should provide some privacy. People feel safer and are more likely to go deeper into the subject material if they do not feel watched or conspicuous. If the best location is away from the work site, you may need to provide transportation so that they can easily get there.

How are worker sessions coordinated with production needs?

Discussion: This is one of the most important issues to clearly resolve before implementing HIV/AIDS education and prevention activities. Production needs are paramount in any work setting, and the HIV/AIDS education and prevention activities cannot be seen as interfering with them. Different work groups will have different production demands, and one must work around the demands of production in order to appropriately schedule the worker sessions. The supervisors and managers of the production areas involved must be included in determining when sessions can be conducted for their workers. To avoid conflict between production needs and the organization's HIV/AIDS activities, it is important that these supervisors and managers understand the importance and relevance of the HIV/AIDS programs. This is a major reason to include these people in the planning process from the beginning. If these supervisors and managers are not supportive of your worker sessions, it will be very difficult to provide ongoing, sustained HIV/AIDS prevention activities for employees.

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APPENDIX 8
GLOSSARY OF AIDS-RELATED TERMS

Acquired Immunodeficiency Syndrome (AIDS): A condition in which the immune system is damaged or compromised from HIV infection so that it is unable to protect the body from bacteria, germs, viruses, and other threats.

AIDS Related Complex (ARC): ARC is a lesser disease response to infection with HIV. The infected individual develops a few or many of the symptoms of AIDS, such as swollen lymph glands, night sweats, diarrhea, and fatigue, but does not develop one of the life threatening diseases that defines AIDS.

AIDS test: Mostly refers to one of the HIV antibody tests. A laboratory test is done on a small sample of blood to detect the presence or absence of antibodies to HIV. The presence of antibodies indicate that a person has been infected with the virus.

Antibody: A substance formed by the body in response to the presence of a foreign agent or antigen. The antibody is one of the ways in which the body defends itself against the particular antigen.

Asymptomatic carrier: A person who has an infectious disease and can transmit it to another but feels and shows no overt symptoms.

Autoimmunity: An inappropriate response of the immune system in which the body's defense mechanisms turn on themselves.

Azidothymidine (AZT): Also known as zidovudine, retrovir. This drug interferes with one of the HIV enzymes (reverse transcriptase) responsible for replication of the virus. The virus can not multiply as quickly, and so damage by the virus to the immune system is slowed down. This anti-viral drug was first given to patients with AIDS in 1987 and, in some cases, has proven effective in prolonging lives of those who have developed AIDS.

Bisexual: A person who is physically attracted to members of either sex. A sexually active bisexual will engage in sex with a member of either sex.

Carrier: A person who is capable of passing an infection to another person. Carriers may have no outward signs or symptoms of the disease they are carrying.

CD4/CD8 Cells: Another nomenclature for T-Helper (CD4) and T-Suppressor (CD8) cells. See also **Helper/Suppressor T-cells.**

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Centers for Disease Control and Prevention (CDC): A health agency that is a branch of the United States Department of Health and Human Services. The CDC provides health and safety guidelines and statistical data on AIDS and other diseases, primarily for the United States, but with some relevance for developing countries, as well.

Chancroid: A genital ulcer disease that has a strong association with HIV transmission in men and women.

Chlamydia: The common name for sexually transmissible infections caused by *Chlamydia trachomatis*. Among the diseases caused by this bacteria are conjunctivitis and genital infection.

Clinical: Pertaining to the study and treatment of disease in human beings by direct observation, as distinguished from laboratory research.

Co-factor: A situation, activity, or agent that may increase a person's susceptibility to acquiring a disease, such as AIDS. Examples of possible co-factors for AIDS are other infections, drugs and alcohol use, poor nutrition, genetic factors, and stress.

Coitus: One of the terms used for penetrative sexual intercourse.

Combination therapy: The use of two or more modes of treatment—surgery, irradiation, chemotherapy, immunotherapy—in combination, alternative or together, to achieve optimum results against cancer.

Commercial Sex Worker (CSW): Individual that exchanges sexual favors for monetary gain. The term commercial sex worker is used instead of prostitute to counteract the negative connotations applied by many people to prostitution. In some cases, the term also allows for the inclusion of individuals who occasionally provide sexual favors as a means to supplement income but cannot be classified as prostitutes.

Condom social marketing: The use of proven commercial marketing techniques for high efficiency, low-cost delivery of condoms, often through existing marketing networks.

Contagious: Easily transmitted from one person to another—directly or indirectly—by the organism that causes the disease. The AIDS virus is not easily transmitted between or among people; it is only spread during activities that expose individuals to body fluids of another person.

Counseling: The art of helping a person to think through a problem.

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Diagnosis: Identifying a disease by its signs, symptoms, course, and laboratory findings.

ELISA: Acronym for Enzyme-Linked-Immuno-Sorbent Assay. It is one of the tests used to detect antibodies the body generates in response to a number of organisms, including HIV.

Epidemiology: The study of how disease is distributed in population groups, of the factors which influence its distribution and incidence, and of environmental causes and control of the disease population.

False negative HIV test: A test failing to detect antibodies to a particular antigen when the person tested does, in fact, have antibodies. This is very rare indeed. In the case of HIV, a person infected with the virus may test negative because they have not yet developed antibodies, or they are in a late stage of infection when the body no longer develops antibodies.

False positive HIV test: A test indicating the presence of antibodies to a particular antigen when the person tested does not, in fact, have antibodies. In the case of HIV, the rate of false positives is currently quite low—approximately one in every 5,000 tests.

Gay: A term for homosexuals, often preferred by homosexual men and women to avoid the negative connotation to the term homosexual applied primarily by those who disapprove of homosexuality.

Gonorrhea: A sexually transmitted disease that affects the genital mucous membranes. In men, symptoms include pain or burning during urination and a discharge of pus from the penis. Women may have an abnormal vaginal discharge, abnormal menses, or be asymptomatic.

Hemophilia: An inherited condition which mainly affects men. The condition involves a reduced capacity for the blood to clot. Because of the high rate of previous HIV infection, hemophiliacs remain a high risk group for AIDS.

Heterosexual: A person who is sexually attracted to members of the opposite sex, and if they have sex, will do so exclusively with an opposite-sex partner.

High-risk behavior: Behaviors that increase the chances of harm to one's body. High-risk behaviors for infection with HIV include anal or vaginal intercourse without a condom, oral-anal contact, semen or urine in the mouth, and sharing intravenous paraphernalia. Having multiple

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sex partners is considered high-risk behavior. These behaviors are often referred to as "unsafe" activities.

High-risk groups: Those groups in which epidemiologic evidence indicate that there is an increased risk of contracting HIV/AIDS. High-risk groups include gay and bisexual men, IV drug users, hemophiliacs, and the sexual partners of any in these groups. High-risk occupations include commercial sex work or jobs where people work outside of their home areas (e.g., truck drivers, construction workers on remote location).

HIV: Human Immunodeficiency Virus, the virus that can lead to AIDS.

HIV positive: a person diagnosed as having antibodies to HIV and is, therefore, presumed to be infected with HIV.

Homosexual: People who are sexually attracted to members of their own sex and, if they have sex, do so with a partner of the same sex. Otherwise known as gay.

IEC: Information, education, and communication.

Immune deficiency: When a person's immune system cannot satisfactorily protect the body resulting in an increased susceptibility to various infections.

Immune system: The body's defense system against bacteria, viruses, harmful food substances, and some proteins. It includes cells which produce antibodies that can recognize materials as foreign to the body, and then attempt to neutralize them without injury to the body.

Incidence: The number of new cases of a disease such as AIDS, for instance, reported over a specified period of time in a specific, defined population.

Incubation period: The period between infection from a pathogen and observation of the first symptoms. In AIDS, this period can be from a few months to seven years or more.

Infectious: A person is infectious when they have been infected with a pathogen like HIV, and are capable of transmitting that pathogen to another person. A person is considered infectious for life once infected with the HIV virus.

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Intravenous drugs (IV): Drugs injected by needle directly into a vein.

IVDU: Intravenous drug user.

Kaposi's Sarcoma (KS): A rare cancer causing tumors of the walls of the blood vessels. It also affects the linings of the internal organs. It usually appears as pink to purple spots on the skin. It is one of the opportunistic infections common in AIDS. Death occurs from major organ involvement.

Latency: A period when a virus is in the body but rests in an inactive—dormant—state.

Men who have sex with men (MWM): The term defines male homosexuals but does not carry the same negative connotations of homosexual. The term is also used to define men who indulge in same gender sex occasionally, but do not define themselves as homosexuals.

Nongovernmental Organization (NGO): An organization, not associated with government, that works toward socioeconomic development and is not intended to make profit. Financial profits are generally channeled back into activities that do not directly benefit the organization.

Opportunistic infection: Infections caused by organisms to which the body is normally immune. When the immune system is impaired, as in AIDS, opportunistic infections can take hold. These infections include tuberculosis, Kaposi's Sarcoma, Pnuemocystiscrinii, and diarrhea.

Pathogen: A living organism or virus capable of producing disease.

Person With AIDS (PWA): A term developed by individuals diagnosed with AIDS to counteract the more negative "AIDS victim" and the less assertive "AIDS patient." The term was coined by PWAs who did not want to be referred to as AIDS victims or sufferers.

Prevalence: The total number of persons in a given population with a disease at a given point in time, usually expressed in a percentage.

Retrovirus: A class of viruses that contain the genetic material RNA and that have the capability to copy their RNA into the DNA of the cells of an infected person. The AIDS virus, HIV, is a retrovirus.

Sarcoma: A form of cancer that arises in the connective tissue and muscles, such as bone and cartilage.

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HIV Seroconversion: When an individual who is HIV antibody negative becomes antibody positive after exposure to the virus (i.e., blood serum has converted from negative to positive). During this process, the person may suffer an acute illness. In the case of HIV infection, the symptoms may be those of flu and/or swollen glands. Sometimes, no symptoms are observed.

Seropositive: A condition in which antibodies to a particular disease-producing organism are found in the blood. The presence of antibodies indicates that a person has been infected with the organism but does not distinguish between an active infection and a past infection.

Sexually Transmitted Diseases (STDs): Infectious diseases, such as gonorrhea and chlamydia, that are transmitted through sexual intercourse.

Spermicide: Any substance used as a contraceptive for its ability to kill sperm. One spermicide, nonoxynol 9, has been shown to kill the AIDS virus in laboratory tests. It has been used in sexual lubricants and marketed as a method of reducing the risk of AIDS, but its actual effectiveness during sex has not been proven.

Syndrome: A set of signs and symptoms that together suggest specific etiologies (causes of disease).

Syphilis: An STD that is transmitted sexually or perinatally. It is associated with HIV transmission.

Target audience: The desired or intended audience for program messages and materials. The primary target audience consists of those individuals the program is designed to affect. The secondary target audience is a group that can help reach or influence the primary audience.

T-cell: A white blood cell that matures in the thymus gland. Subsets of T-cells have a variety of specialized functions within the immune system.

Therapy: The treatment of disease; an approach to enhancing and maintaining health.

Trichomoniasis: It is a common sexually transmitted disease which causes a vaginal discharge in women and burning during urination in men.

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Vaccine: A substance containing the antigen of an organism which stimulates active immunity and future protection against infection by that organism. New applications of biotechnology may produce different approaches to vaccine development.

Virus: A tiny living parasite which invades cells and alters their chemistry, so that the cells are compelled to produce more virus particles. Viruses cause many diseases, including colds and flu.

Western blot HIV test: A blood test used to detect antibodies to the AIDS virus. Compared to the ELISA test, the Western blot is more detailed and more expensive. It can be used to confirm the results of the ELISA test.

White blood cells: General definition of the cells in the blood that are responsible for fighting infection. There are several types of white blood cells, including T-cells and B-cells.

Window period: The period when a person has been infected with a disease, but has not yet produced antibodies. In HIV infection, this period is usually no longer than three months. A few individuals take longer to produce antibodies.

APPENDIX 9
CALCULATING THE COST OF AIDS TO BUSINESSES

I. Introduction

One of the most important issues management is to consider in making a decision about how to handle HIV/AIDS at the workplace is the financial risk the disease presents to the organization. Managers are likely to want some type of cost-benefit analysis in the process of making this decision. To date, the costs of STDs and HIV/AIDS to businesses and the benefits of prevention have been extremely difficult to estimate.

The precise benefit or value of a prevention program is still difficult to estimate and is likely to vary in relation to the quality and comprehensiveness of the program, and the availability of other programs in the community.

II. Calculating the Impact of AIDS in the Workplace

There are several broad categories of data used in determining the economic impact of HIV/AIDS (and other STDs) in the workplace. Those categories include:

- number of employees and average salaries
- labor turnover
- training
- reduced productivity
- funeral attendance
- absenteeism
- recruitment
- annual health costs
- burial costs/death benefits

In addition, employees can be described in several broad types.

- SecStf - Secretarial or support staff
- ManLab - Manual laborers
- SupMgr - Supervising managers
- TecPro - Technical professionals
- SenMgr - Senior managers

If staff categories are substantially different, the organization can modify the categories as necessary. If a company decides not to use the suggested employee categories, different categories can be used or simply include all employees and use one of the columns as "Total number of employees." Detailed notes on each line item in the form are provided at the end of the spreadsheet.

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IMPACT OF HIV/AIDS SPREADSHEET

		Category of Employee*				
		SecStf	ManLab	SupMgr	TecPro	SenMgr
I. EMPLOYEES/SALARY						
A. Number (#) of employees	[total # in each category of staff in company]	_____	_____	_____	_____	_____
B. Gross weekly salary	[gross weekly salary of all staff in each category]	_____	_____	_____	_____	_____
II. LABOR TURNOVER						
C. # of weeks to hire new employees in each category		_____	_____	_____	_____	_____
D. *Lost labor cost*	**[C*B/A]**	_____	_____	_____	_____	_____
III. TRAINING						
E. Trainer's time in weeks	[# of weeks trainer is training each staff category]	_____	_____	_____	_____	_____
F. Trainer's wage per week	[weekly gross salary of trainer]	_____	_____	_____	_____	_____
G. Class size	[the typical class size for training each staff category]	_____	_____	_____	_____	_____
H. Trainees' time	[# of weeks trainees are in training]	_____	_____	_____	_____	_____
I. Weekly training wage per trainee	[% of gross weekly wage, B, paid to trainee]	_____	_____	_____	_____	_____
J. Training cost per employee	[(E*F)/G]	_____	_____	_____	_____	_____
K. Total salary paid employee during training	[H* I]	_____	_____	_____	_____	_____
L. *Total training cost*	**[J +K]**	_____	_____	_____	_____	_____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

		Category of Employee*				
		SecStf	ManLab	SupMgr	TecPro	SenMgr
IV. REDUCED PRODUCTIVITY						
M.	# of weeks after training before productivity reaches 100%	_____	_____	_____	_____	_____
N.	Productivity immediately after training [% productivity after training]	_____%	_____%	_____%	_____%	_____%
O.	Percentage productivity lost [100-N]	_____	_____	_____	_____	_____
P.	Total wages paid to employee before productivity reaches 100% [M*B/A]	_____	_____	_____	_____	_____
Q.	***Total productivity cost*** **[(.5*O*P)/100]**	_____	_____	_____	_____	_____
V. FUNERAL ATTENDANCE						
R.	Average # of paid leave days a worker takes to attend a co-worker's funeral	_____	_____	_____	_____	_____
S.	Average # of workers who took paid leave to attend *each* co-worker's funeral this year	_____	_____	_____	_____	_____
T.	***Productivity loss per co-worker funeral attended*** **[R/5*S*B/A]**	_____	_____	_____	_____	_____
VI. ABSENTEEISM						
U.	Average # of absent days for employees	_____	_____	_____	_____	_____
V.	AIDS absenteeism [# of days during this year workers with AIDS were absent]	_____	_____	_____	_____	_____
W.	***AIDS cost*** **[B/A*(V-U)/5]**	_____	_____	_____	_____	_____
X.	HIV absenteeism [# of days this year workers with HIV were absent]	_____	_____	_____	_____	_____
Y.	***HIV cost*** **[B/A*(X-U)/5]**	_____	_____	_____	_____	_____
Z.	STD absenteeism [# of days this year workers with STD were absent]	_____	_____	_____	_____	_____
AA.	***STD cost*** **[B/A*(Z-U)/5]**	_____	_____	_____	_____	_____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

IMPACT OF HIV/AIDS SPREADSHEET

			Category of Employee*				
			SecStf	ManLab	SupMgr	TecPro	SenMgr
VII.	**RECRUITMENT**						
AB.	***Recruitment cost*** **[recruitment cost per employee hired in each category]**		____	_____	_____	_____	_____
VIII.	**ANNUAL HEALTH COSTS**						
AC.	Total cost of all employee claims this year		_____	_____	_____	_____	_____
AD.	Total # of employee claims this year		_____	_____	_____	_____	_____
AE.	**Cost per claim this year**	**[AC/AD]**	_____	_____	_____	_____	_____
AF.	Average # of health claims per employee with full-blown AIDS		_____	_____	_____	_____	_____
AG.	Average # of HIV-related claims per employee, prior to full-blown AIDS		_____	_____	_____	_____	_____
AH.	Average # of STD-related claims per employee		_____	_____	_____	_____	_____
AI.	***Health care cost per employee due to AIDS***	**[AE*AF]**	_____	_____	_____	_____	_____
AJ.	***Health care cost per employee due to HIV***	**[AE*AG]**	_____	_____	_____	_____	_____
AK.	***Health care cost per employee due to STD***	**[AE*AH]**	_____	_____	_____	_____	_____
IX.	**BURIAL COSTS/DEATH BENEFITS PER EMPLOYEE**						
AL.	Cost of a coffin (if paid for by organization), plus other death benefits paid to family		_____	_____	_____	_____	_____
AM.	Other costs (not paid to family), excluding lost labor due to funeral attendance		_____	_____	_____	_____	_____
AN.	***Total burial cost***	**[AL+AM]**	_____	_____	_____	_____	_____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

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		Category of Employee*				
		SecStf	ManLab	SupMgr	TecPro	SenMgr
X. HIV/AIDS Rates (may assume the same for each category of employee unless specific information available)						
AO. AIDS prevalence (%)		_____%	_____%	_____%	_____%	_____%
AP. HIV prevalence (%)		_____%	_____%	_____%	_____%	_____%
AQ. STD prevalence (%)		_____%	_____%	_____%	_____%	_____%
AR. AIDS cases	[A*AO/100]	_____	_____	_____	_____	_____
AS. HIV cases	[A*AP/100]	_____	_____	_____	_____	_____
AT. STD cases	[A*AQ/100]	_____	_____	_____	_____	_____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

ANTICIPATED DECREASED REVENUES & INCREASED EXPENDITURES

DECREASED REVENUES

			Category of Employee*				
			SecStf	ManLab	SupMgr	TecPro	SenMgr
AU.	**Organization revenue**	**[revenue for the organization this year]**				_____	
AV.	Labor turnover	[AR*D]	_____	_____	_____	_____	_____
AW.	Training	[AR*L]	_____	_____	_____	_____	_____
AX.	Reduced productivity	[AR*Q]	_____	_____	_____	_____	_____
AY.	Funeral attendance	[AR*T]	_____	_____	_____	_____	_____
AZ.	AIDS absenteeism	[AR*W]	_____	_____	_____	_____	_____
BA.	HIV absenteeism	[AS*Y]	_____	_____	_____	_____	_____
BB.	STD absenteeism	[AT*AA]	_____	_____	_____	_____	_____
BC.	***Decreased revenues in each category***	**[sum of AV through BB]**	_____	_____	_____	_____	_____
BD.	***Summary revenue impact of STD/HIV/AIDS across categories***	**[sum of all categories in BC]**				_____	
BE.	***Total revenue with STD/HIV/AIDS***	**[AU-BD]**				_____	

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*				
			SecStf	ManLab	SupMgr	TecPro	SenMgr
INCREASED EXPENDITURES							
BF.	***Organization expenditures*** **[expenditures incurred by the organization this year as reported]**					_____	
BG.	Recruitment	[AR*AB]	_____	_____	_____	_____	_____
BH.	Health care costs - AIDS	[AR*AJ]	_____	_____	_____	_____	_____
BI.	Health care costs - HIV	[(AS*AI)]	_____	_____	_____	_____	_____
BJ.	Health care costs - STD	[AT+AK]	_____	_____	_____	_____	_____
BK.	Total health care cost	[sum BH to BJ]	_____	_____	_____	_____	_____
BL.	Burial	[AR*AN]	_____	_____	_____	_____	_____
BM.	***Anticipated increased expenditures in each category due to STD/HIV/AIDS***	**[BG+BK+BL]**	_____	_____	_____	_____	_____
BN.	***Summary of anticipated expenditure impact of STD/HIV/AIDS across categories***	**[sum of all categories in BM]**				_____	
BO.	***Total expenditure with STD/HIV/AIDS***	**[BF+BM]**				_____	

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

IMPACT OF HIV/AIDS SPREADSHEET

SUMMARY OF HIV/AIDS IMPACT ON ORGANIZATION

PROJECTED HIV & AIDS CASES

BP.	AIDS cases (this year)	[sum across AR]	_____
BQ.	HIV cases (this year)	[sum across AS]]	_____
BR.	STD cases (this year)	[sum across AT]]	_____

DISTRIBUTION OF COSTS

BS.	Organization profits without AIDS	[AU-BF]	_____
BT.	Organization profits with STD/HIV/AIDS	[BE-BO	_____
BU.	**Decrease in profits as a result of STD/HIV/AIDS**	**[BS-BT]**	_____

DISTRIBUTION OF COSTS

Labor turnover	[sum across AV]	$ _____	[sum across AV*100/BU]	_____%
Training	[sum across AW]	$ _____	[sum across AW*100/BU]	_____%
Reduced productivity	[sum across AX]	$ _____	[sum across AX*100/BU]	_____%
Funeral attendance	[sum across AY]	$ _____	[sum across AY*100/BU]	_____%
AIDS absenteeism	[sum across AZ]	$ _____	[sum across AZ*100/BU]	_____%
HIV absenteeism	[sum across BA]	$ _____	[sum across BA*100/BU]	_____%
STD absenteeism	[sum across BB]	$ _____	[sum across BB*100/BU]	_____%
Recruitment	[sum across BG]	$ _____	[sum across BG*100/BU]	_____%
Health care	[sum across BK]	$ _____	[sum across BK*100/BU]	_____%
Burial	[sum across BL]	$ _____	[sum across BL*100/BU]	_____%

STD/HIV/AIDS impact per employee **$** _____

Technical Notes for Impact Spreadsheet

The letters in the left-hand column correspond to the letters of individual lines found in the spreadsheet. The technical notes describe the data needed for the individual lines and, in some cases, suggest where those data can be obtained.

I. EMPLOYEES/SALARY

A. The number of employees, by each employee category in the organization, obtained from organization records.

B. This number is obtained by dividing the gross wage (including benefits) of all employees in each category by the number of employees in that category.

II. LABOR TURNOVER

Labor turnover is treated as a loss in revenue since the number of weeks it takes to hire employees is a period of lost revenue (this cost may also represent increased expenditures if workers are hired or existing employees must be paid overtime). The cost of training is treated as a decrease in revenue because new employees in training do not contribute to productivity.

C. The number of weeks it takes to hire an employee in each category.

D. This number is obtained by multiplying line item B by line item C.

III. TRAINING

E. The number of weeks a trainer/supervisor spends in training an employee, by each employee category. This is based on how long it takes to train this cadre of employees.

F. The trainer's weekly wage is his/her weekly wage.

G. This number represents the typical class size for trainees in each employee category. If training is predominantly on a one-to-one basis, the average class size should be set to 1.

H. This is the length of time in weeks that new or promoted employees receive training, by each employee category.

I. The gross wage of a trainee per week, in each employee category. It is assumed here that the trainee will be paid a certain percentage of normal weekly gross pay. That percentage is multiplied by the average gross weekly wage. For example, if the average weekly gross wage is X (obtained from line item B), and a trainee is paid 90 percent of that during training, then the pay would be .9*X.

J. This is the training cost per employee, by each employee category. The number is obtained by multiplying E by F and then dividing the product by G (weekly salary paid to trainer divided by number of trainees).

K. This is the total salary paid to employee while in training. This number is obtained by multiplying H by I (weekly training wage per employee by the number of weeks spent in training).

L. This number represents the total cost of training each employee, obtained by adding J to K (training cost per employee added to total salary paid to employee while in training).

IV. REDUCED PRODUCTIVITY

M. Once an employee has been trained, he/she will begin working but at less than 100 percent productivity. The organization will provide information on how long it takes before a trainee reaches 100 percent productivity. If the information is in percentage (e.g. 30 percent of the year), multiply this number by 52 weeks in a year and divide the product by 100 to get the number of weeks the trainee is not yet at full productivity.

N. The organization will provide information on the employee's level of productivity after training.

O. This number represents the percentage productivity lost. It is obtained by subtracting N from 100.

P. Total wages paid to employees before they reach 100 percent productivity. It is assumed that the employee will be paid the same salary as regular employees after training.

Q. The total productivity cost is obtained by multiplying O by 0.5 and by P, and then the product is divided by 100.

Note that O through Q refer to the reduced productivity of new employees who have not reached a level of full proficiency. There is also reduced productivity due to absenteeism, but this is calculated elsewhere: AZ to BB, revenue loss due to HIV and AIDS absenteeism.

V. FUNERAL ATTENDANCE

Funeral attendance is seen as a decrease in revenue, since those who attend take time off to attend a funeral do not contribute to productivity, thus resulting in a reduction in revenue generated by the organization.

R. The organization provides the average number of paid leave days employees in each category take to attend each funeral.

S. This is the average number of workers who took paid leave to attend each co-workers' funeral. The organization provides the number of employees in each employee category.

T. Productivity loss per co-worker funeral attended, obtained by multiplying T by R/5 and by B/A.

VI. ABSENTEEISM

Absenteeism because of STDs and HIV/AIDS is treated as a loss in revenue because absent employees do not contribute to productivity. Once again, depending on how the organization responds to absenteeism, this cost may actually be an increased expenditure rather than lost revenue.

U. Average number of absent days for employees.

V. The organization provides information on the number of days during the year employees with AIDS were absent. If not available, use 65 days.

W. The cost of AIDS absenteeism to the organization, obtained by multiplying the gross weekly wage of each employee category- -i.e. B/A—by (V-U) and then by dividing the result by 5.

X. The organization provides information on the number of days during the year employees with HIV (without full-blown AIDS) were absent. If not available, use 15 days.

Y. This represents the cost of HIV absenteeism to the organization. This figure is obtained by multiplying (B/A) by (V-X) and then by dividing the result by 5.

Z. The organization provides information on the number of days during the year employees with STDs were absent. If not available, use 10 days.

AA. This represents the cost to the organization of absenteeism resulting from STDs. The figure is obtained by multiplying (B/A) by (V-Z), then dividing the result by 5.

VII. RECRUITMENT

AB. The cost the organization incurs in hiring each employee, by each category. Examples include advertising costs, medical exams, transportation reimbursement, etc.

VIII. ANNUAL HEALTH COSTS

AC. The total cost of all health claims by employees in each category, this year. If not available, obtain the total cost of all health claims for all employees in all categories, this year.

AD. The total number of employee health claims made, by each employee category. If not available, obtain the total number of claims made by all employees in all categories, this year.

AE. This number is obtained by dividing AC by AD.

AF. This is the average number of HIV-related claims made by employees during the year.

AG. This is the average number of AIDS-related claims made by employees during the year.

AH. This is the average number of STD-related claims made by employees during the year.

AI. This is the health cost per employee due to HIV, obtained by multiplying AE by AF.

AJ. This is the health cost per employee due to AIDS, obtained by multiplying AE by AG.

AK. This is the health cost per employee due to STDs, obtained by multiplying AE by AH.

IX. BURIAL COSTS/DEATH BENEFITS PER EMPLOYEE

AL. The market price of a coffin this year plus benefits paid to the deceased's family, in cash or kind. If in kind, give cash value equivalent.

AM. The cost of organization representation in funerals this year (excluding lost labor due to funeral attendance). Examples of this include transportation of employees to funerals, flowers, per diem, etc.

AN. This is the total burial cost, obtained by adding AL to AM.

X. HIV/AIDS RATES

(assume the same for each category of employee unless specific information available)

AO. To obtain AIDS prevalence rates (%), use the rates of the city/area/region where the organization is located. If this information is not available, use the national AIDS prevalence rates.

AP. Use the same rule as in AO above to obtained HIV prevalence rates.

AQ. Use the same rule as in AO above to obtain STD prevalence rates.

AR. This number is obtained by multiplying the AIDS prevalence rate, AO, by the number of employees in each employee category, A. For example, if the AIDS prevalence rate is X and the number of employees in the support employee category is Y, the number of new AIDS cases will be obtained by X*Y and divide the result by 100.

AS. This number is obtained by multiplying the HIV prevalence rate, AP, by the number of employees, in each employee category, A then dividing by 100. For example, if the HIV prevalence rate is X and the number of employees in the support employee category is Y, then the new HIV cases is X*Y/100.

AT. This number is obtained by multiplying the STDs prevalence rate, AQ, by the number of employees, in each employee category. For example, if the STDs prevalence rate is X and the number of employees in the support employee category is Y, then the new STDs cases in this category will be X*Y/100.

ANTICIPATED DECREASED REVENUES AND INCREASED EXPENDITURES

AU. The organization will provide the revenue figure for the year.

AV. To calculate decreased revenues due to labor turnover, multiply D by AR.

AW. To calculate decreased revenues due to training, multiply L by AR.

AX. To calculate decreased revenue due to productivity loss, multiply Q by AR.

AY. To calculate decreased revenue due to funeral attendance, multiply U by AR.

AZ. To calculate decreased revenue due to AIDS absenteeism, multiply W by AR.

BA. To calculate decreased revenue due to HIV absenteeism, multiply Y by AS.

BB. To calculate decreased revenue due to STDs absenteeism, multiply AA by AT.

Where the epidemic has hit some categories of workers expecially hard, some companies have resorted to double hiring in anticipation of higher labor turnover due to AIDS. Thus, the values in AV through BA will increase to reflect these costs.

BC. To get total decreased revenue due to HIV/AIDS, add AV through BB.

BD. To get total decreased revenue across all categories, add BC across all employee categories.

BE. To get total revenue in the presence of STDs, HIV and AIDS, calculate the difference between AU and BD.

BF. The organization will provide the expenditure figure for the year.

BG. To calculate the increased expenditure for recruitment due to AIDS, multiply AB by AR.

BH. To calculate increased expenditures due to AIDS, multiply AJ by AR.

BI. To calculate increased expenditures due to HIV, multiply AI by AS.

BJ. To calculate increased expenditures due to STDs, multiply AK by AT.

BK. To calculate the total health care cost, add BH to BJ.

BL. To calculate the increased expenditure due to burial, multiply AN by AR.

BM. To calculate increased expenditures due to HIV/AIDS/STDs in each category, add BG, BH, and BI.

BN. The summary of anticipated expenditure due to HIV/AIDS/STDs is obtained by adding BM across all employee categories.

BO. Total expenditure in the presence of HIV/AIDS/STDs is the sum of BF and BN.

BP. To get the total number of new AIDS cases in the organization this year, add AR across all employee categories.

BQ. Total number of new HIV cases in the organization this year is obtained by adding AS across all employee categories.

BR. To get the total number of new STDs cases in the organization this year, add AT across all employee categories.

BS. To calculate profits under the no-AIDS scenario, substract the difference between AU and BF.

BT. To calculate profits under the AIDS scenario, substract the difference between BE and BL.

BU. To calculate the decrease in profits due to AIDS, substract the difference between BP and BQ.

III. ILLUSTRATIVE EXAMPLE OF IMPACT SPREADSHEET

DETERMINING THE FINANCIAL IMPACT OF HIV/AIDS ON A WORKPLACE:
An Example from a Kenya Company
(cost figures in US$)

		Category of Employee*					
		SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
I.	**EMPLOYEES/SALARY**						
A.	Number (#) of employees [total # in each category of staff in the organization]	1,008	44	28	5	5	1,090
B.	Gross weekly salary [gross weekly salary of all staff in each category]	31,752	660	1,638	750	3,125	37,925
II.	**LABOR TURNOVER**						
C.	# of weeks to hire an employees in each category	1	1	9	9	9	29
D.	***Lost labor cost*** **[C*B/A]**	32	135	527	1,350	18,125	20,168
III.	**TRAINING**						
E.	Trainers' time in weeks [# of weeks trainer is training in each staff category]	7	2	2	2	4	17
F.	Trainers' wage per week [weekly gross salary of trainers]	32	15	59	150	625	880
G.	Class size [the typical class size for training in each category]	10	3	3	1	1	18
H.	Trainees' time [# of weeks trainees are in training]	7	2	2	2	4	17

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

IMPACT OF HIV/AIDS SPREADSHEET

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
I.	Weekly training wage per trainee [% of gross weekly wage, B, paid to trainee]		29	14	53	137	569	801
J.	Trainer cost per employee	[(E*F)/G]	22	10	39	300	2,500	2,871
K.	Total salary paid employee during training	[H*I]	201	27	106	273	2,275	2,882
L.	Total training cost	[J+K]	223	37	145	573	4,775	5,753
IV.	**REDUCED PRODUCTIVITY**							
M.	# of weeks after training before productivity reaches 100%		19	2	13	13	13	60
N.	Productivity immediately after training [% productivity immediately after training]		80.0	80.0	80.0	80.0	80.0	
O.	Percentage productivity lost	[100-N]	20.0	20.0	20.0	20.0	20.0	
P.	Total wages paid to the employee before productivity reaches 100%	[M*B/A]	599	30	761	1,950	8,125	11,464
Q.	***Total productivity cost***	**[(.5*O*P)/100]**	60	3	76	195	813	1,146
V.	**FUNERAL ATTENDANCE**							
R.	Average # of paid leave days a worker takes to attend a co-worker's funeral		3	3	3	3	3	15
S.	Average # of workers who took paid leave to attend each co-worker's funeral this year		20	5	3	2	1	31
T.	***Productivity loss per co-worker funeral attended***		378	45	105	180	375	1,083

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

		Category of Employee*					
		SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
VI.	**ABSENTEEISM**						
U.	Average # of absent days for employees	10	10	10	10	10	50
V.	AIDS absenteeism [# of days during this year workers with AIDS were absent]	75	75	75	75	75	375
W.	***AIDS cost*** **[B/A*(V-U)/5]**	410	195	761	1,950	8,125	11,440
X.	HIV absenteeism [# of days this year workers with HIV were absent]	25	25	25	25	25	125
Y.	***HIV cost*** **[B/A*(X-U)/5]**	95	45	176	450	1,875	2,640
Z.	STD absenteeism [#of days this year workers with STDs were absent]	20	20	20	20	20	100
AA.	***STD cost*** **[B/A*(Z-U)/5]**	63	30	117	300	1,250	1,760
VII.	**RECRUITMENT**						
AB.	***Recruitment cost*** [recruitment cost per employee hired in each category]	80	80	200	200	200	760
VIII.	**ANNUAL HEALTH COSTS**						
AC.	Total cost of all employee claims this year	3,000	3,000	2,000	2,000	2,000	12,000
AD.	Total # of employee claims this year	463	463	45	45	45	1,061
AE.	***Cost per claim this year*** **[AC/AD]**	6	6	44	44	44	146
AF.	Average # of health claims per employee with full-blown AIDS	4	4	4	4	4	20

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

IMPACT OF HIV/AIDS SPREADSHEET

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
AG.	Average # of HIV-related claims per employee, prior to full-blown AID		3	3	3	3	3	15
AH.	Average # of STD-related claims per employee		2	2	2	2	2	10
AI.	***Health care cost per employee due to AIDS***	**[AE*AF]**	26	26	178	178	178	585
AJ.	***Health care cost per employee due to HIV***	**[AE*AG]**	19	19	133	133	133	439
AK.	***Health care cost per employee due to STD***	**[AE*AH]**	13	13	89	89	89	293

IX. BURIAL COSTS/DEATH BENEFITS PER EMPLOYEE

AL.	Cost of a coffin (if paid for by organization) plus other death benefits paid to family		100	100	100	100	100	500
AM.	Other costs (not paid to family), excluding lost labor due to funeral attendance		20	20	20	20	20	100
AN.	***Total burial cost***	**[AL+AM]**	120	120	120	120	120	600

X. HIV/AIDS rates (may assume the same for each category of employee unless specific information available)

AO.	AIDS Prevalence (%)		1.20	1.17	1.17	1.17	1.17	5.88
AP.	HIV prevalence (%)		14.00	14.00	14.00	14.00	14.00	70.00
AQ.	STD prevalence (%)		10.00	10.00	10.00	10.00	10.00	50.00
AR.	AIDS cases	[A*AO/100]	12	1	0	0	0	13
AS.	HIV cases	[A*AP/100]	141	6	4	1	1	153
AT.	STD cases	[A*AQ/100]	101	4	3	1	1	109

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* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total

ANTICIPATED DECREASED REVENUES & INCREASED EXPENDITURES

DECREASED REVENUES

AU.	**Organization revenue without AIDS [revenue for this year as given by organization]**							6,219,713
AV.	Labor turnover	[AR*D]	381	69	172	79	1,060	1,762
AW.	Training	[AR*L]	2,694	19	48	34	279	3,074
AX.	Reduced productivity	[AR*Q]	724	2	25	11	48	809
AY.	Funeral attendance	[AR*T]	4,572	23	34	11	22	4,662
AZ.	AIDS absenteeism	[AR*W]	4,953	100	249	114	475	5,892
BA.	HIV absenteeism	[AS*Y]	13,336	277	688	315	1,313	15,929
BB.	STD absenteeism	[AT*AA]	6,350	132	328	150	625	7,585
BC.	***Decreased revenues in each category*** **[sum of AV through BB]**		33,011	623	1,544	714	3,822	39,713
BD.	***Summary revenue impact of STD/HIV/AIDS across categories***	**[sum of all categories in BC]**	39,713					
BE.	***Total revenue with STD/HIV/AIDS***	**[AU-BD]**	6,180,000					

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

IMPACT OF HIV/AIDS SPREADSHEET

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
INCREASED EXPENDITURES								
BF.	***Organization expenditures without AIDS*** **[expenditures incurred by organization this year as reported]**							5,261,656
BG.	Recruitment	[AR*AB]	968	41	66	12	12	1,098
BH.	Health care costs - AIDS	[AR*AI]	314	13	58	10	10	406
BI.	Health care costs - HIV	[AS*AU]	2,743	120	523	93	93	3,572
BJ.	Health care costs - STD	[AT*AK]	1,306	57	249	44	44	1,701
BK.	Total health care costs	[Sum BH to BJ]	4,363	190	830	148	148	5,679
BL.	Burial	[AR*AN]	1,452	62	39	7	7	1,567
BM.	***Anticipated increased expenditures in each category due to STD/HIV/AIDS***	**[BG+BK+BL]**	6,782	293	935	167	167	8,344
BN.	***Summary of anticipated expenditure impact of STD/HIV/AIDS across categories***	**[sum of all categories in BM]**						8,344
BO.	***Total expenditures with STD/HIV/AIDS***	**[BF+BN]**						5,270,000

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* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

B

	Category of Employee*					
	SecStf	ManLab	SupMgr	TecPro	SenMgr	Total

SUMMARY OF ESTIMATED STD/HIV/AIDS IMPACT ON THE ORGANIZATION

PROJECTED HIV & AIDS CASES

BP.	AIDS cases (this year)	[sum across AR]	13
BQ.	HIV cases (this year)	[sum across AS]	153
BR.	STD cases (this year)	[sum across AT]	109

DISTRIBUTION OF COSTS

BT.	Organization profits without STD/HIV/AIDS	[AU-BF]	958,057
BS.	Organization profits with STD/HIV/AIDS	[BE-BO]	910,000
BU.	**Decrease in profits as a result of STD/HIV/AIDS**	**[BS-BT]**	48,057

	Amount		Percentage	
Labor turnover	1,762	[sum across AV]	3.67%	[sum across AV*100/BU]
Training	3,074	[sum across AW]	6.40%	[sum across AW*100/BU]
Reduced productivity	809	[sum across AX]	1.68%	[sum across AW*100/BU]
Funeral attendance	4,662	[sum across AY]	9.70%	[sum across AY*100/BU]
AIDS absenteeism	5,892	[sum across AZ]	12.26%	[sum across AZ*100/BU]
HIV absenteeism	15,929	[sum across BA]	33.15%	[sum across BA*100/BU]
STD asbsenteeism	7,585	[sum across BB]	15.78%	[sum across BB*100/BU]
Recruitment	1,098	[sum across BG]	2.28%	[sum across BG*100/BU]
Health care	5,679	[sum across BH]	11.82%	[sum across BG*100/BU]
Burial	1,567	[sum across BI]	3.26%	[sum across BI*100/BU]
STD/HIV/AIDS cost per employee	**44**			

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

Projected Financial Impact of HIV/AIDS on the Organization in the Year 2005 (Summary)

Projected HIV/AIDS and STDs

AIDS cases	33
HIV cases	262
STD cases	218

Distribution of Costs

Organization profits without HIV/AIDS/STDs	958,057
Organization profits with HIV/AIDS/STDs	787,066
Decrease in profits due to HIV/AIDS/STDs	170,991

	Amount	Percent
Labor turnover	953	0.56%
Training	6,735	3.94%
Reduced productivity	1,810	1.06%
Funeral attendance	11,431	6.68%
AIDS absenteeism	99,066	57.94%
HIV absenteeism	22,861	13.37%
STD absenteeism	12,700	7.43%
Recruitment	2,753	1.61%
Health care	8,758	5.12%
Burial	3,924	2.29%
Cost per employee	**157**	

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APPENDIX 10
CALCULATING THE COST OF A PREVENTION PROGRAM

The spreadsheet within this Appendix can be used to calculate the cost to an organization of establishing or expanding a HIV/AIDS prevention program in the workplace. Detailed notes on each line item in the form are provided at the end. In some cases, information asked for may not be readily available. The column "Formula or suggested figure" offers a generic, but reasonable, estimate to replace specific data. Of course, users can substitute other estimates or actual numbers.

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	Formula or suggested figure	Data	Total
I. FORMAL EDUCATION			
Employee Leave Time (If break or other unpaid times used, skip to E, below):			
A. Average (avg.) hourly employee wage		_____	
B. Total number of employees		_____	
C. Average number of hours per month of formal HIV/AIDS prevention education	[1 hour]	_____	
D. Total annual cost of leave time to attend formal education	[A*B*C*12]		_____
Educators' Time:			
E. Average educator hourly wage		_____	
F. Average number of hours per month each educator devotes to formal education	[4 hours]	_____	
G. Number of paid educators	[1 or 2]	_____	
H. Total annual cost of educators' time	[E*F*G*12]		_____
Materials Used for Formal Education:			
I. Average monthly cost per employee	[US$0.10 per employee]	_____	
J. Total annual cost of materials used for formal education	[I*B*12]		_____

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	Formula or suggested figure	Data	Total
II. INFORMAL EDUCATION			
Peer Educators' time:			
K. Average peer educator hourly wage		_____	
L. Average number of hours per month each peer educator spends on education	[20 hours per month]	_____	
M. Average number of hours per year each peer educator spends on education	[L*12]	_____	
N. Number of peer educators for every 100 employees	[2 per 100 employees]	_____	
O. Total number of peer educators in the organization	[N*B/100; round off]	_____	
P. Total annual cost of peer educators' time	[K*M*O]		_____
Materials Used for Informal Education:			
Q. Average monthly cost of informal education materials per employee	[US$0.10 per employee]	_____	
R. Total annual cost of materials used for informal education	[Q*B*12]		_____
III. CONDOM DISTRIBUTION			
Distribution Management:			
S. Distributor's hourly wage		_____	
T. Number of hours per month spent per 100 employees on condom mgmt	[1 hour]	_____	
U. Number of hours per month spent on all employees for condom mgmt	[T*B/100]	_____	
V. Total annual cost of condom distribution mgmt	[S*U*12]		_____

	Formula or suggested figure	Data	Total
Condoms:			
W. Unit cost per condom purchased by organization	[US$0.05-0.10]	_____	
X. Price charged per condom sold to employee	[US$0.05-0.10]	(_____)	
Y. Net cost per condom to organization	[W-X]	_____	
Z. Average number of condoms per employee per week	[3 per week]	_____	
AA. Average number of condoms per employee per year	[Z*52]	_____	
AB. Total annual cost of condom procurement	[Y*AA*B]		_____

IV. STD DIAGNOSIS AND TREATMENT

Clinician time (if no additional clinician time charged, skip to line AI, below):

AC. Clinician hourly wage		_____	
AD. Annual average STD prevalence rate (in percent)		_____%	
AE. Annual average STD prevalence (in decimal value)	[AD/100]	.____	
AF. Total number of employees with STDs	[AE*B]	_____	
AG. Number of hours providing diagnosis and treatment per STD client	[.75 hour]	_____	
AH. Total annual cost of clinician time for STD diagnosis and treatment	[AC*AF*AG]		_____

Employee Leave Time (if break or other unpaid time used, skip to line AJ, below):

AI. Total annual cost of employee leave time for STD diagnosis and treatment	[A*AF*AG]		_____

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	Formula or suggested figure	Data	Total
STD Drugs (for employee and wife/regular sexual partner):			
AJ. Average drug costs for entire STD treatment	[US$8?]	_____	
AK. Total number of employees and partners receiving STD treatment	[AF*2]	_____	
AL. Total annual cost of STD drugs	[AJ*AK]		_____

V. COUNSELING/SUPPORT SERVICES

AM. Counselor hourly wage		_____	
AN. Total Average number of hours counselor works with each HIV+ employee and family annually	[12 hours]	_____	
AO. Annual Average HIV prevalence rate (in percent)		_____%	
AP. Annual Average HIV prevalence (in decimal value)	[AO/100]	_____	
AQ. Total number of employees with HIV infection	[AP*B]	_____	
AR. Total annual cost of counseling/support services	[AM*AN*AQ]		_____

Recurrent Operating Expenses

AS. Annual Total Organization Cost:	[add all figures in Total column]	_____
AT. Annual Organization Cost Per Employee:	[AS/B]	_____
AU. Average Monthly Total Organization Cost:	[AS/12]	_____
AV. Average Monthly Organization Cost Per Employee:	[AT/12]	_____

	Formula or suggested figure	Data	Total
First Year Start-up Costs			
Condom Distribution (if not using condom machines, skip to line AZ, below):			
AW. Cost of condom dispensing machines	[US$500 each]	_____	
AX. number of machines	[1/4-1/2 of all bathrooms]	_____	
AY. Total cost of machines	[AW*AX]		_____
Clinician STD Training:			
AZ. Clinician 2-day STD Training Workshop	[US$500]		_____
Peer Educator Training:			
BA. 5-day training workshop cost per peer educator	[US$200]	_____	
BB. Total cost of a peer educator training workshop	[BA*O]		_____
Miscellaneous Other Materials, Equipment:			
BC. Unit cost per employee	[US$1]	_____	
BD. Total cost of miscellaneous materials	[BC*B]		_____
Total First Year Start-up Costs			
BE. Total Organization First Year Start-up Costs:	[add Totals, AY+AZ+BB+BD]		_____
BF. Total First Year Start-up Costs Per Employee:	[BE/B]		_____

	Formula or suggested figure	Data	Total
Grand Total Program Cost			
BG. Total Program Cost in First Year (Start-up+Recurrent)	[AS+BE]		_____
BH. Total Program Cost in First Year Per Employee	[BG/B]		_____

Technical Notes for Prevention Program Spreadsheet:

The letters in the lefthand column refer to the corresponding lines on the spreadsheet.

Formal Education

Formal education refers to time employees spend in lectures, workshops and other structured HIV/AIDS education sessions. If company-paid lunch time or other break times are used to conduct these sessions, there will be no lost labor time and the wage cost will be zero.

A. The average hourly wage can be calculated by dividing the total daily wage by the total number of hours worked by all employees.

B. The total number of employees in the organization.

C. It is estimated that, on average, employees spend an average of one hour per month in formal HIV/AIDS prevention education sessions.

D. If paid leave time is used to conduct employee HIV/AIDS education sessions, the annual cost of this labor can be calculated by multiplying the average hourly wage, the number of employees, and the number of hours used on average for these sessions each month by the number of months in a year.

E. If the organization pays educators to conduct prevention education activities, enter the average hourly wage they receive.

F. The number of hours per month each educator is paid to conduct prevention activities. An estimate of 4 hours per month is suggested.

G. It is likely that 1 or 2 educators would be retained by a large organization.

H. The annual cost of the educators' labor is calculated by multiplying their average hourly wage, the number of hours they work on these activities each month, and the number of educators, by the number of months in a year.

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I. This refers to the average cost of materials used for formal education on a per-employee basis. An estimate of the equivalent of US$0.10 is offered here. Examples of materials include posters, brochures, handouts, and demonstration equipment.

J. The annual cost of materials used for formal education is calculated by multiplying the average monthly cost per employee and the total number of employees by the number of months in a year.

Informal Education

Informal education refers to HIV/AIDS education provided in an inter-personal or casual manner; no formalized curriculum is used. Peer educators often deliver information informally. Employee time receiving peer education is not costed in this model because this form of education is usually done during breaks or other unpaid time.

K. Average hourly wage of peer educators.

L. It is suggested that each peer educator will devote an average of 5 hours per week (or 20 hours per month) to informal education activities.

M. Average number of hours per year spent on informal education. This number is obtained by multiplying L by 52.

N. This is the number of peer educators for every 100 employees. Though the number can vary, a suggested minimum number of peer educators for every 100 employees is 2.

O. The total number of peer educators for the organization is calculated by multiplying the number of peer educators for every 100 employees (N) and the total number of employees (B), and dividing by 100. Round up fractions to the nearest whole number.

P. The total annual cost for providing peer educators is calculated by multiplying the average hourly wage of peer educators (K) and the average number of hours peer educators work annually on prevention activities (M) by the total number of peer educators in the organization (O).

Q. This refers to materials to be used by educators in the provision of informal HIV/AIDS education. An estimate of the equivalent of US$0.10 per employee per month is suggested. Enter the chosen per employee cost estimate in the form (e.g., US$0.10).

R. The annual cost of informal education materials is calculated by multiplying the average monthly cost per employee (Q) and the total number of employees (B) by the number of months in a year.

Condom Distribution

This section reflects the cost of providing condoms to employees. Condom distribution management is the labor cost of overseeing the procurement and distribution system for condoms.

S. This is the hourly wage of distributors. Peer educators can be used as distributors.

T. It is estimated here that for every 100 employees, 2 hours per month would be needed to manage the distribution program (e.g., stocking condom dispensers, socially marketing condoms, etc.).

U. To calculate the total number of hours per month spent on condom distribution, multiply the number of hours per 100 employees (T) and the total number of employees (B), then divide by 100.

V. To calculate the annual labor cost of condom distribution, multiply the distributor's hourly wage (S) and the number of hours per month on condom distribution (U) by the number of months in a year.

W. The cost per condom the organization pays to procure condoms. The equivalent of US$0.05-0.10 is a reasonable estimate of the cost to purchase condoms in quantity.

X. If the organization sells condoms to employees, enter the average price charged per condom.

Y. The net cost to the organization per condom is calculated by subtracting the unit cost by the unit price charged.

Z. If no figures are available, a reasonable estimate of the average number of condoms obtained by employees is 3 per week.

AA. The total number of condoms per employee per year is calculated by multiplying the weekly total (Z) by the number of weeks in a year.

AB. To calculate the annual cost of condoms to the organization, multiply the net cost per condom (Y) and the average number of condoms demanded by each employee annually (AA) by the total number of employees (B).

STD Diagnosis and Treatment

The calculation in this section will yield the total cost for diagnosing and treating STDs. Treatment should be available to both employees and their partners, as STDs cannot be effectively eliminated unless both partners are treated.

AC. If clinician's time is already accounted for and the organization does not have to increase the total number of hours paid to medical staff for STD services, skip to AL. If treatment of STDs raises clinician wage costs to the organization, enter the average hourly wage of clinicians.

AD. Organization or community medical clinics can usually provide an average annual STD prevalence rate. If no rates are available, 5 percent is a conservative estimate.

AE. Convert the STD prevalence rate (in %) to proportion (decimal value) by dividing AD by 100.

AF. The total annual number of employees with STDs is calculated by multiplying the proportional STD prevalence rate (AE) by the total number of employees (B).

AG. An estimate of three-quarters of an hour of clinician time per STD episode for medical diagnosis and treatment time is suggested here. This includes clinician time spent for treatment of employees and, when applicable, their partners.

AH. The total annual cost of clinician time for STD diagnosis and treatment is obtained by multiplying the clinician hourly wage (AC) and the total number of employees with STDs (AF) by the total number of hours spent per STD episode (AG).

AI. If employees use unpaid time to seek medical assistance, such as breaks or after working hours, skip to AJ, since there is then no organization employee wage cost for STD diagnosis and treatment.

AJ. The cost of STD drugs for each employee and his or her partner. If no estimate of average drug cost is available, the equivalent of US$8 is a reasonable estimate.

AK. The total number of employees and partners receiving STD treatment is calculated by multiplying the estimated number of employees with STDs (AG) by two.

AL. The total annual cost of STD drugs is calculated by multiplying the average drugs cost for the entire STD treatment (AJ) by the number of employees and partners receiving treatment (AK).

Counseling and Support Services

This section accounts for the cost of providing counseling and support services to HIV-positive employees.

AM. Average hourly wage of counselors. If no estimate is available, counselor wages would likely be similar to those of a clinician.

AN. A rough estimate of counseling and support services to HIV-positive employees and their families is 12 hours annually.

AO. National or community HIV prevalence rates may be used here to estimate the number of HIV-positive employees. The exact HIV prevalence rate is unlikely to be known in the organization because mandatory HIV testing is not recommended.

AP. Convert the HIV prevalence rate (in %) to proportion (decimal value) by dividing AO by 100.

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AQ. The total number of employees with HIV infection is calculated by multiplying the HIV prevalence rate (AP) by the total number of employees (B).

AR. The total annual cost of counseling and support services is calculated by multiplying AM and AN by AQ.

Recurrent Operating Expenses

The recurrent operating expenses reflect the total annual operating cost to the organization of providing HIV/AIDS prevention services to employees. These figures do not include initial start-up costs for investments in equipment and training.

AS. The annual total organization cost is calculated by adding all of the figures in the Total column.

AT. The annual organization cost per employee is calculated by dividing the total organization cost (AS) by the total number of employees (B).

AU. To calculate the average monthly expense of operating the program, divide the annual total by 12 months.

AV. To calculate the average monthly expense per employee, divide the monthly average (BB) by the number of employees.

First-year start-up cost of the program.

AW. This reflects the capital cost of any condom dispensing machines installed. The average cost of a high-quality condom dispensing machine is approximately US$500. If condom machine costs are prohibitive, other less expensive distribution methods may be used. For example, the organization canteen and/or peer educators could distribute condoms.

AX. It is recommended that at least one quarter to one half of male and female restrooms have dispensers. Enter the number of bathrooms that will have condom dispensing machines.

AY. The total cost of condom dispensing machines is calculated by multiplying AW by AX.

AZ. This is the cost of clinician STD training. To obtain the total cost of training clinicians for 2 days, add the salaries, cost of training equipment, etc. A rough estimate of the total cost of running a 2-day program for a small group of clinicians is the equivalent of US$500.

BA. An initial 5-day training workshop is suggested for all peer educators. A rough estimate of the cost per peer educator for a 5-day workshop is US$200.

BB. The total cost of the peer educator training workshop is calculated by multipying BA by the number of peer educators (O).

BC. Other initial handout materials, posters, equipment, etc., needed to start an HIV/AIDS program. A cost of US$1 per employee is suggested here.

BD. The total cost of miscellaneous materials is calculated by multiplying BC by B.

BE. The total estimated first year start-up cost is calculated by adding the figures in the total column from lines AY through BD.

Grand Total Program Cost

BG. The grand total HIV/AIDS program cost for the first year is the sum of the recurrent and first year start-up costs. It is calculated by adding AS and BF.

BH. The grand total HIV/AIDS program cost for the first year on a per-employee basis is calculated by dividing the grand total cost (BG) by the number of employees (B).

DETERMINING THE COST OF A WORKPLACE HIV/AIDS PREVENTION PROGRAM:

An Example of a Kenyan Business

(figures in US$)

		Formula or suggested figure	Data	Total
I.	**FORMAL EDUCATION**			
Employee Leave Time [if break or other unpaid time used, fill in A and B, then skip to E.]:				
A.	Average hourly employee wage		0.95	
B.	Total number (#) of employees		1,090	
C.	Average # of hours per month of formal HIV/AIDS prevention education	[1 hour]	0	
D.	Total annual cost of leave time to attend formal education	[A*B*C*12]		0.00
Educators' Time:				
E.	Average educator hourly wage		1.40	
F.	Average # of hours per month each educator devotes to formal education	[4 hours]	4	
G.	# of paid educators	[1 or 2]	2	
H.	Total annual cost of educators' time	[E*F*G*12]		134.40
Materials used for Formal Education:				
I.	Average monthly cost per employee	[US$0.10 per employee]	0.10	
J.	Total annual cost of materials used for education	[I*B*12]		1308.00

		Formula or suggested figure	Data	Total
II.	**INFORMAL EDUCATION**			
Peer Educators' Time				
K.	Average peer educator hourly wage		0.95	
L.	Average # of hours per month each peer educators spends on education	[20 hours per month]	20	
M.	Average # of hours per year each peer educators spends on education	[L*12]	240	
N.	# of peer educators for every 100 employees	[2 per 100 employees]	2	
O.	Total # of peer educators in the organization	[N*B/100; round to whole #]	22	
P.	Total annual cost of peer educators' time	[K*M*O]		5016.00
Materials used for Informal Education				
Q.	Average monthly cost of informal education materials per employee	[US$0.10 per employee]	0.10	
R.	Total annual cost of materials used for informal education	[Q*B*12]		1308.00
III.	**CONDOM DISTRIBUTION**			
Distribution Management (mgmt)				
S.	Distributors' hourly wage	[same as peer educator]	0.95	
T.	# of hours per month spent per 100 employees on condom mgmt	[1 hour]	1	
U.	# of hours per month spent on all employees for condom mgmt	[T*B/100]	10.9	
V.	Total annual cost of condom distribution mgmt	[S*U*12]		124.26

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		Formula or suggested figure	Data	Total
Condoms:				
W.	Unit cost per condom purchased by organization	[US$0.05-0.10]	0.08	
X.	Price charged per condom sold to employee	[US$0.00-0.10]	0.05	
Y.	Net cost per condom to organization	[W-X]	0.03	
Z.	Average # of condoms per employee per week	[3 per week]	3	
AA.	Average # of condoms per employee per week	[Z*52]	156	
AB.	Total annual cost of condom procurement	[Y*AA*B]		5101.20

IV. STD DIAGNOSIS AND TREATMENT

Clinician time [if no additional clinician time charged, skip to AI]:

AC.	Clinician hourly wage		3.00	
AD.	Annual average STD prevalence rate (in percent)		10	
AE.	Annual average STD prevalence (in decimal value)	[AD/100]	0.1	
AF.	Total # of employees with STDs	[AE*B]	109	
AG.	# of hours providing diagnosis and treatment per STD client	[.75 hours]	0.75	
AH.	Total annual cost of clinician time for STD diagnosis and treatment	[AC*AF*AG]	245.25	

Employee Leave Time [if break or other unpaid time used, skip to AJ]:

AI.	Total annual cost of employee leave time for STD diagnosis and treatment	[A*AF*AG]		77.66

		Formula or suggested figure	Data	Total
STD Drugs [for employee and partner]:				
AJ.	Average drug cost for entire STD treatment	[US$8]	8.00	
AK.	Total # of employees and partners receiving STD treatment	[AF*2]	218	
AL.	Total annual cost of STD drugs	[AJ*AK]		1744.00
V.	**COUNSELING/SUPPORT SERVICES**			
AM.	Counselor hourly wage		2.00	
AN.	Average # of hours annually HIV+ employee and family counseled	[12 hours]	10	
AO.	Annual average HIV prevalence rate (in percent)		14	
AP.	Annual average HIV prevalence (in decimal value)	[AO/100]	0.14	
AQ.	Total # of employees with HIV infection	[AP*B]	152.6	
AR.	Total annual cost of counseling/support services	[AM*AN*AQ]		3052.00
RECURRENT OPERATING EXPENSES				
AS.	Annual Total Organization Cost:	[Sum all figures in Total column]		18110.77
AT.	Annual Organization Cost Per Employee:	[AS/B]		16.62
AU.	Average Monthly Total Organization Cost:	[AS/12]		1509.23
AV.	Average Monthly Organization Cost Per Employee:	[AT/12]		1.38

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FIRST YEAR START-UP COSTS

		Formula or suggested figure	Data	Total
Condom Distribution [If not using condom machines, skip to AZ]:				
AW.	Cost of condom dispensing machines	[US$500 each]	500.00	
AX.	# of machines	[1/4 - 1/2 of all bathrooms]	4	
AY.	Total cost of machines	[AW*AX]		2000.00
Clinician STD Training:				
AZ.	Clinician 2-day STD Training Workshop	[US$500]		500.00
Peer Educator Training:				
BA.	5-day training workshop cost per peer educator	[US$200]	200.00	
BB.	Total cost of peer educator training workshop	[BA*O]		4400.00
Miscellaneous Other Materials, Equipment, Etc.:				
BC.	Unit cost per employee	[US$1]	1.00	
BD.	Total cost of miscellaneous materials	[BC*B]		1090.00

		Formula or suggested figure	Data	Total
TOTAL FIRST YEAR START-UP COSTS				
BE.	Total Organization First Year Start-up Costs:	[Sum totals, AY+AZ+BB+BD]		7990.00
BF.	Total First Year Start-up Costs Per Employee:	[BE/B]	7.33	
GRAND TOTAL PROGRAM COST				
BG.	Total Program Cost in First Year (Start-up+Recurrent)	[AS+BE]		26100.77
BH.	Total Program Cost in First Year Per Employee	[BG/B]		23.95

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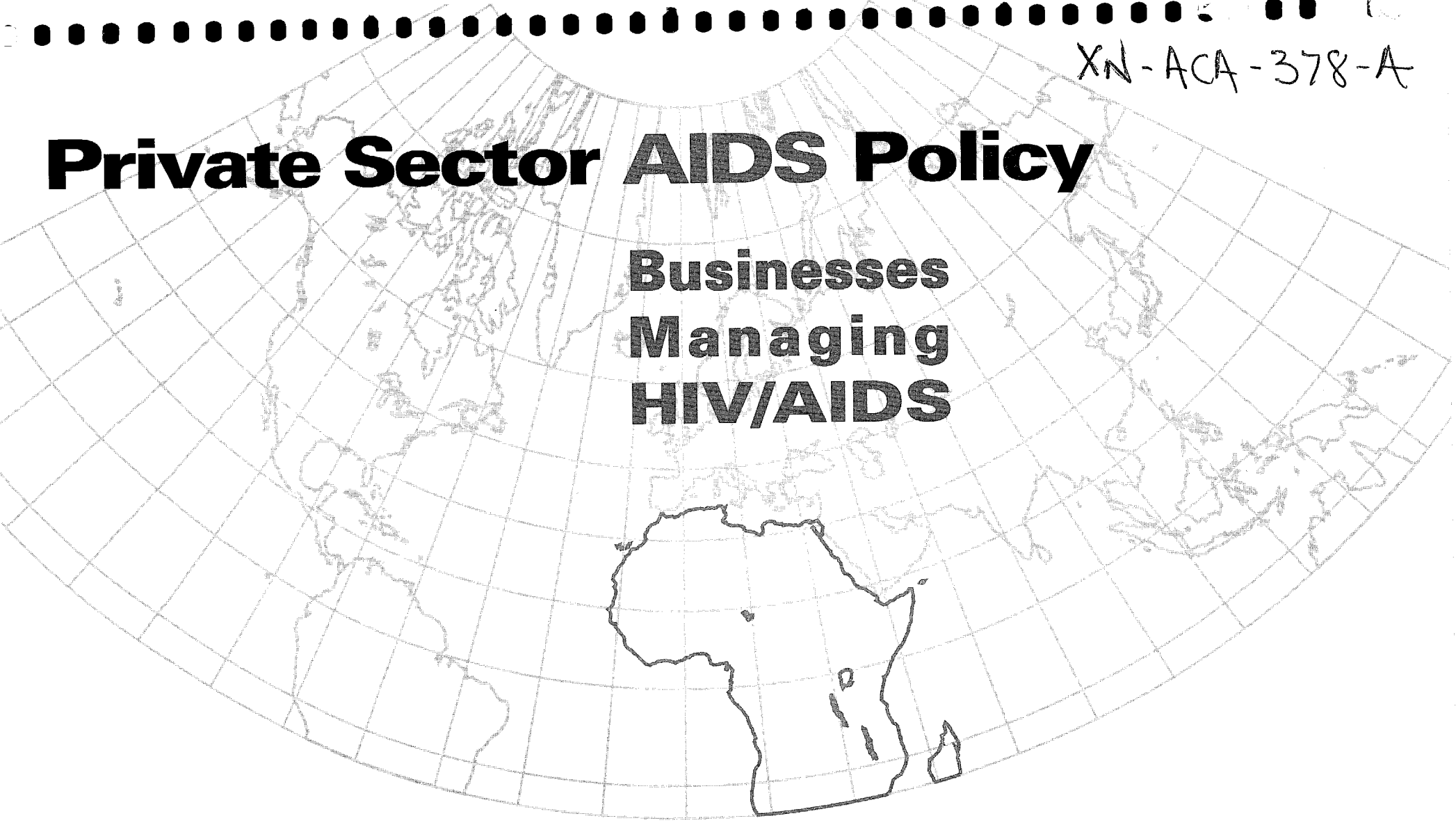
Private Sector AIDS Policy

Businesses Managing HIV/AIDS



FACILITATOR'S GUIDE FOR CONDUCTING BUSINESS MANAGERS' SENSITIZATIONS AND WORKSHOPS

USAID

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INTRODUCTION TO *PRIVATE SECTOR AIDS POLICY*

OVERVIEW OF THE PSAP MATERIALS

The Private Sector AIDS Policy (PSAP) materials are designed to stimulate businesses to take seriously the impact of HIV/AIDS on company productivity and profitability. The materials provide guidance for businesses to develop both HIV/AIDS policies to fit their workplaces and prevention programs that will protect all employees.

The PSAP materials are flexible and can be used in a variety of settings and under a broad range of circumstances. In some cases, it may not be feasible to organize presentations and workshops for managers. In such cases, distribution of the written materials for management is possible. In other places, where organizations exist to offer training for business leaders, presenters (or "facilitators") can prepare business-oriented workshops on HIV/AIDS using the training materials.

The Private Sector AIDS Policy materials are incorporated into four separate but related volumes.

- A *Manager's Guide*, which provides guidelines on HIV/AIDS policy and program development and worksheets for determining the potential economic impact of HIV/AIDS on business profits and the cost of mounting a prevention program. The *Manager's Guide* is divided into six modules.
- *African Workplace Profiles*, a set of 17 company case studies, based on research in Kenya, Senegal, Botswana, and Zimbabwe.
- A *Facilitator's Guide*, which provides content outlines, suggested methodology, and background materials to assist in the preparation of two types of workshops for business managers. The first workshop is a 30 to 40-minute presentation, designed to "hook" managers into the realities of HIV/AIDS in the workplace. The second workshop covers two days and provides business managers with an in-depth introduction to designing workplace policies and programs.

- A volume entitled *Conducting a Workplace HIV/AIDS Policy Needs Assessment*, which provides guidelines for assessing a company's existing HIV/AIDS policies and identifying gaps in those policies.

Each of these volumes includes an introductory explanation of their use. Taken as a whole, the PSAP materials demonstrate to business managers that HIV/AIDS requires their investment in workplace prevention activities and will guide that investment.

AUDIENCES FOR PSAP MATERIALS

The PSAP has two primary audiences. The first audience is business managers and representatives of workers' groups who will use the PSAP materials to develop workplace policies and prevention activities. Examples of business managers include general managers of private and parastatal organizations, human resources or personnel managers, and company medical doctors. Workers' representatives would include education, medical, and benefits program representatives, as well as company-organized workers' groups or committees, whether unionized or informally representing labor concerns.

The second audience is training facilitators, who will use the materials to make presentations to managers about the importance of establishing or enhancing workplace policies and programs.

The *Manager's Guide* and *African Workplace Profiles* are intended for the first audience. *Conducting a Workplace HIV/AIDS Policy Needs Assessment* can be used by both managers and consultants. These materials can be distributed during the two-day workshops for business managers. The workshop outline provided in this *Facilitator's Guide* is partly structured around hands-on use of the *Manager's Guide* and *African Workplace Profiles* by participants. Introductory chapters in each volume summarize the content and intended use.

PREPARING PRESENTATIONS AND WORKSHOPS FOR BUSINESS MANAGERS

Entering the late-1990s, most businesses did not have HIV/AIDS policies or prevention programs. However, there was growing concern and demand from businesses to learn more. The PSAP materials can be used by business associations (e.g., employer federations, chambers of commerce), management institutes, universities, for-profit consulting firms, and others to develop a fee-based training program to offer to businesses. Through creative financing approaches, such as corporate membership dues, fee-for-service arrangements, for-profit workshops and consulting activities with businesses, HIV/AIDS-related service organizations will be able to help businesses create workplace programs and sustain themselves as well.

Although the *Facilitator's Guide* provides a detailed process outline, background materials, and illustrative overheads for conducting the short presentations and two-day workshops, facilitators are expected to bring their own knowledge and gather additional information. The *Facilitator's Guide*, in fact, indicates when such information is needed and likely sources of such information. For example, both the short presentation and workshop require current HIV and AIDS prevalence rates.

Presenting to business managers may be a new experience. Though managers are in many ways like anyone else, they are also somewhat unique. Managers may have more education and come from a higher socioeconomic group than other people with whom the facilitators have worked. Managers are generally used to being in charge and are likely to expect greater deference to their views and actions. Facilitators new to working with the business community should carefully assess or anticipate the background and expectations of their audience and plan accordingly.

HIV/AIDS in the Workplace: A Presentation for Business Managers

INTRODUCTION TO PRESENTATION TO BUSINESS MANAGERS

This section of the *Facilitators Guide* provides an outline, suggested activities, and background notes for preparing a brief HIV/AIDS prevention presentation to business leaders, private sector representatives, and firm managers. The presentation is intended to:

- Raise the awareness of the audience to the impact of HIV/AIDS on the private sector.
- Indicate how managers can protect their profits and productivity with prevention programs and policies.

The presentation is designed to be a "baited hook." A short meeting to present and discuss the business dimensions of the AIDS pandemic is used as "bait" to "hook" business managers who want to learn more about how they can appropriately and effectively respond.

The response of the private sector to HIV/AIDS prevention has been mixed. Some companies responded early and aggressively to provide information to employees and to shape policies to guide the corporate system. Other companies deny, after a decade or more of the epidemic, that HIV/AIDS is a problem for their business operations.

Business people are interested in profits and a work force that will assure the steady generation of profits. They may be moved, in part, by appeals to ethics, national interest, and compassion. But they will not be moved if the appeals do not offer the probability of improved profits.

The structure of the *Facilitators Guide* includes:

PART 1: An overview of the presentation.

PART 2: A suggested structure and methods for conducting the presentation.

PART 3: Background materials for the facilitator. Where background materials exist for specific parts of the curriculum, this symbol is used to aid the facilitator. Several sample overheads also are provided that can be made into transparencies.

BG #

PART 1: PRESENTATION OVERVIEW

1. Overview of PSAP Presentation

For Whom	Business managers and other business-related decision makers. This may include private sector, parastatal and other organizational managers, business community leaders, union leaders, and others.
Purpose	To stimulate private sector HIV/AIDS prevention programs and policies in the workplace.
Where	Presentations can be made at business managers' meetings and luncheons, such as chamber of commerce luncheons, Rotary Club meetings, management seminars, etc. Presentations can also be made to selected companies through pre-arranged meetings with managers and/or the board of directors.
Format	Oral Presentation (20–30 minutes) Questions and Answers (5–10 minutes)
Audience Size	Any size possible, though average is likely to be 15-50 in group settings.
Equipment and Materials Needed	___ Overhead projector ___ Handout materials ___ Screen ___ Paper for recording participants' names, addresses, and phone numbers ___ Flip chart ___ Facilitators' business cards

2. The Agenda (and approximate times)

A. Introduction

1. Who you are and why you are there (1–2 minutes)
2. Overview of presentation (2–3 minutes)

B. Reasons for Having a Workplace Program

1. Global, regional, and national impact of AIDS (3–5 minutes)
2. The impact of AIDS on companies (5 minutes)

C. HIV/AIDS Prevention: The Benefits for Businesses

1. Workplace prevention programs (3 minutes)
2. Appropriate policies (2 minutes)
3. What other companies have done (5 minutes)

D. Closing the Deal

1. Examples of what the day-long workshop covers (5 minutes)
2. Information on how to participate in the workshop (5 minutes)
3. Questions and answers (5–10 minutes)

3. Facilitator's Preparation

It is expected that each facilitator of this short presentation on HIV/AIDS in the workplace will adapt the following materials to their particular style and to the interests of the expected audience. In addition to the equipment and materials suggested above, facilitators who follow the outline provided in this guide will want to have available the following:

Preparation Items	Source of Information
Overheads or flipsharts for use during the:	
■ "Introduction"	Facilitator's Guide curriculum notes
■ discussion of HIV/AIDS global and national prevalence rates	
■ reference to the cost of HIV/AIDS to businesses	
■ mention of the four action items for businesses	
■ review of the benefits of HIV/AIDS prevention programs	
■ review of the benefits of HIV/AIDS policies	
HIV/AIDS prevalence data for the country and/or the local area	National AIDS Control Program or recent reports
Data on the cost of HIV/AIDS to businesses (if available)	Business associations or recent reports

PART 2: ORGANIZING THE PRESENTATION

1. Introduction (3–5 minutes)

Objectives:

- Establish your credibility
- Spark the interest of the audience

MESSAGE:	METHODS
■ Introduce yourself; describe your experience with the private sector, running a business, training, and/or AIDS work. What makes you an expert to discuss HIV/AIDS prevention in the workplace? ■ Describe the reasons for the presentation. From a business point-of-view, the audience wants to know if AIDS will affect the operations of their business. For example, a simple statement can set the tone: "This discussion will briefly demonstrate that HIV/AIDS is a concern for everyone, including businesses." **BG #1** ■ Indicate that this short presentation and a follow-on workshop will provide employers the information they need to respond to and reduce the costs of HIV/AIDS to their companies.	■ It may be effective to ask a couple of rhetorical questions to provoke interest (without necessarily asking for answers at this time), such as: □ "What financial impact can HIV/AIDS have on your business?" □ "Are your employees afraid of contracting HIV from a co-worker, customer, or client?" □ "Do you offer prevention or education programs that help reduce your employees risk?" An overhead of the questions above is provided.

2. Reasons for Having a Workplace Program

Objective: ■ Demonstrate that HIV/AIDS is a threat to the nation and to businesses

MESSAGE:	METHODS
Global and Regional Impact of AIDS **BG #2** ■ AIDS is a global disease. It affects people of all backgrounds and classes. Men and women, children and people in the prime of their lives are affected. ■ AIDS is a dynamic disease. For over a decade, the number of people living with HIV infection has steadily increased. Over 17 million people were infected as of mid-year 1995; by the year 2000, an estimated 30–40 million people may be infected. In sub- Saharan Africa, some 11 million people are HIV-infected. ■ AIDS reaches into households, factories, government offices, and sports teams. **National Impact of AIDS** ■ People in this country, too, are infected with the HIV virus. Current estimates by the National AIDS Control Program are that [x number] people are HIV infected. [x number] of AIDS cases have been reported. ■ It is estimated that within five years [x number] of people will be infected with the HIV virus.	Overheads or flip charts can be used to illustrate some of the HIV/AIDS numbers presented in this section.

MESSAGE:	METHODS
Impact of AIDS at the Level of Firms and Policies **BG #3** ■ Medical staff and personnel managers often admit readily that HIV exists within the workplace. ■ Studies in Kenya, Botswana, Senegal, Swaziland and elsewhere have all affirmed that managers expect HIV/AIDS to have a significant impact on their businesses. ■ In financial terms, HIV/AIDS will have a substantial impact by both ***reducing business revenues and increasing business expenditures*** ■ **What will HIV/AIDS cost a business over the next 5–10 years?** The answer is unique to each business and, in part, dependent on HIV/AIDS prevention activities within the country. However, businesses are likely to experience lost revenues and increased expenditures because of: □ **Absenteeism** of employees due to HIV and AIDS-related illness and time off for employees attending funerals of colleagues who died of AIDS. □ **Labor turnover and productivity losses** associated with the loss of skilled and experienced staff as well as the fact that new employees are unlikely to be as productive as the people they replace in the first months on the job.	An overhead of the business costs of HIV/AIDS is provided.

MESSAGE:	METHODS
☐ **Administrative and recruitment costs**, including increased human resource staff time, advertising costs, processing time, etc. ☐ **Training costs** for new workers. This generally increases as the level of worker recruited rises. ☐ **Health care** costs will increase. ☐ **Employee benefits**, which may include death benefits.	

3. HIV/AIDS Prevention: The Benefits for Businesses

Objective: ■ Demonstrate that prevention efforts can reduce the impact of AIDS

MESSAGE:	METHODS
■ **The threat of AIDS can be reduced and contained with four specific actions:** □ A commitment by leadership to act to prevent further spread of the epidemic. □ Allocation of human and financial resources for prevention. □ Implementation of prevention activities in which employees play an active role. □ Adoption and implementation of HIV/AIDS policies that both support employees' rights and protect businesses' profits.	An overhead of the four actions is provided.

MESSAGE:	METHODS:
■ These four actions require a commitment in time, energy and financial resources. What returns can be expected from such investments?	
HIV/AIDS prevention program benefits: □ Productivity will suffer less due to employee absenteeism and other losses. □ The financial impact of the disease on business operations will be reduced. □ Morale will be maintained. □ Social responsibility will be sustained.	An overhead is provided that offers figures on the financial cost of HIV/AIDS in several real businesses and the financial benefits of HIV/AIDS prevention programs.
HIV/AIDS policy benefits: **BG #4** □ Provides framework for consistency of practice within business. □ Expresses standards of behavior expected of employees. □ Lets employees know where to get assistance and what assistance is available. □ Instructs supervisors on how to manage HIV/AIDS. □ Assures consistency with any relevant statutes.	An overhead of the benefits of appropriate HIV/AIDS policies is provided.

MESSAGE:	METHODS:
■ How have other companies responded to the HIV/AIDS epidemic? □ Summarize a company case example.	■ For the company case study summary, highlight the following points: □ Background on the company and why it might be typical or similar to the experiences of the audience. □ Reasons why management identified HIV/AIDS as a critical concern to the organization. □ How the company has responded and what kind of programs/policies have been, or are being, established. □ The experience to date with these programs in terms of performance, productivity, and benefits/costs. Four case studies from the *African Workplace Profiles* are particularly good: Botswana Meat Commission, Muhoroni Sugar (Kenya), Africa Beverage Company (southern Africa), and David Whitehead Textiles (Zimbabwe).

4. "Closing the Deal"

Objective:

- Convince managers that they and their companies will benefit from participating in a longer workshop on HIV/AIDS

MESSAGE:	METHODS:
■ HIV/AIDS is a real problem, affecting workers and business operations. ■ HIV/AIDS prevention in the workplace can help control the epidemic and reduce the impact on businesses. ■ Prevention is good business; it will save money and assure continuity in the workforce. ■ Other businesses in Africa have developed prevention programs and policies. Their experiences can be tapped to design workplace programs and policies for your own companies. **BG #5**	■ A strong, forceful statement is needed. ■ If one or two participants have shown interest, ask them: □ "What do you think your company should now do?" ■ Use the responses as a basis for encouraging others to consider or commit to HIV/AIDS prevention. ■ Use two or three strong points from the presentation to reinforce the message of benefits for businesses.

MESSAGE:	METHODS:
■ A one-day workshop is scheduled for [date] to assist your company in developing an appropriate response to HIV/AIDS. The workshop will answer such questions as: □ "What risk does AIDS pose to the work force of my company?" □ "Is testing of applicants or workers for HIV an effective way to control company costs?" □ "What are the components of an effective workplace HIV/AIDS prevention program and what will such a program cost?" ■ The workshop will provide general, medical, and human resource managers with detailed information for creating/expanding HIV/AIDS prevention policies and programs. ■ The workshop is designed for top managers; participants will be among peers.	

PART 3: BACKGROUND INFORMATION FOR FACILITATORS

BG #1

It may be effective to state that managers have a responsibility to protect the interests and assets of the corporation. A healthy and productive work force—one of the key assets of any firm—is at stake with AIDS, and hence the productivity of the organization. Thus, while AIDS is ultimately a human concern and crisis, its also a corporate one. Helping workers to prevent HIV/AIDS is helping the company protect its business and assets.

The principal purpose of PSAP is to demonstrate to private sector leaders the importance of establishing HIV/AIDS prevention programs and supporting policies for their workplaces. While some managers may respond to appeals about public health, they are far more likely to be convinced by messages that focus on the business or financial reasons for taking these actions. Thus, the approach suggested here includes a strong emphasis on the economic implications of HIV/AIDS.

BG #2 HIV and AIDS figures

In 1996 the World Health Organization (WHO) estimated, as of the end of 1994, that:

- Over 6 million people globally already had, or had died, of AIDS. Two-thirds of them resided in sub-Saharan Africa.
- Some 17 million or more persons are currently HIV-infected, and the total including those who already have died is more than 18.5 million people. Of the 17 million people living with HIV infection, over 11 million are in sub-Saharan Africa.
- If present trends continue, some 30 to 40 million persons globally will be HIV-infected and 12 to 18 million of them will have developed AIDS by the year 2000.

The estimates are conservative, as the reporting of HIV/AIDS in many countries is incomplete or up to two years old.

Current numbers for specific countries usually can be obtained from the national AIDS control program (or a national equivalent). Clarify whether the numbers are current estimates or projections.

BG #3 The costs to businesses

Absenteeism, especially when it is sporadic and difficult to predict, reduces overall productivity and threatens timely delivery of orders. Even among "low-skill" workers, unexpected absences in critical departments (such as shipping) can have substantial effects on an organization's operations, delivery time, and more.

In a recent study of Kenyan companies, HIV- and AIDS-related illness accounted for approximately 36 percent and 15 percent of the corporate costs of absenteeism, respectively. The costs associated with recruitment, training, and lost productivity accounted for a total of 23 percent of costs. Health care costs were nearly 12 percent of the total costs of HIV/AIDS.

HIV/AIDS will be costly for businesses. Based on the Kenya study, the average annual cost of HIV/AIDS to the companies was US$25 per employee in 1994. This is expected to rise to $56 per employee annually if HIV/AIDS rates are not reduced. In 1994, the costs per company were between $8,689 and $61,132, or between $6 and $49 per employee. As more people become infected, this will rise by the year 2005 to between $15,904 and $147,389, or $12 and $98 per worker annually. This is an average per-employee cost of $56 in 2005.

As a percentage of company profits, HIV/AIDS currently costs an average of 1.7 percent of profits and is likely to rise to 4 percent of profits by the year 2005. The costs can vary significantly, however, depending on such factors as the level of labor-intensiveness, medical benefits, training requirements, and the risk factors of the work force. The range of costs as a percentage of profit ranged between less than 1 percent to nearly 7 percent in 1994 and may double by 2005.

The result is that AIDS is having an impact on operations, productivity, profits, and investment decisions, and this impact is going to increase tremendously if HIV continues to spread rapidly through the population. Thus, the private sector has good reason to be concerned with the impact of HIV/AIDS and strong financial incentive to try to reduce the spread of HIV in the work force.

BG #4 Benefits to businesses

Studies from companies around the world demonstrate that work sites are a good place to conduct HIV/AIDS prevention programs. Generally, workers are interested and appreciate education programs and easy access to workplace prevention services such as condom distribution.

- Though the effects of these prevention programs are hard to measure precisely, it is generally found that health care costs are reduced, as are sick and disability days.
- Comparing the Botswana and Kenya company estimates of the cost of HIV/AIDS prevention programs to the impact of HIV/AIDS (see *African Workplace Profiles*) shows the benefits of taking an active stance to reduce HIV transmission among the work force. Workplace prevention programs cost only between 14–78 percent of the present annual impact of HIV/AIDS on these companies. By the year 2005, the programs will cost only 13–31 percent of the economic cost of HIV/AIDS to each company (see benefits of prevention program overhead below).
- Through the concerted efforts of businesses large and small, broad agreement has been reached on a set of what are essentially worldwide standards for workplace policies and practices on HIV/AIDS. These policies have been "tested" and proven to work. Though these policies have been informed by scientific evidence provided by organizations like the World Health Organization and national AIDS control programs in various countries, they have been developed and promoted by business people.

- One of the principal findings has been that clear and equitable policies must go hand in hand with prevention efforts. Such policies benefit the organization for a number of reasons:
  - The policies provide the undergirding for the prevention efforts and for dealing with HIV/AIDS in the workplace. For example, prevention education messages that emphasize that HIV-positive coworkers pose no threat to others in working situations should be backed up with a company AIDS policy that does not allow termination on the basis of HIV serostatus.
  - Clear and fair policies that are discussed and understood reduce the likelihood of labor disputes or conflicts over HIV-related issues.

BG #5 Closing the deal

Because of the limited time available during the presentation, the facilitator may raise a number of specific policy issues in the form of questions for future thought. For example:

- **Transmission of HIV** poses little risk in most work settings, but it is important to be aware of what the risks are and how they can be reduced.

  Employees who are living with HIV infection are likely to be productive workers for years to come. Many companies have established a formal policy of "reasonable accommodation." This means that the company makes changes in the work environment or the way things are normally done to enable otherwise qualified employees to conduct their jobs.

  Employees are aware of the way they and others are treated. Personal experiences will be powerful examples that will either bolster or hurt the organization's external image and workers' commitment to their jobs. The facilitator may also want to point out that, without adequate information and training, co-workers may be afraid to work with others who they know or believe are infected with HIV. This can result in major disruptions in the workplace, even though the infected employee poses no risk.

- **Mandatory HIV testing** is specifically not recommended by the World Health Organization (WHO), the International Labour Office (ILO), and many national governments. A WHO/ILO Statement from a Consultation on AIDS and the Workplace declares that pre-employment screening should not be required and that an employee should be under no obligation to inform his employer of his HIV/HIV/AIDS status.

Businesses that have addressed this and other policy issues recommend against mandatory HIV testing, including major multinational corporations such as Unilever, IBM, Xerox, Polaroid, Campbell's, Levi Strauss, and smaller enterprises.

Business have learned that the mandatory testing of workers for HIV has limited utility:

- ☐ Testing does not ensure that workers have not recently been infected or that they will not become infected in the future.
- ☐ Even if a worker is HIV-infected, she/he is likely to be productive for years to come.
- ☐ Mandatory testing of workers hurts morale and creates an atmosphere of distrust in the workplace.
- ☐ Testing programs are expensive and time consuming to operate.
- ☐ In some places, mandatory testing programs are illegal [Facilitator: check if this is in fact the case in the country].

- **Workplace prevention programs** include training a few workers to be educators for the rest of the work force. Among other things, this involves selecting workers to be trained as peer educators who are trusted by both their peers and management. Management will also have to decide whether to pay educators while they are being trained. And management will have to determine how education sessions can be conducted in the workplace that reach all workers while minimizing the impact on operations. These and other issues involved in establishing prevention programs in the workplace will be addressed in the follow-up workshops.

Message Background:

If the facilitator does not anticipate that a workshop will be available to managers, she/he will instead want to focus attention on helping managers identify alternative sources of information and support. If available, the facilitator can encourage the audience to utilize the PSAP *Manager's Guide*. The facilitator can also refer the audience to other groups or individuals who offer workplace technical assistance on HIV.

Overheads:

The following pages can be photocopied to produce transparency overheads.

Is Your Organization Prepared to Handle AIDS?

- What financial impact can HIV/AIDS have on your business
- Are your employees afraid of contracting HIV from a co-worker, customer, or client?
- Do you offer prevention or education programs that help reduce your employees' risk?

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HIV rates among pregnant women, select urban areas in Africa

Johannesburg	7%
Dar es Salaam	16%
Nairobi	17%
Lusaka	25%
Blantyre	33%
Francistown	34%

(rates for 1992 or 1993: U.S. Bureau of the Census data)

Note: HIV seroprevalence rates for pregnant woment are often used as an indicator for rates in the general population.

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Business Costs of HIV/AIDS

- HIV Absenteeism
- AIDS Absenteeism
- Labor Turnover
- Productivity Losses
- Administrative and Recruitment
- Training
- Health Care
- Employee Benefits, such as Burial Fees

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The Threat of AIDS Can be Reduced with Four Specific Actions

- Commitment by leadership to act to prevent further spread of the epidemic.
- Allocation of human and financial resources for prevention.
- Implementation of prevention activities in which all employees play an active role.
- Adoption and implementation of HIV/AIDS policies that both support employees' rights and protect businesses' profits.

Benefits of Appropriate HIV/AIDS Policies

- Sets foundation for a HIV/AIDS prevention program.
- Provides framework for consistency of practice within business.
- Expresses standards of behavior expected of employees.
- Lets employees know where to get assistance and what assistance is available.
- Instructs supervisors on how to manage employees with HIV/AIDS.
- Assures consistency with relevant government statutes.

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Some Recommended Workplace HIV/AIDS Policies

- Compulsory pre-employment or employee HIV/AIDS screening is not practiced.
- All medical records are to be kept confidential.
- Persons with HIV infection have the same rights and benefits as others with serious illnesses or disabilities.
- Stigmatization and discrimination will not be tolerated.
- HIV/AIDS is not a cause for termination of employment.

Sources: World Health Organization/International Labour Office, 1988; New England Workplace Responses to AIDS, 1989.

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Cost of AIDS and Prevention Benefits of HIV/AIDS Prevention Programs

(US$)

Company	Cost of HIV/AIDS to company	Cost to Company of Impact of HIV/AIDS per employee	Initial annual cost of full HIV/AIDS prevention program	Cost of HIV/AIDS prevention program per employee	Prevention cost as % of impact HIV/AIDS
Botswana Diamond Valuing	125,941	237	23,124	44	18%
Botswana Meat Commission	370,200	268	51,072	37	13%
Auto Kenya*	21,312	17	10,189	8	20%
Muhoroni Sugar, Kenya	58,303	28	21,647	18	37%

x

*Fictitious name of real company

HIV/AIDS Prevention Policies and Programs in the Workplace: A Workshop for Business Managers

INTRODUCTION TO WORKSHOP

This section of the *Facilitator's Guide* is for use during a two-day workshop for business managers seeking to develop or expand HIV/AIDS prevention programs and policies for their companies. The workshop will:

- Offer hands-on exercises to justify the development of prevention programs.
- Provide guidelines for developing company policies and programs to deal with HIV/AIDS in the work force.

The workshop is a follow-on activity from a brief presentation to business managers which would have occurred before the workshop. The short presentation is designed to stimulate interest in the problems of HIV/AIDS in the workplace and spark interest of managers to attend the longer workshop. However, the workshop can be conducted without a prior presentation. The workshop can be adapted to different situations and facilitators are encouraged to adjust sessions to the needs of their audiences.

There are eight sessions in the two-day workshop. Each session deals with a distinct element of HIV/AIDS in the workplace, but all are logically connected. Both a basic message and suggested methods for conveying that message are described for each session. In addition, background information is included at the end of the *Facilitator's Guide* to aid the facilitator in preparing for the workshop. Where background information is available, the following symbol is used in the curriculum.

BG #

The workshop can be seen as training for select staff from companies to become familiar with HIV/AIDS issues and the contents of the *Manager's Guide*. While the *Manager's Guide* can be used without prior training, the workshop will make using it in a workplace setting easier.

Given the complexity of the subject matter and intensity of presentation, it is recommended that two facilitators lead the workshop.

Finally, the training provided during the workshop is a part of a larger package of materials. Those other materials, especially the modules of the *Manager's Guide*, are an important resource in preparing for the workshop.

Workshop Overview

For Whom	Top business managers (for example, finance, personnel, medical directors), with the authority to make decisions and recommendations about company policies and employee benefits.
Purpose	To provide basic information for companies to develop or expand prevention programs and policies within the workplace.
Where	A setting removed from normal work areas, such as a conference or seminar room. The workshop can be held for managers at one company or for managers from several companies.
Format	Eight sessions, involving a combination of oral presentation, group questions and answers and other discussion, and other practical work.
Audience Size	Up to 20 people.
Equipment and Materials Needed	____ Overhead projector ____ Screen ____ Calculators ____ Name tags ____ Pencils and scratch paper ____ Flip chart or other large writing pad ____ Handout materials, including *Manager's Guide* *Africa Workplace Profiles*

The approach adopted in these training materials assumes that HIV/AIDS poses a serious threat to the stability and productivity of businesses. Many companies are awakening to this fact, but may be unclear about how HIV/AIDS will affect their work force and profits over a period of five to ten years. There may be reluctance to invest scarce resources in prevention programs without a better appreciation of the benefits to be gained. Thus, actual case studies of other businesses, guidelines for determining costs, and related business rationales are offered during this workshop.

Workshop Agenda

PART/DAY 1:

Session 1 Introduction (30 minutes)

Objectives:
- Participants become acquainted with one another and facilitator(s).
- Purpose of workshop and outline of content explained.

Session 2 The Cost of AIDS to Companies (150 minutes)

Objectives:
- Increase understanding of the status of the epidemic in the country.
- Sensitize participants to the impact of AIDS on business.

Lunch

Session 3 Basic Facts about HIV and AIDS (90 minutes)

Objectives:
- Acquaint participants with key facts about HIV/AIDS as a public health epidemic.
- Address misconceptions and stereotypes often associated with the epidemic.

Session 4 Businesses Respond to AIDS (60 minutes)

Objectives:
- Review what other businesses have done to confront HIV/AIDS in the workplace.
- Become familiar with the range of business responses and options.
- Identify ideas on how the responses of others can be adapted to specific workplaces.

PART/DAY 2:

Session 5 Planning HIV/AIDS Prevention Programs and Policies (60 minutes)

Objective: ■ Stress the value of planning for effective HIV/AIDS prevention programs and policies.

Session 6 Defining Company HIV/AIDS Policies (120 minutes)

Objective: ■ Provide hands-on experience identifying appropriate policies for each participant's company.

Lunch

Session 7 HIV/AIDS Prevention Programs within the Workplace (120 minutes)

Objective: ■ Become familiar with the basic components of a comprehensive workplace HIV/AIDS prevention program.

Session 8 Summing Up (15 minutes)

Objective: ■ Gain participant commitment to take next steps within their own companies.

FACILITATOR'S PREPARATION

Preparation for this workshop involves being very familiar with the materials in the *Manager's Guide*, which will be a reference resource for participants after the workshop. The sessions of the workshop generally follow the layout and content of the *Manager's Guide*. The curriculum outline, below, is structured to include a "Message" section which provides a guide on the ideas and information to be conveyed to participants. A "Methods" section suggests ways to conduct the training. Finally, background details are provided, including copies of suggested overheads, handouts and worksheets. These latter can be photocopied.

Facilitators may have the most difficult time with Session 2, "The Cost of AIDS to Companies." A very detailed worksheet will be used during that session. The worksheet allows companies to estimate the financial impact of AIDS on profits. In the *Manager's Guide* there is a worksheet to determine the cost of creating or expanding a HIV/AIDS prevention program in the workplace. The worksheet involves basic mathematics calculations, but not anything that can not be done without a hand calculator. The detail in the spreadsheet is a result of making the determination of costs as comprehensive as possible. It may be helpful to have a person with an economics or business management background assist with the session, although it is by no means essential.

Facilitators also can make Session 2 easier by informing participants ahead of time to bring some basic financial data that will be used in the spreadsheets. Data can include:

- number of employees
- average gross monthly wage/salary of employees
- average monthly cost of employee benefits,
- or annual/monthly health costs
- average number of absent days for employees
- HIV prevalence rate of employees, if known (in fact, unlikely to be known)

- average number of weeks required to hire new employee
- average time to train new employees to 100% efficiency
- average hourly employee wage/salary

Also, encourage participants to bring hand calculators.

Other preparations will include:

- A printed agenda
- Packets with PSAP materials: *Manager's Guide*, *African Workplace Profiles.*
- Copies of a handout with names and addresses of organizations able to offer businesses assistance with HIV/AIDS program and policy development
- All overheads (many from the short presentation can be used)
- Copies of the impact of AIDS and cost of prevention programs spreadsheets
- Copies of "Company Profile" matrix (BG6)
- Copies of the handout of "Components of a Comprehensive Prevention Program" and "Features for Success" (BG7)
- Copies of prevention program worksheets (BG14)
- Copies of worksheet for "Company Action Plan" (BG15)

HIV/AIDS PREVENTION IN THE WORKPLACE
PART/DAY 1

Session 1: INTRODUCTION (30 minutes)

Objectives:

- Participants become acquainted with one another and facilitator(s)
- Purpose of workshop and outline of content explained

MESSAGE:	METHODS:
■ Welcome; facilitator(s) introduce themselves. ■ Explain purpose of the workshop. □ Part One: To familiarize company managers with the potential impact of HIV/AIDS on their businesses and how clear policies and prevention programs can reduce that impact and save money. □ Part Two: To provide hands-on experience with developing company policies and programs to reduce HIV infection and the costs of HIV/AIDS to businesses. □ Overall, the workshop will provide practical information that can be used by companies to develop HIV/AIDS prevention policies and programs that meet their needs.	■ A clear and concise purpose statement for the workshop will help set the tone for the day's activities. □ The facilitator may wish to add more information than indicated in the message section, such as identifying the sponsors of the workshop, where else the workshop has been held, and the positive outcomes of other workshops.

INTRODUCTION (continued)

MESSAGE:	METHODS:
■ Participant introductions. Participants can give the following information about themselves and then in three or four sentences complete the three statements: name ** company ** position Statements for participants: □ Other, similar experiences I've had include... □ I'm attending the workshop because... □ I hope to learn more about ... ■ Review agenda for both Part 1 and Part 2 of the workshop. Briefly explain how the different sections of the agenda link together and how the agenda topics address the learning expectations of participants.	■ Introductions always run the risk of becoming lengthy (and thus time consuming), especially if there are many participants. □ The open-ended statements for participants provide facilitators with some ideas about the concerns and expectations of participants. □ On two pages of a flip chart—one page labeled "Why Here?" and the other "Expectations for Workshop"—record the responses so there is a written list for all to see. ■ Encourage participants to ask questions, offer observations, and contribute from their own experiences. An interactive format enhances the learning of everyone involved. ■ A printed agenda for the workshop should be available for each participant. Distribute these after Introductions. □ Quickly describe the agenda, referring on two or three occasions to how the agenda will address some of the concerns and/or expectations of participants. For example, the facilitator might say, "Those people who are concerned about the costs of AIDS will learn more about that issue at this point during the morning." ■ Clarify any questions or concerns at the end of this section. Ask people if the purpose of the workshop is clear.

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Session 2: THE COST OF AIDS TO COMPANIES (150 minutes)

Objectives:

- Increase understanding of the status of the epidemic in the country
- Sensitize participants to the imact of AIDS on business

MESSAGE:	METHODS:
■ Current epidemiological data for the country [and for urban areas, if available] indicate that HIV and AIDS are well established. ■ Using mathematical models, analysts have prepared projections of how the HIV/AIDS epidemic is likely to grow in the country without effective prevention interventions. The graphs that are presented illustrate the likely scenarios in [select either Senegal or Kenya]. As the projections indicate, the epidemic is dynamic and—without efforts to counter it—rates will continue to rise. **BG #1** ■ Combining economic and demographic data with current epidemiologic rates and future projections provides some indication of the impact AIDS will have. For example,... □ **Cost to health care systems:** In many countries hard hit by AIDS, half or more of hospital beds are used by AIDS patients. That means less access to health care for people with other ailments.	■ This session first offers a brief overview of the HIV/AIDS epidemic. The amount of detail in the overview can be modified, as appropriate. It will then involve participants in discussions and a hands-on activity designed to give some information about the potential impact of AIDS on individual businesses. Both parts of this session provide background on the impact of the epidemic to help demonstrate the need for companies to adopt or expand HIV/AIDS prevention efforts. ■ The facilitator can use a combination of presentation and soliciting of participant feedback during the first part of this session. For example, the session can begin with the question: □ Are current HIV infection rates in the country above or below 5 percent of the adult population? □ Use the responses as a basis for describing current HIV and AIDS rates, offering both national and more local data. ■ Briefly explain that current and historical rates for HIV and AIDS provide the basis for developing projections of the course of the epidemic over the next five to ten years.

Session 2 (continued)

MESSAGE:	METHODS:
□ **Orphans and street children:** In some East African countries, the number of orphans due to AIDS deaths may exceed 1 million by early in the next century. It is already possible to see more and more young people on the streets; a growing number are AIDS orphans. □ **Changes in business productivity and profits:** Across Africa, many companies are seeing changes in business operations, even if only to a limited extent. For example, mining management and medical officers in southern African countries are devoting increasing amounts of time to treating employees with AIDS-related illnesses. ■ Taken together, these data indicate an epidemic that could get worse without greater prevention efforts at all levels. □ In countries where the epidemic is well established and where studies have been done, HIV/AIDS in the work force is cutting into productivity and profits. □ Absenteeism due to AIDS-related illnesses appears in many places to be the major cost facing businesses. Work schedules and production are disrupted. Other major costs associated with AIDS include medical and insurance costs, recruitment and training, funeral and death payments, and unrecorded costs linked to employee morale.	■ Overheads available for the short presentation can also be used in this session. ■ Create an overhead from the graph, "Projected Adult HIV Prevalence in Rates." Kenya is used as an example in the graph; check with the National AIDS Control Programme in the country for projections applicable there. **BG #2** ■ Combining these projections with available economic data, it is possible to estimate the cost of AIDS to a country over time. Create an overhead from the graph, "Projected Economic Costs of AIDS." Again, Kenya is used as an example; specific information may be available for your country. **BG #3** ■ Encourage participants to discuss the impact of HIV/AIDS on their business operations. Some of the questions which can be asked include: □ Have there been changes in worker productivity over the past two-three years? □ Is absenteeism a problem? Why? □ Is it evident that AIDS is costing your company money?

Session 2 (continued)

MESSAGE:	METHODS:
■ One of the best ways to determine the impact of HIV/AIDS is to focus on a single company. The exercise that follows is designed to have participants review the cost of HIV/AIDS to a typical business in Africa by using a spreadsheet model. ■ The data that will be used for the exercise are drawn from actual companies in eastern and southern Africa. However, the figures do not come from one specific company but represent the experiences of several companies to provide an overall picture of the impact of HIV/AIDS. It should be noted that many companies do not have all the data asked for in the model. For example, it may not be known how many employees are HIV positive. In those cases, estimates can be used. ■ The results of the exercise can be compared with the likely cost of mounting a HIV/AIDS prevention campaign in the workplace—an activity which will be done on the second day of the workshop. In that way, companies can compare the costs and benefits of prevention efforts. ■ The model used in the exercise can be applied in your own companies. A computer version is available and is provided on disk in the *Manager's Guide* packet.	■ Briefly explain the purpose of the exercise: to help participants become familiar with the spreadsheet model for estimating the impact of HIV/AIDS on an individual company. By doing the exercise, participants will also become clear about the financial effects of HIV/AIDS on businesses. The exercise will take about 1½ hours. ■ Photocopy and distribute the worksheets and data sheets for the exercise. The template/worksheet is provided in the background and is the same as the one in Appendix 9 of the *Manager's Guide*. **BG #4** ■ Provide guidance on the use of the template. □ It is recommended that only one of the several categories of workers be assessed in this exercise. There is not enough time to do all categories. □ The exercise is designed to make users familiar with the template. When planning is under way back in the office, the entire template can be completed. □ Users should be as precise as possible, but if certain information is not known, make a reasonable guess.

Session 2 (continued)

MESSAGE:	METHODS:
■ Also in the *Manager's Guide* is a worksheet for determining the cost of a HIV/AIDS prevention program for the workplace. The worksheet is similar in layout to the one just completed and is also available on computer disk.	□ The template includes some averages and standard data, developed by the creators of the materials, to deal with differences between companies. If the suggested figures do not apply to your company, use the figures that are most relevant. □ Participants can work individually or in groups of two, three, or four people. Pencils and scratch paper should be available. If available, calculators should be used. The exercise is not meant to test people's math skills, but instead yield answers that will more fully inform businesses about the costs of HIV/AIDS. □ Once the exercise is under way, occasionally check with participants for questions or problems. □ It may be appropriate to call a break in the middle of the exercise. ■ A debriefing on the exercise should occur in the final 15–20 minutes. Participants can give their opinions of the model as well as what they think of the results obtained.

Session 3: BASIC FACTS ABOUT HIV AND AIDS (90 minutes)

Objectives:

- Acquaint participants with key facts about HIV/AIDS as a public health epidemic
- Address misconceptions and stereotypes often associated with the epidemic

MESSAGE:	METHODS:
■ The two areas where basic information about HIV/AIDS is critical in business operations include the biology of the disease—how it is and is not spread and how the virus affects a person over time—and the basic means of preventing transmission of the disease.	■ This session will convey basic information about HIV/AIDS. Although most people have heard about HIV/AIDS and know how it is transmitted, a lot of misinformation remains. Moral judgements may obscure what is known about the disease. For many people, it is difficult to separate the reality of HIV/AIDS from the values held about sex, personal relationships, and social roles. Thus, it is important to describe what is known about HIV/AIDS and to try to relate people's opinions and views to the known facts. ■ Basic facts about HIV/AIDS can be found in Module 1 of the *Manager's Guide*. This information can be used in preparation for the session. ■ It is recommended that facilitators invite an informed expert on HIV/AIDS, such as a doctor, nurse, or trained counselor who can provide a brief overview on HIV/AIDS and assist in answering questions.

Session 3 (continued)

MESSAGE:	METHODS:
■ In addition to the facts about HIV/AIDS, there are many opinions and beliefs that should be raised and addressed during the session. ■ There are also ethical situations facing managers. Many are not easily resolved and force managers to make choices and decisions that are difficult for them, for the company, and for the employees, too.	■ Some participants will have strongly held beliefs. For example, they may argue that condoms are immoral or ineffective or that discussions about sexuality contribute to promiscuity. As much as possible, the facilitator should respond to such statements with what is known, permit some discussion, but not let the issue become the center of a prolonged debate. Current knowledge about several issues—condoms, the links between STDs and HIV, and sex education for youth—that have provoked controversy in parts of Africa is outlined in the Background section. **BG #5** ■ Clear information and honest responses to questions will be appreciated by most participants. ■ Participant questions and discussion are very important in this session. This may be one of the few occasions where managers have an opportunity to voice their concerns and views on AIDS and to hear responses that offer accurate and current information.

Session 4: BUSINESSES RESPOND TO HIV/AIDS (60 minutes)

Objectives:

- Review what other businesses have done to confront HIV/AIDS in the workplace
- Become familiar with the range of business responses and options
- Identify ideas on how the responses of others can be adapted to specific workplaces

MESSAGE:	METHODS:
■ The potential impact of HIV/AIDS on company productivity and profits can be minimized with effective prevention programs. ■ Many companies are working to lessen the impact of HIV/AIDS and promote policies and programs that assist workers. The experiences of those companies can inform other companies as they create or expand HIV/AIDS prevention programs. ■ Have participants review one or two selected company case studies to gain an understanding of how prevention programs have been put together. Participants will work in groups to review the case studies and discuss the implications for their own businesses.	■ Several case studies, based on studies of businesses in Kenya, Senegal, and Botswana, are available in *Africa Business Profiles*. Select one or two of these for analysis and discussion by the participants. Four case studies are particularly positive: Botswana Meat Commission, Muhoroni Sugar (Kenya), Africa Beverage Company (southern Africa), and David Whitehead Textiles (Zimbabwe). **BG #6** □ Depending upon the number of workshop participants, two or more discussion groups can be formed. Allow about four people per group. □ Participants in each group should read the case study to themselves and then as a group discuss the case study, focusing on the "Lessons Learned" from the company experiences. Ask each group to select a presenter who will identify two or three "Lessons Learned" by the group. The "Lessons" will be shared with all workshop participants during a report back at the end of the session.

Session 4 (continued)

MESSAGE:	METHODS:
■ During the report back of "Lessons Learned," following the case study discussions, be sure that the following points are identified. These features have been found from the review of company experiences to be important in the success of HIV/AIDS prevention programs: □ Clear, widely understood, consistently applied HIV/AIDS policies and practices. □ Participation of workers at all levels in the design and implementation of education and prevention programs. □ Periodic, on going, and comprehensive HIV/AIDS prevention programs for all employees (including management). The four features of a comprehensive prevention program are: ● Formal and informal HIV/AIDS prevention education ● Condom distribution ● STD diagnosis and treatment ● Counseling and support services □ Visible and on going top management support. □ Long-term commitment of human and financial resources.	■ During the report back, try to keep reports brief so that questions and answers can be added by others. ■ A handout that lists these four components and the "features of success" can be provided to participants. **BG #7**

Session 4 (continued)

MESSAGE:	METHODS:
■ Lessons gained from companies with similar programs are: □ Raising awareness and prevention education alone are not enough to make up a comprehensive program. □ The apparent cost of a comprehensive HIV/AIDS prevention program in the workplace is off set by a healthy work force that gets management support, thereby making companies productive and profitable. □ Companies need not have all components of a comprehensive program *in-house* if effective alternatives are accessible to employees through other channels. However, management cannot assume that components exist elsewhere—confirmation is needed.	

BACKGROUND INFORMATION FOR PART 1/DAY 1 SESSIONS

Session 2

BG #1 Even rates that appear low—as low as 1 percent—mean that the epidemic is well established. Rates of 5 percent or higher indicate that the epidemic is widespread and likely to be rapidly expanding. As can be seen in the graph of adult HIV prevalence in Kenya, the epidemic is projected to level off at about 9 percent in the first decade of the 21st century.

It is typical of epidemics that once they peak, fairly level prevalence continues unless prevention and control measures are fully implemented. In the case of Kenya, it is projected that between 9 and 10 percent of adults will be infected at any one time in the early part of the 21st century.

Usually, current data are available from the national AIDS control program (NACP) offices or the epidemiologic unit of the Ministry of Health. Projections of the future course of the epidemic may be more difficult to obtain. Again, ask the NACP or epidemiologic unit for help. Although the situation in your country will be different from the situation described in these projections, the relationship between current and future status can be implied.

BG #2 Where HIV prevalence rates exceed 1 percent of the adult population or of a typical group, such as pregnant women, the epidemic is at a stage for rapid growth.

Looking at how the numbers have changed in other country over a four to five year period can be useful. The graph that shows the increasing number of HIV infections in the adult population of Kenya demonstrates how rapidly the epidemic can grow.

HIV/AIDS is very dynamic, as are other epidemics. HIV spreads rapidly. That spread is not always evident or easily seen, as data collection systems may be weak or the analysis and reporting of the data may be delayed by months or years. However, projections indicate that without strong prevention measures, thousands of people in Kenya will die of AIDS by the year 2005.

Business managers will want specific figures to make assessments of their own. There are risks in the use of any numbers. For example, participants may dismiss prevalence rates of 1 percent as being too low to be of concern. Such rates may be seen as confirming the popular image of AIDS as confined to certain marginalized, high-risk groups. By comparing the situation in other countries that have had low rates that later rose, the case for taking 1percent seriously can be made.

BG #3 There are two graphs that can be used here. The first shows the projected economic impact of HIV/AIDS on the health sector in Kenya, based on the projections of HIV prevalence rates and the 1993 costs of providing medical care in that country.

The second graph illustrates the cost of HIV/AIDS in the workplace. All the companies surveyed for the information in the graph were large, with hundreds, and sometimes thousands, of employees. The costs to the companies included insurance, health benefits, funeral costs, absenteeism due to illness and care giving, and recruitment and training for replacement employees.

Very high prevalence rates may be discouraging: "What can we do?" may be a common response. High rates are disheartening, because we are dealing with the lives of people. However, it is true that in many countries, policy makers in government and business have been unwilling to act until there have been a large number of deaths. The high rates are, in part, the result of delays in providing people with accurate prevention information and making available prevention resources. Because AIDS is dynamic, it is never too late to institute prevention, to prevent new infections, to protect workers.

Use epidemiologic data and projections carefully and in moderation. Do not overwhelm participants with more data than can be easily absorbed. Three or four sets of data and a similar number of projection graphics will be sufficient.

BG #4 The worksheets and data sheets for the exercise were designed to acquaint participants with the extent of factors to be considered when assessing the impact of HIV/AIDS on their own companies. The data are derived from a survey of several businesses in Kenya. The data reflect averages, rather than the experiences of any one company.

CALCULATING THE COST OF AIDS TO BUSINESSES

I. INTRODUCTION

One of the most important issues management is to consider in making a decision about how to handle HIV/AIDS at the workplace is the financial risk the disease presents to the organization. Managers are likely to want some type of cost-benefit analysis in the process of making this decision. To date, the costs of STDs and HIV/AIDS to businesses and the benefits of prevention have been extremely difficult to estimate.

The precise benefit or value of a prevention program is still difficult to estimate and is likely to vary in relation to the quality and comprehensiveness of the program, and the availability of other programs in the community.

II. CALCULATING THE IMPACT OF AIDS IN THE WORKPLACE

There are several broad categories of data used in determining the economic impact of HIV/AIDS (and other STDs) in the workplace. Those categories include:

- number of employees and average salaries
- labor turnover
- training
- reduced productivity
- funeral attendance
- absenteeism
- recruitment
- annual health costs
- burial costs/death benefits

In addition, employees can be described in several broad types.

- SecStf - Secretarial or support staff
- ManLab - Manual laborers
- SupMgr - Supervising managers
- TecPro - Technical professionals
- SenMgr - Senior managers

If staff categories are substantially different, the organization can modify the categories as necessary. If a company decides not to use the suggested employee categories, different categories can be used or simply include all employees and use one of the columns as "Total number of employees." Detailed notes on each line item in the form are provided at the end of the spreadsheet.

		Category of Employee*				
		SecStf	**ManLab**	**SupMgr**	**TecPro**	**SenMgr**
I. EMPLOYEES/SALARY						
A. Number (#) of employees	[total # in each category of staff in company]	_____	_____	_____	_____	_____
B. Gross weekly salary	[gross weekly salary of all staff in each category]	_____	_____	_____	_____	_____
II. LABOR TURNOVER						
C. # of weeks to hire new employees in each category		_____	_____	_____	_____	_____
D. *Lost labor cost*	**[C*B/A]**	_____	_____	_____	_____	_____
III. TRAINING						
E. Trainer's time in weeks	[# of weeks trainer is training each staff category]	_____	_____	_____	_____	_____
F. Trainer's wage per week	[weekly gross salary of trainer]	_____	_____	_____	_____	_____
G. Class size	[the typical class size for training each staff category]	_____	_____	_____	_____	_____
H. Trainees' time	[# of weeks trainees are in training]	_____	_____	_____	_____	_____
I. Weekly training wage per trainee	[% of gross weekly wage, B, paid to trainee]	_____	_____	_____	_____	_____
J. Training cost per employee	[(E*F)/G]	_____	_____	_____	_____	_____
K. Total salary paid employee during training	[H* I]	_____	_____	_____	_____	_____
L. *Total training cost*	**[J +K]**	_____	_____	_____	_____	_____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

		Category of Employee*				
		SecStf	ManLab	SupMgr	TecPro	SenMgr
IV. REDUCED PRODUCTIVITY						
M.	# of weeks after training before productivity reaches 100%	_____	_____	_____	_____	_____
N.	Productivity immediately after training [% productivity after training]	_____%	_____%	_____%	_____%	_____%
O.	Percentage productivity lost [100-N]	_____	_____	_____	_____	_____
P.	Total wages paid to employee before productivity reaches 100% [M*B/A]	_____	_____	_____	_____	_____
Q.	***Total productivity cost*** **[(.5*O*P)/100]**	_____	_____	_____	_____	_____
V. FUNERAL ATTENDANCE						
R.	Average # of paid leave days a worker takes to attend a co-worker's funeral	_____	_____	_____	_____	_____
S.	Average # of workers who took paid leave to attend *each* co-worker's funeral this year	_____	_____	_____	_____	_____
T.	***Productivity loss per co-worker funeral attended*** **[R/5*S*B/A]**	_____	_____	_____	_____	_____
VI. ABSENTEEISM						
U.	Average # of absent days for employees	_____	_____	_____	_____	_____
V.	AIDS absenteeism [# of days during this year workers with AIDS were absent]	_____	_____	_____	_____	_____
W.	***AIDS cost*** **[B/A*(V-U)/5]**	_____	_____	_____	_____	_____
X.	HIV absenteeism [# of days this year workers with HIV were absent]	_____	_____	_____	_____	_____
Y.	***HIV cost*** **[B/A*(X-U)/5]**	_____	_____	_____	_____	_____
Z.	STD absenteeism [# of days this year workers with STD were absent]	_____	_____	_____	_____	_____
AA.	***STD cost*** **[B/A*(Z-U)/5]**	_____	_____	_____	_____	_____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*				
			SecStf	**ManLab**	**SupMgr**	**TecPro**	**SenMgr**
VII.	**RECRUITMENT**						
AB.	***Recruitment cost*** **[recruitment cost per employee hired in each category]**		____	____	____	____	____
VIII.	**ANNUAL HEALTH COSTS**						
AC.	Total cost of all employee claims this year		____	____	____	____	____
AD.	Total # of employee claims this year		____	____	____	____	____
AE.	**Cost per claim this year**	**[AC/AD]**	____	____	____	____	____
AF.	Average # of health claims per employee with full-blown AIDS		____	____	____	____	____
AG.	Average # of HIV-related claims per employee, prior to full-blown AIDS		____	____	____	____	____
AH.	Average # of STD-related claims per employee		____	____	____	____	____
AI.	***Health care cost per employee due to AIDS***	**[AE*AF]**	____	____	____	____	____
AJ.	***Health care cost per employee due to HIV***	**[AE*AG]**	____	____	____	____	____
AK.	***Health care cost per employee due to STD***	**[AE*AH]**	____	____	____	____	____
IX.	**BURIAL COSTS/DEATH BENEFITS PER EMPLOYEE**						
AL.	Cost of a coffin (if paid for by organization), plus other death benefits paid to family		____	____	____	____	____
AM.	Other costs (not paid to family), excluding lost labor due to funeral attendance		____	____	____	____	____
AN.	***Total burial cost***	**[AL+AM]**	____	____	____	____	____

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

		Category of Employee*				
		SecStf	**ManLab**	**SupMgr**	**TecPro**	**SenMgr**
X. HIV/AIDS Rates (may assume the same for each category of employee unless specific information available)						
AO. AIDS prevalence (%)		_____%	_____%	_____%	_____%	_____%
AP. HIV prevalence (%)		_____%	_____%	_____%	_____%	_____%
AQ. STD prevalence (%)		_____%	_____%	_____%	_____%	_____%
AR. AIDS cases	[A*AO/100]	_____	_____	_____	_____	_____
AS. HIV cases	[A*AP/100]	_____	_____	_____	_____	_____
AT. STD cases	[A*AQ/100]	_____	_____	_____	_____	_____

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* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

ANTICIPATED DECREASED REVENUES & INCREASED EXPENDITURES

DECREASED REVENUES

			Category of Employee*				
			SecStf	ManLab	SupMgr	TecPro	SenMgr
AU.	**Organization revenue**	**[revenue for the organization this year]**				_____	
AV.	Labor turnover	[AR*D]	_____	_____	_____	_____	_____
AW.	Training	[AR*L]	_____	_____	_____	_____	_____
AX.	Reduced productivity	[AR*Q]	_____	_____	_____	_____	_____
AY.	Funeral attendance	[AR*T]	_____	_____	_____	_____	_____
AZ.	AIDS absenteeism	[AR*W]	_____	_____	_____	_____	_____
BA.	HIV absenteeism	[AS*Y]	_____	_____	_____	_____	_____
BB.	STD absenteeism	[AT*AA]	_____	_____	_____	_____	_____
BC.	***Decreased revenues in each category***	**[sum of AV through BB]**	_____	_____	_____	_____	_____
BD.	***Summary revenue impact of STD/HIV/AIDS across categories***	**[sum of all categories in BC]**				_____	
BE.	***Total revenue with STD/HIV/AIDS***	**[AU-BD]**				_____	

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*				
			SecStf	ManLab	SupMgr	TecPro	SenMgr
INCREASED EXPENDITURES							
BF.	***Organization expenditures*** **[expenditures incurred by the organization this year as reported]**					_____	
BG.	Recruitment	[AR*AB]	_____	_____	_____	_____	_____
BH.	Health care costs - AIDS	[AR*AJ]	_____	_____	_____	_____	_____
BI.	Health care costs - HIV	[(AS*AI)]	_____	_____	_____	_____	_____
BJ.	Health care costs - STD	[AT+AK]	_____	_____	_____	_____	_____
BK.	Total health care cost	[sum BH to BJ]	_____	_____	_____	_____	_____
BL.	Burial	[AR*AN]	_____	_____	_____	_____	_____
BM.	***Anticipated increased expenditures in each category due to STD/HIV/AIDS***	**[BG+BK+BL]**	_____	_____	_____	_____	_____
BN.	***Summary of anticipated expenditure impact of STD/HIV/AIDS across categories***	**[sum of all categories in BM]**				_____	
BO.	***Total expenditure with STD/HIV/AIDS***	**[BF+BM]**				_____	

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

SUMMARY OF HIV/AIDS IMPACT ON ORGANIZATION

PROJECTED HIV & AIDS CASES

BP.	AIDS cases (this year)	[sum across AR]	_____
BQ.	HIV cases (this year)	[sum across AS]]	_____
BR.	STD cases (this year)	[sum across AT]]	_____

DISTRIBUTION OF COSTS

BS.	Organization profits without AIDS	[AU-BF]	_____
BT.	Organization profits with STD/HIV/AIDS	[BE-BO	_____
BU.	**Decrease in profits as a result of STD/HIV/AIDS**	**[BS-BT]**	_____

DISTRIBUTION OF COSTS

Labor turnover	[sum across AV]	$ _____	[sum across AV*100/BU]	_____%
Training	[sum across AW]	$ _____	[sum across AW*100/BU]	_____%
Reduced productivity	[sum across AX]	$ _____	[sum across AX*100/BU]	_____%
Funeral attendance	[sum across AY]	$ _____	[sum across AY*100/BU]	_____%
AIDS absenteeism	[sum across AZ]	$ _____	[sum across AZ*100/BU]	_____%
HIV absenteeism	[sum across BA]	$ _____	[sum across BA*100/BU]	_____%
STD absenteeism	[sum across BB]	$ _____	[sum across BB*100/BU]	_____%
Recruitment	[sum across BG]	$ _____	[sum across BG*100/BU]	_____%
Health care	[sum across BK]	$ _____	[sum across BK*100/BU]	_____%
Burial	[sum across BL]	$ _____	[sum across BL*100/BU]	_____%

STD/HIV/AIDS impact per employee **$** _____

Technical Notes for Impact Spreadsheet

The letters in the left-hand column correspond to the letters of individual lines found in the spreadsheet. The technical notes describe the data needed for the individual lines and, in some cases, suggest where those data can be obtained.

I. EMPLOYEES/SALARY

A. The number of employees, by each employee category in the organization, obtained from organization records.

B. This number is obtained by dividing the gross wage (including benefits) of all employees in each category by the number of employees in that category.

II. LABOR TURNOVER

Labor turnover is treated as a loss in revenue since the number of weeks it takes to hire employees is a period of lost revenue (this cost may also represent increased expenditures if workers are hired or existing employees must be paid overtime). The cost of training is treated as a decrease in revenue because new employees in training do not contribute to productivity.

C. The number of weeks it takes to hire an employee in each category.

D. This number is obtained by multiplying line item B by line item C.

III. TRAINING

E. The number of weeks a trainer/supervisor spends in training an employee, by each employee category. This is based on how long it takes to train this cadre of employees.

F. The trainer's weekly wage is his/her weekly wage.

G. This number represents the typical class size for trainees in each employee category. If training is predominantly on a one-to-one basis, the average class size should be set to 1.

H. This is the length of time in weeks that new or promoted employees receive training, by each employee category.

I. The gross wage of a trainee per week, in each employee category. It is assumed here that the trainee will be paid a certain percentage of normal weekly gross pay. That percentage is multiplied by the average gross weekly wage. For example, if the average weekly gross wage is X (obtained from line item B), and a trainee is paid 90 percent of that during training, then the pay would be .9*X.

J. This is the training cost per employee, by each employee category. The number is obtained by multiplying E by F and then dividing the product by G (weekly salary paid to trainer divided by number of trainees).

K. This is the total salary paid to employee while in training. This number is obtained by multiplying H by I (weekly training wage per employee by the number of weeks spent in training).

L. This number represents the total cost of training each employee, obtained by adding J to K (training cost per employee added to total salary paid to employee while in training).

IV. REDUCED PRODUCTIVITY

M. Once an employee has been trained, he/she will begin working but at less than 100 percent productivity. The organization will provide information on how long it takes before a trainee reaches 100 percent productivity. If the information is in percentage (e.g. 30 percent of the year), multiply this number by 52 weeks in a year and divide the product by 100 to get the number of weeks the trainee is not yet at full productivity.

N. The organization will provide information on the employee's level of productivity after training.

O. This number represents the percentage productivity lost. It is obtained by subtracting N from 100.

P. Total wages paid to employees before they reach 100 percent productivity. It is assumed that the employee will be paid the same salary as regular employees after training.

Q. The total productivity cost is obtained by multiplying O by 0.5 and by P, and then the product is divided by 100.

Note that O through Q refer to the reduced productivity of new employees who have not reached a level of full proficiency. There is also reduced productivity due to absenteeism, but this is calculated elsewhere: AZ to BB, revenue loss due to HIV and AIDS absenteeism.

V. FUNERAL ATTENDANCE

Funeral attendance is seen as a decrease in revenue, since those who attend take time off to attend a funeral do not contribute to productivity, thus resulting in a reduction in revenue generated by the organization.

R. The organization provides the average number of paid leave days employees in each category take to attend each funeral.

S. This is the average number of workers who took paid leave to attend each co-workers' funeral. The organization provides the number of employees in each employee category.

T. Productivity loss per co-worker funeral attended, obtained by multiplying T by R/5 and by B/A.

VI. ABSENTEEISM

Absenteeism because of STDs and HIV/AIDS is treated as a loss in revenue because absent employees do not contribute to productivity. Once again, depending on how the organization responds to absenteeism, this cost may actually be an increased expenditure rather than lost revenue.

U. Average number of absent days for employees.

V. The organization provides information on the number of days during the year employees with AIDS were absent. If not available, use 65 days.

W. The cost of AIDS absenteeism to the organization, obtained by multiplying the gross weekly wage of each employee category- -i.e. B/A—by (V-U) and then by dividing the result by 5.

X. The organization provides information on the number of days during the year employees with HIV (without full-blown AIDS) were absent. If not available, use 15 days.

Y. This represents the cost of HIV absenteeism to the organization. This figure is obtained by multiplying (B/A) by (V-X) and then by dividing the result by 5.

Z. The organization provides information on the number of days during the year employees with STDs were absent. If not available, use 10 days.

AA. This represents the cost to the organization of absenteeism resulting from STDs. The figure is obtained by multiplying (B/A) by (V-Z), then dividing the result by 5.

VII. RECRUITMENT

AB. The cost the organization incurs in hiring each employee, by each category. Examples include advertising costs, medical exams, transportation reimbursement, etc.

VIII. ANNUAL HEALTH COSTS

AC. The total cost of all health claims by employees in each category, this year. If not available, obtain the total cost of all health claims for all employees in all categories, this year.

AD. The total number of employee health claims made, by each employee category. If not available, obtain the total number of claims made by all employees in all categories, this year.

AE. This number is obtained by dividing AC by AD.

AF. This is the average number of HIV-related claims made by employees during the year.

AG. This is the average number of AIDS-related claims made by employees during the year.

AH. This is the average number of STD-related claims made by employees during the year.

AI. This is the health cost per employee due to HIV, obtained by multiplying AE by AF.

AJ. This is the health cost per employee due to AIDS, obtained by multiplying AE by AG.

AK. This is the health cost per employee due to STDs, obtained by multiplying AE by AH.

IX. BURIAL COSTS/DEATH BENEFITS PER EMPLOYEE

AL. The market price of a coffin this year plus benefits paid to the deceased's family, in cash or kind. If in kind, give cash value equivalent.

AM. The cost of organization representation in funerals this year (excluding lost labor due to funeral attendance). Examples of this include transportation of employees to funerals, flowers, per diem, etc.

AN. This is the total burial cost, obtained by adding AL to AM.

X. HIV/AIDS RATES

(assume the same for each category of employee unless specific information available)

AO. To obtain AIDS prevalence rates (%), use the rates of the city/area/region where the organization is located. If this information is not available, use the national AIDS prevalence rates.

AP. Use the same rule as in AO above to obtained HIV prevalence rates.

AQ. Use the same rule as in AO above to obtain STD prevalence rates.

AR. This number is obtained by multiplying the AIDS prevalence rate, AO, by the number of employees in each employee category, A. For example, if the AIDS prevalence rate is X and the number of employees in the support employee category is Y, the number of new AIDS cases will be obtained by X*Y and divide the result by 100.

AS. This number is obtained by multiplying the HIV prevalence rate, AP, by the number of employees, in each employee category, A then dividing by 100. For example, if the HIV prevalence rate is X and the number of employees in the support employee category is Y, then the new HIV cases is X*Y/100.

AT. This number is obtained by multiplying the STDs prevalence rate, AQ, by the number of employees, in each employee category. For example, if the STDs prevalence rate is X and the number of employees in the support employee category is Y, then the new STDs cases in this category will be X*Y/100.

ANTICIPATED DECREASED REVENUES AND INCREASED EXPENDITURES

AU. The organization will provide the revenue figure for the year.

AV. To calculate decreased revenues due to labor turnover, multiply D by AR.

AW. To calculate decreased revenues due to training, multiply L by AR.

AX. To calculate decreased revenue due to productivity loss, multiply Q by AR.

AY. To calculate decreased revenue due to funeral attendance, multiply U by AR.

AZ. To calculate decreased revenue due to AIDS absenteeism, multiply W by AR.

BA. To calculate decreased revenue due to HIV absenteeism, multiply Y by AS.

BB. To calculate decreased revenue due to STDs absenteeism, multiply AA by AT.

Where the epidemic has hit some categories of workers expecially hard, some companies have resorted to double hiring in anticipation of higher labor turnover due to AIDS. Thus, the values in AV through BA will increase to reflect these costs.

BC. To get total decreased revenue due to HIV/AIDS, add AV through BB.

BD. To get total decreased revenue across all categories, add BC across all employee categories.

BE. To get total revenue in the presence of STDs, HIV and AIDS, calculate the difference between AU and BD.

BF. The organization will provide the expenditure figure for the year.

BG. To calculate the increased expenditure for recruitment due to AIDS, multiply AB by AR.

BH. To calculate increased expenditures due to AIDS, multiply AJ by AR.

BI. To calculate increased expenditures due to HIV, multiply AI by AS.

BJ. To calculate increased expenditures due to STDs, multiply AK by AT.

BK. To calculate the total health care cost, add BH to BJ.

BL. To calculate the increased expenditure due to burial, multiply AN by AR.

BM. To calculate increased expenditures due to HIV/AIDS/STDs in each category, add BG, BH, and BI.

BN. The summary of anticipated expenditure due to HIV/AIDS/STDs is obtained by adding BJ across all employee categories.

BO. Total expenditure in the presence of HIV/AIDS/STDs is the sum of BF and BJ.

BP. To get the total number of new AIDS cases in the organization this year, add AR across all employee categories.

BQ. Total number of new HIV cases in the organization this year is obtained by adding AS across all employee categories.

BR. To get the total number of new STDs cases in the organization this year, add AT across all employee categories.

BS. To calculate profits under the no-AIDS scenario, substract the difference between AU and BF.

BT. To calculate profits under the AIDS scenario, substract the difference between BE and BL.

BU. To calculate the decrease in profits due to AIDS, substract the difference between BP and BQ.

III. ILLUSTRATIVE EXAMPLE OF IMPACT SPREADSHEET

DETERMINING THE FINANCIAL IMPACT OF HIV/AIDS ON A WORKPLACE:
An Example from a Kenya Company
(cost figures in US$)

		Category of Employee*					
		SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
I.	**EMPLOYEES/SALARY**						
A.	Number (#) of employees [total # in each category of staff in the organization]	1,008	44	28	5	5	1,090
B.	Gross weekly salary [gross weekly salary of all staff in each category]	31,752	660	1,638	750	3,125	37,925
II.	**LABOR TURNOVER**						
C.	# of weeks to hire an employees in each category	1	1	9	9	9	29
D.	***Lost labor cost*** **[C*B/A]**	32	135	527	1,350	18,125	20,168
III.	**TRAINING**						
E.	Trainers' time in weeks [# of weeks trainer is training in each staff category]	7	2	2	2	4	17
F.	Trainers' wage per week [weekly gross salary of trainers]	32	15	59	150	625	880
G.	Class size [the typical class size for training in each category]	10	3	3	1	1	18
H.	Trainees' time [# of weeks trainees are in training]	7	2	2	2	4	17

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
I.	Weekly training wage per trainee [% of gross weekly wage, B, paid to trainee]		29	14	53	137	569	801
J.	Trainer cost per employee	[(E*F)/G]	22	10	39	300	2,500	2,871
K.	Total salary paid employee during training	[H*I]	201	27	106	273	2,275	2,882
L.	Total training cost	[J+K]	223	37	145	573	4,775	5,753
IV.	**REDUCED PRODUCTIVITY**							
M.	# of weeks after training before productivity reaches 100%		19	2	13	13	13	60
N.	Productivity immediately after training [% productivity immediately after training]		80.0	80.0	80.0	80.0	80.0	
O.	Percentage productivity lost	[100-N]	20.0	20.0	20.0	20.0	20.0	
P.	Total wages paid to the employee before productivity reaches 100%	[M*B/A]	599	30	761	1,950	8,125	11,464
Q.	***Total productivity cost***	**[(.5*O*P)/100]**	60	3	76	195	813	1,146
V.	**FUNERAL ATTENDANCE**							
R.	Average # of paid leave days a worker takes to attend a co-worker's funeral		3	3	3	3	3	15
S.	Average # of workers who took paid leave to attend each co-worker's funeral this year		20	5	3	2	1	31
T.	***Productivity loss per co-worker funeral attended***		378	45	105	180	375	1,083

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

		Category of Employee*					
		SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
VI.	**ABSENTEEISM**						
U.	Average # of absent days for employees	10	10	10	10	10	50
V.	AIDS absenteeism [# of days during this year workers with AIDS were absent]	75	75	75	75	75	375
W.	***AIDS cost*** **[B/A*(V-U)/5]**	410	195	761	1,950	8,125	11,440
X.	HIV absenteeism [# of days this year workers with HIV were absent]	25	25	25	25	25	125
Y.	***HIV cost*** **[B/A*(X-U)/5]**	95	45	176	450	1,875	2,640
Z.	STD absenteeism [#of days this year workers with STDs were absent]	20	20	20	20	20	100
AA.	***STD cost*** **[B/A*(Z-U)/5]**	63	30	117	300	1,250	1,760
VII.	**RECRUITMENT**						
AB.	***Recruitment cost*** [recruitment cost per employee hired in each category]	80	80	200	200	200	760
VIII.	**ANNUAL HEALTH COSTS**						
AC.	Total cost of all employee claims this year	3,000	3,000	2,000	2,000	2,000	12,000
AD.	Total # of employee claims this year	463	463	45	45	45	1,061
AE.	***Cost per claim this year*** **[AC/AD]**	6	6	44	44	44	146
AF.	Average # of health claims per employee with full-blown AIDS	4	4	4	4	4	20

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
AG.	Average # of HIV-related claims per employee, prior to full-blown AID		3	3	3	3	3	15
AH.	Average # of STD-related claims per employee		2	2	2	2	2	10
AI.	***Health care cost per employee due to AIDS***	**[AE*AF]**	26	26	178	178	178	585
AJ.	***Health care cost per employee due to HIV***	**[AE*AG]**	19	19	133	133	133	439
AK.	***Health care cost per employee due to STD***	**[AE*AH]**	13	13	89	89	89	293

IX. BURIAL COSTS/DEATH BENEFITS PER EMPLOYEE

AL.	Cost of a coffin (if paid for by organization) plus other death benefits paid to family		100	100	100	100	100	500
AM.	Other costs (not paid to family), excluding lost labor due to funeral attendance		20	20	20	20	20	100
AN.	***Total burial cost***	**[AL+AM]**	120	120	120	120	120	600

X. HIV/AIDS rates (may assume the same for each category of employee unless specific information available)

AO.	AIDS Prevalence (%)		1.20	1.17	1.17	1.17	1.17	5.88
AP.	HIV prevalence (%)		14.00	14.00	14.00	14.00	14.00	70.00
AQ.	STD prevalence (%)		10.00	10.00	10.00	10.00	10.00	50.00
AR.	AIDS cases	[A*AO/100]	12	1	0	0	0	13
AS.	HIV cases	[A*AP/100]	141	6	4	1	1	153
AT.	STD cases	[A*AQ/100]	101	4	3	1	1	109

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

ANTICIPATED DECREASED REVENUES & INCREASED EXPENDITURES

DECREASED REVENUES

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
AU.	**Organization revenue without AIDS [revenue for this year as given by organization]**							6,219,713
AV.	Labor turnover	[AR*D]	381	69	172	79	1,060	1,762
AW.	Training	[AR*L]	2,694	19	48	34	279	3,074
AX.	Reduced productivity	[AR*Q]	724	2	25	11	48	809
AY.	Funeral attendance	[AR*T]	4,572	23	34	11	22	4,662
AZ.	AIDS absenteeism	[AR*W]	4,953	100	249	114	475	5,892
BA.	HIV absenteeism	[AS*Y]	13,336	277	688	315	1,313	15,929
BB.	STD absenteeism	[AT*AA]	6,350	132	328	150	625	7,585
BC.	***Decreased revenues in each category*** **[sum of AV through BB]**		33,011	623	1,544	714	3,822	39,713
BD.	***Summary revenue impact of STD/HIV/AIDS across categories***	**[sum of all categories in BC]**	39,713					
BE.	***Total revenue with STD/HIV/AIDS***	**[AU-BD]**	6,180,000					

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*					
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total
INCREASED EXPENDITURES								
BF.	***Organization expenditures without AIDS*** **[expenditures incurred by organization this year as reported]**							5,261,656
BG.	Recruitment	[AR*AB]	968	41	66	12	12	1,098
BH.	Health care costs - AIDS	[AR*AI]	314	13	58	10	10	406
BI.	Health care costs - HIV	[AS*AU]	2,743	120	523	93	93	3,572
BJ.	Health care costs - STD	[AT*AK]	1,306	57	249	44	44	1,701
BK.	Total health care costs	[Sum BH to BJ]	4,363	190	830	148	148	5,679
BL.	Burial	[AR*AN]	1,452	62	39	7	7	1,567
BM.	***Anticipated increased expenditures in each category due to STD/HIV/AIDS***	**[BG+BK+BL]**	6,782	293	935	167	167	8,344
BN.	***Summary of anticipated expenditure impact of STD/HIV/AIDS across categories***	**[sum of all categories in BM]**						8,344
BO.	***Total expenditures with STD/HIV/AIDS***	**[BF+BN]**						5,270,000

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

			Category of Employee*				
			SecStf	ManLab	SupMgr	TecPro	SenMgr	Total

SUMMARY OF ESTIMATED STD/HIV/AIDS IMPACT ON THE ORGANIZATION

PROJECTED HIV & AIDS CASES

BP.	AIDS cases (this year)	[sum across AR]	13
BQ.	HIV cases (this year)	[sum across AS]	153
BR.	STD cases (this year)	[sum across AT]	109

DISTRIBUTION OF COSTS

BT.	Organization profits without STD/HIV/AIDS	[AU-BF]	958,057
BS.	Organization profits with STD/HIV/AIDS	[BE-BO]	910,000
BU.	**Decrease in profits as a result of STD/HIV/AIDS**	**[BS-BT]**	48,057

	Amount		Percentage	
Labor turnover	1,762	[sum across AV]	3.67%	[sum across AV*100/BU]
Training	3,074	[sum across AW]	6.40%	[sum across AW*100/BU]
Reduced productivity	809	[sum across AX]	1.68%	[sum across AW*100/BU]
Funeral attendance	4,662	[sum across AY]	9.70%	[sum across AY*100/BU]
AIDS absenteeism	5,892	[sum across AZ]	12.26%	[sum across AZ*100/BU]
HIV absenteeism	15,929	[sum across BA]	33.15%	[sum across BA*100/BU]
STD asbsenteeism	7,585	[sum across BB]	15.78%	[sum across BB*100/BU]
Recruitment	1,098	[sum across BG]	2.28%	[sum across BG*100/BU]
Health care	5,679	[sum across BH]	11.82%	[sum across BG*100/BU]
Burial	1,567	[sum across BI]	3.26%	[sum across BI*100/BU]
STD/HIV/AIDS cost per employee	**44**			

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

Projected Financial Impact of HIV/AIDS on the Organization in the Year 2005 (Summary)

Projected HIV/AIDS and STDs

AIDS cases	33
HIV cases	262
STD cases	218

Distribution of Costs

Organization profits without HIV/AIDS/STDs	958,057
Organization profits with HIV/AIDS/STDs	787,066
Decrease in profits due to HIV/AIDS/STDs	170,991

	Amount	Percent
Labor turnover	953	0.56%
Training	6,735	3.94%
Reduced productivity	1,810	1.06%
Funeral attendance	11,431	6.68%
AIDS absenteeism	99,066	57.94%
HIV absenteeism	22,861	13.37%
STD absenteeism	12,700	7.43%
Recruitment	2,753	1.61%
Health care	8,758	5.12%
Burial	3,924	2.29%
Cost per employee	**157**	

* SecStf = Secretarial or support staff; ManLab = Manual laborers; SupMgr = Supervising managers; TecPro = Technical professionals; SenMgr = Senior managers

SESSION 3:

BG #5 The information in this background note represents current (late 1995) scientific and educational thinking and experience about condom efficacy, the relationship between STDs and HIV, and sex education for youth. Facilitators may want to consider photocopying the notes for future reference by participants. The myths are statements that are frequently voiced to discredit HIV/AIDS prevention efforts.

CONDOM FACTS

Myth: Condoms are ineffective in preventing the transmission of HIV.

Fact: A number of recent studies have demonstrated that latex condoms are highly effective in preventing the sexual transmission of HIV when the condoms are used regularly and correctly. The Centers for Disease Control and Prevention (CDC) in the United States reports:

> "In a study of discordant couples in Europe, among 124 couples who reported *consistent* condom use, *none* of the uninfected partners became infected. In contrast, among the 121 couple who used condoms inconsistently, 12 of the uninfected partners became infected."(1)

A study of discordant couples in Italy found that two percent of uninfected partners who used condoms consistently became HIV-infected. The rate was 15 percent among couples who used condoms inconsistently.(2)

The incidence of condom breakage during sexual intercourse is about 1 percent.(3) Inconsistent use of condoms plays a much larger role in HIV transmission than does the structural failure of condoms.(4)

Laboratory studies have demonstrated that HIV cannot pass through latex condoms, even when virus concentrations are higher than those found in semen.(5) A study of 12 brands of condoms found that the eight brands with the highest strength test scores produced no leakage of HIV. Among the five brands with the lowest strength test scores, 7 percent (3 of 40) were not leak free.(6)

The greatest failure with condoms is in their use (or non-use). Incorrect placement on the penis, use of a non-water-based lubricant, and/or late withdrawal contribute to potential breakage or slippage.

Myth: Condoms are ineffective in stemming the epidemic.

Fact: Condoms are a crucial part of an overall campaign for HIV/AIDS prevention. Thailand is recognized as having an active commercial sex industry, cultural norms that sanction pre-marital intercourse with commercial sex workers (CSW), and high rates of HIV and other STDs. The country is also recognized as having taken aggressive measures to control the epidemic. Those measures have included highly visible educational campaigns, increased availability of STD treatment, promotion of condom use, and a policy requiring clients of CSWs in brothels to use condoms in all sexual encounters in the brothels. By 1993, prevalence rates among military conscripts were 3.7 percent nationwide, and more than 12 percent in the far North. That year seems to have been the peak of the epidemic in Thailand. In 1994, national prevalence declined to 3.0 percent and prevlance in the far North declined to 7.9 percent. The authors of this study conclude that "this decline is most likely due to changes in behavior. The prevalence in CSW has not been decreasing; therefore, other factors, including condom use, less frequent visits to CSW, and decreasing STD may have contributed to the lower rate of infections."(7)

(1) Centers for Disease Control and Prevention, "Update: Barrier protection against HIV infection and other sexually transmitted diseases," *Morbidity and Mortality Weekly Report*, 42, 30 (1993), pp. 589–91.

(2) As reported in *Network*, 14, 2, p. 1. The study was carried out by the HIV Centre of Ospedale San Raffaele, Milano, Italy.

(3) C. Chan-Che, et al., "Use and misuse of condoms," *Genitourinary Medicine*, 67 (1991), p. 173.

(4) Alexa E. Albert, et al., "Condom use among female commercial sex workers in Nevada's legal brothels," *American Journal of Public Health*, 85, 11 (November 1995), pp. 1514–20.

(5) F.M. Judson, et al., "In vitro evaluation of condoms with and without nonoxynol-9 as physical and chemical barriers against chlamydia trachomatis, HSV type 2 and HIV," *Sexually Transmitted Diseases*, 16 (1989), pp. 51–56; cited in Peter Lamptey, "Barrier contraceptives and the interaction between HIV and other sexually transmitted diseases," in *Heterosexual Transmission of AIDS*. Nancy J. Alexander, et al. (eds). New York: Wiley-Liss, 1990, pp. 255–265.

(6) Bruce Voeller, "Relevance of condom testing," in *Heterosexual Transmission of AIDS*. Nancy J. Alexander, et al. (eds). New York: Wiley-Liss, 1990, pp. 365–378.

(7) Carl J. Mason, et al., "Declining prevalence of HIV-1 infection in young Thai men," *AIDS*, 9 (1995), pp. 1061–65.

SEX EDUCATION AND YOUTH SEXUAL BEHAVIOR

Myth: Condom promotion contributes to promiscuity and early on set of sexual relations.

Fact: Sexual activity for adolescents tends to begin in the middle or late teenage years. Studies from Africa indicate onset of sexual relations for at least of half of young people by age 16. Few of these sexual encounters among adolescents involve condom use.(1) Often adolescents have little information about the changes occurring in their bodies or about sexual relations. However, most young people would like to have more information about sexuality and most would like to receive that information from sources they trust most: parents, informed peers, and other respected adults.(2)

A survey commissioned by the World Health Organization, Global Programme on AIDS (WHO/GPA) of research on adolescent sexual behavior in developing and developed countries indicated that sex education provided in schools does not lead to earlier or increased sexual activity among young people.(3)

One such study, of Latino youth in two cities in the northeastern United States, sought to answer questions about the influence of condom promotion on sexual behavior. The researchers concluded that "an HIV prevention program that included the promotion and distribution of condoms provided no evidence to suggest that the availability of condoms increased sexual activity or promoted promiscuity in the target population of Latino adolescents."(4)

(1) For a report on the impact of an AIDS education campaign, see Knut-Inge Klepp, et al., "AIDS education for primary school children in Tanzania: an evaluation study," *AIDS*, 8 (1994), pp. 1157–62.

(2) MAP International, Nairobi, Kenya. Unpublished study, 1995.

(3) Anne Grunsett and Susan Kippax, *Effects of Sex Education on Young People's Sexual Behavior*, Geneva: WHO/GPA, 1993.

(4) Deborah E. Sellers, Sarah A. McGraw and John B. McKinlay, "Does the promotion and distribution of condoms increase teen sexual activity? Evidence from an HIV prevention program for Latino youth," *American Journal of Public Health*, 84, 12 (12–1994), pp. 1952–58.

STDS AND HIV

HIV is one of a number of sexually transmitted diseases (STDs). STDs affect both men and women, although several common STDs of women do not produce visible symptoms. STDs are infections and may cause open sores or genital discharges. The most common STDs that cause genital ulcers are chancroid, syphilis and herpes. Chlamydial infection, gonorrhea, and trichomoniasis are also common but doe not cause genital ulcers.

HIV is carried in bodily fluids, and the presence of genital ulcers increases the likelihood that the bodily fluids carrying the virus will enter the body. STDs are thought to increase a person's susceptibility to HIV or infectiousness for HIV infection. STDs do this by causing breaks in the skin, either large or microscopic, or by increasing the number of cells susceptible to HIV at the site of the STD.(1,2,3)

(1) Gina Dallabetta, "The STD-HIV link," *AIDSCAPTIONS* (May 1996), p. 8.

(2) J.N. Wasserheit, "Epidemiological synergy: Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases," *Sexually Transmitted Diseases*, 19, 2 (1992), pp. 61–77.

(3) "Controlling Sexually Transmitted Diseases," *Population Reports*, series L, 9 (1993), p. 6.

Session 4:

BG #6 Each group can work on the same case study or each group can use a different example. This decision should be made by the facilitator. If everyone uses the same case study, a common base for discussion will exist. However, two or three case studies offer diversity and different experiences to learn from.

The case studies in *Africa Workplace Profiles* give some guidance in selecting ones for use, since they include a heading referring to the country and the type of business. The background of participants may influence the facilitator's choice.

On the next page is a matrix that can be used by participants to list the major features of the companies they review.

The case studies were written at a time when a limited number of companies had responded to HIV/AIDS. Even fewer companies were willing or able to provide financial data for assessing the impact of AIDS on company profitability. The case studies represent company situations in the latter half of 1994 or early 1995. The companies are, for the most part, large and well-established. They represent a cross-section of commercial activities, from agriculture to finance to transportation. The research for the case studies was undertaken by indigenous and expatriate researchers. The methodology for the research is described in the *Conducting a Workplace HIV/AIDS Policy Needs Assessment*.

HIV/AIDS PREVENTION PROGRAMS

COMPANY PROFILE

Type of Prevention Program	Education & Awareness	Condom Distribution	STD Treatment	Counseling
When implemented				
Regularity				
When provided				
Where provided				
Who designs & delivers				
Employee response				
Management response				
Impact				

BG #7 The next page can be used as a hand out or as an overhead.

Components of a Comprehensive HIV/AIDS Prevention Program

Formal and informal HIV/AIDS prevention education
Condom distribution
STD diagnosis and treatment
Counseling and support services

Features that Lead to Success of HIV/AIDS Prevention in the Workplace

Clear, widely understood policies and practices
Participation by all workers
Prevention for all employees
Visible senior management support
Long-term commitment of resources

HIV/AIDS PREVENTION IN THE WORKPLACE
PART/DAY 2

Session 5: PLANNING HIV/AIDS PREVENTION PROGRAMMES AND POLICIES (60 minutes)

Objective:

- Stress the value of planning for effective HIV/AIDS prevention programs and policies

MESSAGE:	METHODS:
■ The previous sessions dealt with the reasons for HIV/AIDS prevention and provided experience in assessing the impact of HIV/AIDS on a company and the cost of mounting prevention efforts. The sessions today are designed to provide practical, hands-on guidelines for developing, modifying, or expanding HIV/AIDS prevention programs and policies. ■ The experiences of other businesses that have developed in-house employee enhancement programs—including AIDS awareness and prevention programs—point to three factors that help ensure the success of company programs and policies: □ Management support and commitment to workplace prevention efforts, including a commitment of staff time and company financial resources;	■ Facilitate participant discussion to gather their input on elements of business planning. The facilitator might ask participants what steps their companies take in planning, and relate these steps to the three factors. From the comments, refer to those similar to the three factors. Summarize the responses on a flip chart and hang it along with a flip chart list of the three factors. **BG #9**

Session 5 (continued)

MESSAGE:	METHODS:
□ Employee interest and participation in planning and implementation; □ Background information to create the content of policies and programs. ■ These requisites are not unique to HIV/AIDS prevention planning, but are seen in most planning efforts. Thus, we will not discuss them in detail. However, the work today will refer occasionally to these requisites and illustrate their importance to companies planning a HIV/ AIDS prevention program within the workplace. **BG #8**	

Session 6: DEFINING COMPANY HIV/AIDS POLICIES (120 minutes)

Objective: ■ Provide hands-on experience identifying appropriate policies for each participant's organization

MESSAGE:	METHODS:
■ This session will provide each participant the opportunity to identify policies and procedures to best address HIV/AIDS prevention in the workplace. ■ It is not the purpose to have fully developed or finalized policies by the end of the session; as discussed earlier, an in-house commitment and process can guide policy development and implementation. The exercise during this session will make participants familiar with policies so they can be informed contributors to the process within their own companies. ■ Companies will benefit from HIV/AIDS policies because they: □ Offer a **foundation** for a company prevention program. □ Provide a framework for **consistency of practice** in the business. □ Express **standards of behavior** expected of all employees. □ **Inform** employees about available assistance and how to obtain it.	■ Briefly outline how HIV/AIDS policies will assist businesses. **BG #10** Ask participants to identify issues related to HIV/AIDS that are a concern in their companies. If responses are slow, the facilitator can ask questions like: □ Are employees concerned about working with people who may be HIV-positive? □ Are medical benefits available for all employees who become ill with AIDS? Record the issues on a flip chart, trying to build a list of at least five or six issues.

Session 6 (continued)

MESSAGE:	METHODS:
□ **Guide supervisors** on how to manage situations involving HIV/AIDS in the workplace. □ Assure **consistency with** national and local **statutes.** ■ The exercise during this session provides an opportunity to design HIV/AIDS prevention policies. The exercise is divided into four parts: □ Read the section in Module 6 of the *Manager's Guide* that discusses the rationale for HIV/AIDS policies. □ Group discussion based on the reading. □ A hands-on exercise to begin to design policies for your companies. □ Feedback on the exercise. The purpose is to address some of the key issues likely to exist in your companies. Some of the examples can be taken back to your businesses, but it is primarily an exercise to think about types of policies and how those policies can be prepared. As guidance, the *Manager's Guide* provides illustrative HIV/AIDS policies. Also, the case studies in *African Workplace Profiles* provide examples of policies of several African companies. Use these to inform your policy planning, but come up with policies that are relevant to your company.	■ Provide participants with the list of issues and questions found in the Background materials. These will assist participants to make decisions about the issues to be addressed in their policies and the level of detail they decide to include. **BG #11 & 12** ■ Divide participants into working groups of three to four people. It is preferable that people with similar job functions (e.g. human resources, medical officers) work together. That will provide more coherence to the working group discussions. ■ A report-back session, following work on company policies, will provide groups the chance to discuss their work. Use the three questions below to focus the discussion, or prepare other questions that are relevant to the specific group. ■ The facilitator can draw upon the comments from the report-back session to frame a concluding statement. Try to link one or more of the points from the report-back to a particular issue, policy planning, or participation.

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Session 6 (continued)

MESSAGE:	METHODS:
Also, some guiding questions are available to help your considerations. ■ During report back, each group should report on the following: □ What level of detail was selected and why? □ What was the most difficult policy to prepare and why? □ From this experience, what lessons are learned that will make preparing company policies easier?	

Session 7: HIV/AIDS PREVENTION PROGRAMS WITHIN THE WORKPLACE (120 minutes)

Objective:

- Become familiar with the basic components of a comprehensive workplace HIV/AIDS prevention program

MESSAGE:	METHODS:
■ This session will provide hands-on experience in developing the basic components of a comprehensive HIV/AIDS prevention program for the workplace. Participants can do the activity in as much detail as they want. They can outline a whole prevention program or focus on one part of such a program and provide lots of detail. In either case, participants should be encouraged to think in terms of what will be most helpful for their organization in the design process. It is helpful to keep three points in minds: □ Keep the program manageable by building as much as possible upon existing company benefits/welfare programs and/or planning processes. □ As much as possible, the program should be comprehensive. □ Whatever is designed also has to be implemented; make sure the planning is realistic.	■ Present a brief overview of the session. **BG #13** In a 20–30 minute presentation, outline the four major components of a workplace HIV/AIDS prevention program. Use examples from your own experience and/or from the *African Workplace Profiles* volume. Specific company examples will provide depth and clarity to the four components.

Session 7 (continued)

MESSAGE:	METHODS:
■ Some companies decide to develop and implement a prevention program with their own staff and resources. Other choose to contract with another organization that has expertise in such programs. In either case, management needs to know what to do and what to look for and to have an overview of the entire program. This session will help provide that overview. ■ A comprehensive HIV/AIDS prevention program includes: □ Prevention information and education, designed to alter people's sexual behavior □ Condom distribution □ STD diagnosis and treatment □ Counseling services The comprehensive program presented reflects the experiences of HIV/AIDS prevention specialists through 1996. Components and emphasis may change as new information and experiences occur. Also, each company will shape a program to fit its needs. ■ There are materials available to help the planning. Module 5 of the *Manager's Guide* describes in detail the four components above. It is not recommended that participants read Module 5 now, but refer to it for ideas and guidance.	■ Following the introductory presentation, the session should be largely hands-on for participant. ■ Distribute the four HIV/AIDS prevention program worksheets. The worksheets are a tool for participants to use as an initial step in designing prevention programs in the workplace. Participants will make short notes within the matrix for each prevention program component. When finished, they will have the outline of a prevention program. **BG #14** The worksheets will be completed by each individual. Allow 40 minutes for completion of all four worksheets.

Session 7 (continued)

MESSAGE:	METHODS:
■ Report back on the HIV/AIDS prevention program planning. Answer the following questions: □ Are there components of the program that you did not include? If so, what was the reason? □ For people who plan to have an outside organization help develop and/or implement their program, what was the reason?	■ Use the feedback from the groups to stimulate a discussion about the composition of prevention programs provided by each participant's company. Look for commonalities in the responses. Ask participants the reasons why they made the choices they did. The discussion should stimulate sharing of information and rationales for designing prevention program components.
■ Putting it all together: Who? What? When? Where? How? Several options exist for companies developing a HIV/AIDS prevention programs. For example: □ Hire organizations with experience in the design and implementation of prevention education programs. □ Use existing systems for acquiring condoms for distribution to employees. Government or non-governmental organizations are likely to have existing condom acquisition and distribution programs. □ Contract with organizations experienced in training counselors or in providing counseling to people seeking HIV tests, who are HIV-positive, or who are affected by people who are HIV-positive.	

Session 7 (continued)

MESSAGE:	METHODS:
□ The provision of medical services, such as STD treatment, is likely to depend on company size. Companies without medical services may rely on an employees' own contacts or may seek to contract with a doctor or other medical provider. In companies in which a well-developed training infrastructure exists, it may be decided to develop the additional skills for in-house education and counseling. The same could occur with medical facilities.	

Session 8: SUMMING UP (15 minutes)

Objective: ■ Gain participant commitment to take next steps within their own companies

MESSAGE:	METHODS:
■ Summarize the workshop activities, emphasizing the major points you as facilitator made. Also emphasize the major points raised by participants.	■ Present participants with a summary of the main points of the day.
■ Use the summary to ask participants: "Where do you go from here?"	■ Use the question listed in the **Message** section to stimulate discussion of next steps.
The question is intended to imply that today's workshop is one part of the foundation for ensuring that AIDS does not become an economic burden on your companies. The information presented in the workshop and that can be found in the *Manager's Guide* will help design or expand your prevention programs. An "Action Plan" matrix is being distributed that can help organize steps for making AIDS prevention a reality.	■ Distribute the matrix for a "Company Action Plan." The matrix is only an outline, but it suggests some of the steps that companies can incorporate into their HIV/AIDS prevention planning. **BG #15**
	■ If the facilitators' organization is able to provide technical assistance to companies, let participants know how to contact you.
	■ Take any final questions.
■ There are other sources of information and assistance, as well. These are listed on a handout.	■ Distribute any remaining handouts, including the list of technical contacts for further information. **BG #16**

BACKGROUND INFORMATION FOR PART/DAY 2 SESSIONS

SESSION 5:

Conclude this section by stressing that the planning process fits the nature of the epidemic. As in any public health epidemic, rapid

BG #8

changes in the HIV/AIDS epidemic can be expected to occur over the next several years. A growing number of people who are HIV infected will become ill and die. There may be disruptions in production. Business planning—whether to increase profits or establish certain workplace conditions—is designed to respond to changing conditions and new opportunities. The dynamic nature of AIDS is a challenge to businesses, but the pressures for changes in business practices need not be considered new or unusual.

One of the challenges for businesses will be to adapt to the evolution of the epidemic. For example, the information provided by an initial prevention education program will need to be up-dated, modified and supplemented as months and years go by. The basic safe-sex messages that are likely to be a part of an employee awareness education program may become boring after being repeated several times. Other ways to stress safe-sex will have to be devised. The program is likely to move from awareness to more specific education about care of people with AIDS, employee morale, and company policies.

The point is that there is no single program that can remain unchanged over months and years. Effective planning at the beginning, and continued monitoring and up-dating, will permit effective changes over the years.

BG #9

Different organizations may have different planning approaches. In general, however, a planning structure will be logical, sequential and include the following steps (or elements):

- Problem identification
- Background and supporting information collection and analysis
- Options outlined and prioritized
- Program design
- Implementation
- Evaluation

See Module 2 in the "Manager's Guide" for a discussion of the key elements in the planning process.

SESSION 7:

BG #10

It is assumed that participants know what a policy is. However, the word policy is often used without a common understanding. As used here, **policy (or a set of policies)** is the framework for guiding the activities of an organization/company. A policy offers the reason for more specific directions and actions; the more detailed actions are described through rules and procedures. A policy is a general statement setting out an organization's position on an issue.

Example: *It is the policy of this company that newly hired support staff will work for a probationary period of three months and professional staff for a probationary period of six months. At the end of the probationary period, both the staff person and the company will determine whether the probationary period has resulted in satisfactory performance and whether employment will become permanent.*

Policies provide guidance on procedures and expected processes:

Example: *It is the policy of this company that employees will receive year-end bonuses, if their annual work performance assessment is at least satisfactory and if company profitability permits. The company board of directors will determine the level of bonuses, but no employee will receive an amount greater than ten time that of any other employee.*

Some companies have *decided* not to have explicit policies regarding HIV/AIDS. Levi Strauss, a multinational headquartered in the United States, introduced an aggressive prevention education program for all employees, but determined that HIV/AIDS would be treated as a medical condition similar to cancer, high blood pressure, or other chronic illnesses. In other words, it was felt that no specific policy relating to AIDS was necessary.

Thus, HIV/AIDS prevention policies may be developed in detail or not exist at all. However, each company must examine the issues and decide what policies will best meet their needs. This is not the same as saying that companies can ignore policies. Levi Strauss and others spent extensive time reviewing issues and assessing what policies and programs would best meet their needs.

BG #11

Among the HIV/AIDS issues which businesses may consider for policy adoption are:

- Testing of applicants and employees (which is not recommended)
- Adjustments within the workplace and work schedules for HIV-positive employees
- Provision of benefits to HIV-positive employees, employees with AIDS, and for death of employees
- Provision of benefits and services for families of employees
- Confidentiality of employee serostatus

Each of these issues has several components. See BG#12 for examples of the additional components.

BG #12 QUESTIONS THAT CAN HELP SHAPE HIV/AIDS POLICIES FOR BUSINESSES

1) **Testing for HIV**

- Will applicants and existing employees be tested for HIV virus?
- Will employment for potential employees and/or existing employees be dependent upon HIV status?
- If testing is considered appropriate, how often will existing employees be required to take HIV tests?
- Will pre-and post-test counseling be available?
- Will employees be informed they are being tested for the HIV virus?
- What action will be taken if existing employees are tested and found to be HIV positive?
- Will testing conflict with existing national laws or company policies or guidelines on discrimination against particular groups?
- Will employees selected for training be subject to HIV testing?

2) **Confidentiality**

- Who has access to medical records of employees?
- Will confidentiality be maintained for employees known to be HIV positive?
- How will the company assure both individual confidentiality and workplace preparedness and accommodation?

3) **Provision of Benefits**

- Will health status (or more specifically, HIV status) be a criteria in determining qualification for health, insurance, leave and death benefits?
- Will the company offer prevention education for some/all employees?
- Will the company permit designated and trained peer educators to provide services on company time?
- Will the company make condoms available (either free or for sale) to employees and assure a regular and adequate supply?
- Will the company offer counseling services to HIV positive employees or employees with HIV positive family members?

4) **Work Conditions**

- Will an employee's HIV status be a factor in continued employment?
- How will the company deal with absenteeism related to HIV illnesses?
- Is the company prepared to shift HIV positive personnel to positions that are less demanding, if physical conditions require it?
- How will the company respond to employee fears/concerns about working with co-workers who are (or who are suspected of being) HIV positive?

Other Questions

- To whom does the policy apply, all employees or certain groups?
- How will the policy be communicated to employees?
- Who is responsible for interpreting the policy if and when questions arise?
- Does the policy clearly describe the responsibilities of employees and employer?
- Does the policy require a means for appeal? If so, does the policy outline an appeal process?
- What is the potential impact of the policy on company operations and employee work behavior?
- If the policy includes benefits or penalties, are those benefits or penalties clearly outlined?

SESSION 7

BG #13 **Four Components of a Workplace HIV/AIDS Prevention Program**

- **Prevention Information & Education**
- **Condom Distribution**
- **STD Diagnosis and Treatment**
- **Counseling & Support Services**

See Module 5 of the *Manager's Guide* for a discussion of the prevention components.

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BG #14 The four worksheets on the following pages can be used by participants to develop HIV/AIDS prevention programs. There are four worksheets, one for each of the four main types of prevention programs: formal and informal education, condom availability, STD services, and counseling services. The worksheets can be used in the initial stages of planning prevention interventions, to help participants think through basic questions about types, levels and extent of services. Once a general outline is available, more in-depth planning can occur.

Each worksheet has instructions. Except for the worksheet on "Awareness and Education," the other three worksheets involve working down the columns and not across the rows.

Awareness and Education in the Workplace: Worksheet for Program Planning

Note: Fill in the columns as completely as possible for each type of education format.

- List all audiences that the particular education format will be targeted toward.
- "Frequency" means how often a particular resource or activity will be displayed or presented.
- "Who Designs" refers to whether the resources or activities will be prepared in-house or by an outside organization.
- "Who Delivers" refers to who will be responsible for displaying, distributing or presenting the resources/materials.

Types of Education Formats	Who is the Audience	Frequency of Activities	Who Designs & Updates	Who Delivers
Posters				
Brochures & pamphlets				
Videos				
Lapel pins or badges				
Informal discussions—in groups, one-on-one, with peer				
Workshops/seminars				
Lectures				
Peer Educators				

Condom Availability and Distribution in the Workplace

Note: Work down the columns, not across the rows. The wide columns identify issues to consider in planning condom distribution in the workplace and offers several options for addressing the issue. The narrow columns allow either a check mark or other response in the next column to indicate the most feasible option. Add other options likely to exist in your company.

How will condoms be obtained by the company		How will condoms be distributed to employees		Cost of condoms to employees*		How will condoms be promoted		Department responsible for ordering and distribution
Private sector wholesalers & distributors		Dispensing machines (where located?)		Free		Not promoted		Medical Department
Government stores or ministries		Open access at several locations		Nominal charge		Posters or signs		Human Resources
Social Marketing groups (e.g. PSI)		Through peer educators		At the cost paid by the company		Company newsletter or similar publication		Union or worker association
Local NGOs		Will HIV/AIDS information be included?		For a profit to the company		Through supervisor		
		Will not be distributed in workplace				Through peer educators		

* As a rule of thumb, the annual employee expenditure for condoms should not exceed 1% of an employee's salary. It will be useful to provide a rationale for the each option chosen.

STD Services in the Workplace

Note: Work down the columns. The wide columns identify issues to consider in planning STD services in the workplace and offers several options for addressing the issue. The narrow columns allow either a check mark or other response against the most feasible option. Add other options likely to exist in your company.

The table assumes that the company will provide some form of STD services to employees. If no STD services are planned, alternatives should be described.

Where will STD services be provided		Cost to employee		Who will be covered by the service		Level of services to be provided		Sources of drugs		Other services offered with STD treatment
In-house clinic		Free		All permanent employees		Diagnosis		Wholesalers		HIV test
Contract with private provider for in-house services		Nominal charge		Select grades of employees:		Treatment, including drug prescription(s)		Government Stores·		Counseling
Contract with private provider for services in their clinic		At cost to company		Family members of employees		Information and referral				Condom distribution
Through public clinics		For profit to company		Regular partners of employees						
		Existing public & private prices								

Counseling and Support Services

Note: Work down the columns. The wide columns identify issues to consider in planning counseling services in the workplace and offers several options for addressing the issue. The narrow columns allow either a check mark or other response against the most feasible option. Add other options likely to exist in your company.

Types of Counseling Services		For Whom		Who Pays		Where and When Provided
Only with voluntary HIV test		All employees		Company pays all (directly or reimbursement)		In-house, during work hours
With required HIV test		Select group of employees:		Company pays for some [identify] counseling services		In-house, after work hours
With STD diagnosis and treatment		New hires		Employee pays all		Company-identified private providers
Behavior change		Family members		Employee pays for select services		Employee-identified public or private providers
Referrals		Regular partners		Company pays all for employee but not family/ partner		
Inter-personal sexual relations		Those who are interested		Company pays all/part for employee and part for family/partner		
Training in the care of people with HIV and AIDS				Company pays all/part for employee and part/all for family		

SESSION 8

BG #15

The next steps rely mainly on the participants. They are likely to be key spokesperson for HIV/AIDS prevention. A strategy for bringing home the ideas and information from the workshop is needed. "What are the steps necessary to make AIDS prevention real in your workplace?" The "Company Action Plan" matrix (on the next page) is one way to organize the planning.

HIV/AID PREVENTION IN THE WORKPLACE
COMPANY ACTION PLAN

ACTION ITEM	WHO WILL TAKE THE LEAD?	TIME LINE
1) Informing management and workers' representatives to gain their support		
2) Set up planning team(s)		
3) Define policy issues		
4) Develop, review & revise policies		
5) Publicize policies for all employees		
6) Identify & review program components and implementation options		
7) Identify external assistance		
8) Identify in-house staff for training		
9) Develop budget		
10) Plan program implementation		
11) Implementation monitoring		

BG #16 Have available as a handout sources of further information and services for education/training, condoms, counseling and STD treatment. The handout can list the address, phone/fax numbers and contact people, such as:

- National AIDS Control Program
- Business associations, such as Chambers of Commerce and employer federations
- NGO coalitions
- HIV/AIDS education and training organizations. This might be a Red Cross/Red Crescent society, or similar non-profit organization
- Groups representing people who are infected with HIV

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Private Sector AIDS Policy

African Workplace Profiles

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AIDSCAP

USAID

CASE STUDIES ON BUSINESS MANAGING HIV/AIDS

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INTRODUCTION

When business managers consider how to respond to HIV/AIDS in the workplace, they want to know what other companies are doing about the disease. Managers are keenly interested in this information, both to learn from the experiences of others as well as to assess their competition.

This compilation of 17 profiles of businesses in Botswana, Kenya, Senegal, Zimbabwe, and elsewhere in southern and western Africa is one of the first of its kind in the African region. Not only does it offer information drawn directly from management interviews, but it includes financial impact analyses of HIV/AIDS for a number of the businesses. All but the Zimbabwe studies were conducted by Family Health International's AIDS Control and Prevention (AIDSCAP) Project.

The case studies will be of interest to business managers in the private sector and parastatals, to trainers and consultants working with managers or unions, to HIV/AIDS program planners, and to implementing agencies whose activities extend into the workplace. The case studies can be used in a variety of ways. As a collection, the materials illuminate for private sector and parastatal policy makers why and how other businesses created HIV/AIDS prevention programs. Trainers can select one or more of the case studies for in-depth discussion or draw upon several of the case studies for examples that will illustrate points being made in training events.

To be of greatest use, this collection offers profiles of businesses in different geographic areas and sectors with a wide range of responses to the AIDS pandemic. These studies should help other businesses develop effective and innovative HIV/AIDS prevention programs and policies for their workplaces. The profiles may be used in conjunction with the *PSAP Manager's Guide to Workplace HIV/AIDS Policies and Prevention Programs* or as a stand-alone resource.

To the extent possible, given the different types of organizations and writers of the studies, the profiles are in a uniform format to increase the ease of use and comparability. Most of the studies include a brief background on the business; the impact HIV/AIDS is having or is expected to have on the company; management's response to the disease in terms of prevention activities; the policy framework of the company as it relates to dealing with HIV/AIDS in the workplace; and lessons learned and/or observations.

The studies are organized alphabetically by country and region. In several instances, the actual companies preferred not to be identified in published form, although they remained willing to have information from them included in this collection. The names of these companies

have been changed to protect their autonomy. A footnote against the name of the company at the beginning of the case study indicates where ficticious names have been used.

The following table summarizes the primary characteristics of each organization in terms of location, sector, policy framework, and prevention response.

TYPOLOGY OF PROFILE FIRMS

Organization	Location Urban/Rural	Sector	Policy Framework: Addresses HIV/AIDS? Yes or No	Prevention Response: Has ongoing program? Yes or No
Botswana Diamond Valuing	Botswana Urban	Mining	No (planned)	Yes
Botswana Meat Commission	Botswana Urban	Agro-Industrial	Yes	Yes
Quick Print & Copy One	Botswana Urban	Copying Services	No	Yes
Auto Kenya*	Kenya Urban	Vehicle Sales & Service	Yes	No
Kenya Transport*	Kenya Urban & Rural	Transport	No	No
Muhoroni Sugar	Kenya Urban & Rural	Agro-Industrial	Yes	Yes
Western Wood*	Kenya Rural	Manufacturer Wood Processing	No	No
CSPT	Senegal Rural	Mining	No	No (planned)
Parke Davis	Senegal Urban	Manufacturer Pharmaceuticals	No	No
Port Autonome de Dakar	Senegal Urban	Parastatal Port Services	Partial	No (planned)
Africa Beverage Co.*	Southern Africa Urban & Rural	Beverage Producer & Distributor	Yes	Yes
Communication Technologies Inc.*	Western Africa Urban & Rural	Telecommunication Services	No	No (planned)
Sugar Industries Inc.*	Western Africa Urban & Rural	Agro-Industrial	No	No
West African Railways*	Western Africa Urban & Rural	Transport	No	No
David Whitehead Textiles	Zimbabwe Urban & Rural	Manufacturer Textiles	Yes	Yes
Eastern Highland Plantations	Zimbabwe Rural	Agro-Industrial	No	Yes
Rio Tinto Zimbabwe	Zimbabwe Rural	Mining	Yes	No (Discontinued)

**Indicates a fictitious company name. All other information about the organization is accurate.*

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METHODOLOGY

A Nairobi-based consulting firm (HEDRA) was selected by AIDSCAP to help conduct the Kenya company studies. AIDSCAP assisted HEDRA in the pretesting the instruments and participated in a number of the initial interviews. Pretesting began in October, 1993, and the interviews were completed by the end of June, 1994. The Senegal and western Africa studies were conducted by the consulting group, Africa Consultants International (ACI), for AIDSCAP over a three-month period in 1994. All pretesting and interview administration were done by ACI. The Botswana and southern Africa profiles were prepared in 1994–95 by an AIDSCAP consultant. The Zimbabwe profiles are an adaptation of studies previously conducted for ACTIONAID in 1992–93.

Aside from the Zimbabwe studies, the rapid survey instruments employed for all of the profiles were developed by AIDSCAP. An in-depth discussion of the needs assessment methodology and examples of the survey instruments are provided in AIDSCAP's *Conducting a Workplace HIV/AIDS Policy Needs Assessment: A User's Guide.*[1] A semi-open interview questionnaire for managers was developed and employed with the organizations. The organizations were chosen to represent a diversity of business types, including light industrial/manufacturing, mining, agro-industrial and plantation, transport and tourism, and service firms. Representatives from at least two trade unions were also interviewed. Organizations were also selected to represent a range of ownership patterns (foreign, local, and joint foreign/local), sizes (number of employees), and locations.

To capture workers' knowledge of HIV/AIDS and their perceptions of the appropriate role of their companies in offering workplace prevention and policies, focus groups were conducted with workers from 13 of the Kenyan companies. A trained Kenyan focus group specialist employed by HEDRA conducted all focus groups. An assistant recorded the focus group discussions on audiocassette tape and in written notes.

A financial/labor data survey instrument was developed and administered to all the companies willing to share these data. Ultimately, six of the companies provided the data necessary to complete an in-depth microeconomic analysis of the projected impact of AIDS on their businesses.

Estimates of the recurrent costs of operating a workplace HIV/AIDS prevention program are also offered for these six firms. The spreadsheets developed by AIDSCAP for these impact and prevention program estimates can be found in Appendices 9 and 10 of the *Manager's Guide to Workplace HIV/AIDS Policies and Prevention Programs.*

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The figures offered in the following profiles are low-cost estimates of recurrent operating costs. Most of the company estimates are based on the assumption that prevention/education activities are conducted during periods when employees are not paid, such as lunch breaks, and that condom costs are recovered by selling them at cost to employees. First-year operating costs would be higher because of start-up costs (averaging US$5,000–10,000) associated with training, purchasing education materials, and installing condom dispensers.

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SUMMARY OF FINDINGS

This collection of company profiles covers a broad range of business types, locations, and management approaches to responding to HIV/AIDS.

As is typical among larger-scale businesses, virtually all of these companies (at least 14 of the 17) provide extensive medical benefits to their employees. Most of these businesses also provide other significant benefits, particularly funeral expense and/or other death benefits. A notable portion of these firms (7 out of 17) also had made a considerable investment in highly skilled employees who had received extensive training. Perhaps surprisingly, even a couple of firms that described their workers as "unskilled" admitted that they found it difficult to replace lost employees with equally productive workers. This suggests that wage levels in lower-skill categories do not always reflect the true economic value of labor.

With large outlays for employee benefit coverages and training, the economic impact of HIV/AIDS can be substantial. Over half (10 out of 17) of the businesses reported feeling the impact of HIV/AIDS on their workplaces. This impact is primarily felt in disruptions in production due to absenteeism and illness and increased production costs associated with labor turnover and employee benefits. What is interesting is that these concerns are shared by company managers from all of the countries and regions included in the study, from high HIV-prevalence countries such as Botswana and Zimbabwe to low-prevalence areas such as Senegal and elsewhere in western Africa.

A positive policy finding is that most, if not all, of the firms (13 out of 17) report that they do not require HIV tests for applicants or employees (testing policies of four companies are unknown). At least three of the 13 businesses without mandatory testing offer HIV testing to employees on a completely confidential and voluntary basis as part of their health benefits.

Though only seven of the organizations have in place a formal HIV/AIDS prevention program, almost all of them have some of the key elements of a prevention program: 14 regularly distribute condoms at the workplace, and at least 12 of them make STD diagnosis and treatment available to employees. A number of them also have some type of family planning program as part of their health education activities. This is an important finding, for it indicates that many of these companies have experience in preventive health programs in the workplace. Thus, it would require relatively few additional resources or training to establish a workplace prevention program. In fact, the

medical officers of at least four of these businesses with the roots of a prevention program are already convinced of the need for such a program and are seeking senior management support to launch one.

The principal reason expressed for starting an HIV/AIDS prevention program was management's perception that the prevalence of the disease in the country or community would have—or already was having—a significant business effect (e.g., financial, production, productivity). In other words, management felt that the organization has no "immunity" to the disease and must work to prevent transmission of HIV among employees. Other reasons that some companies noted for starting programs were to show concern for workers, address customer concerns, and promote national awareness of the epidemic by conducting such things as HIV/AIDS prevention programs in the surrounding community and by releasing statements encouraging other companies to initiate prevention programs. Some companies also indicated that they were motivated by the concern expressed—and assistance available—from outside governmental and nongovernmental organizations.

The general consensus of managers at firms with prevention programs is that their HIV/AIDS prevention interventions are both relatively inexpensive and well worth the cost. This view is also supported by the financial estimates done for several of these firms, which find that prevention program costs are usually lower by about half than the financial impact of HIV/AIDS.

Most of the managers find that their prevention programs result in significantly lower numbers of cases of sexually transmitted diseases (STDs) and related absenteeism. A number of managers commented that their programs seem to have created a more tolerant and accepting attitude among workers toward HIV-positive employees, with positive effects on morale and productivity. Some managers also noted that the programs promoted their company's image as a good corporate citizen and resulted in good press. Some companies provide one of the few sources of health care and preventive education in their local communities.

In sum, managers of organizations with HIV/AIDS prevention programs believe that their workplace activities are reducing employee risk behavior, health expenses, and other business costs, as well as making positive contributions to the community.

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SUMMARY OF ANNUAL AIDS IMPACT VS. PREVENTION PROGRAM COSTS (US$)

Company Name	AIDS Impact—Total Cost (1994)	AIDS Impact—Total Cost (2005)	AIDS Prevention Program—Total Cost (1994)†	AIDS Impact—Per Employee Cost (1994)	AIDS Prevention Program—Per Employee Cost (1994)
Botswana Diamond Valuing	125,941	136,985	23,124	237	44
Botswana Meat Commission	370,200	400,029	51,072	268	37
Auto Kenya, Kenya*	21,312	50,074	10,189	17	8
Kenya Transport*	61,132	147,389	28,070	28	13
Muhoroni Sugar, Kenya	58,303	117,674	21,647	49	18
Western Wood, Kenya*	40,630	102,499	31,885	25	20

* *Indicates ficticious name of company; other information is accurate.*

† Lowest recurrent cost prevention program estimates.

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BOTSWANA DIAMOND VALUING COMPANY

Company Background

Botswana Diamond Valuing Company (BDVC) was established in 1974 and is a subsidiary of the Debswana Mining Company. Located in Gaborone, the nation's capital, Debswana Mining is a parastatal joint venture between the diamond company, DeBeers, and the Botswana Government. Debswana diamond mines are the largest source of income for Botswana, and BDVC is responsible for the sorting and valuing of Debswana's diamonds.

BDVC employs approximately 525 men and women (in about equal numbers) and the majority are diamond sorters. Management accounts for 10 percent of the organization. Operations are very labor-intensive, and the organization invests significant resources in the training of its employees, particularly those who are new. New hires undergo six months of training, during which time they are placed on probationary status. After this initial six-month period, trainees are placed into line positions, and their training continues on the job.

BDVC provides private medical insurance for all its employees except those in the initial training program. BDVC pays 100 percent of the insurance plan subscription costs for its employees and 50 percent of subscription costs for all dependents. Ten percent of the costs for medical treatment is paid by employees, while the remaining 90 percent is paid by the insurance plan.

Men and women are entitled to retirement benefits at 60 and 55, respectively. There is no formal ill health retirement policy, although there is some type of payment for employees when they are required to stop work on medical grounds. BDVC also provides a life insurance scheme for its employees, and all subscription costs are paid by the company. Specific payments are determined by salary level. Upon death, an employee's beneficiaries receive payment from the insurance company.

The Impact of HIV/AIDS

In spite of the high HIV prevalence rate in Gaborone (ranging between 19 percent to 30 percent, based on 1993 sentinel surveillance figures for pregnant women and male STD clinic patients, respectively), BDVC reports no visible impact of HIV/AIDS on the company.

Key Points:

- BDVC has a substantial investment in its employees—new employees receive six months of training followed by lengthy on-the-job training.
- BDVC's prevention program is estimated to cost only about one-fifth that of the estimated 279,870 pula (US$125,941) annual cost of AIDS on the company.
- BDVC's program has received considerable attention and praise from outside the organization, thus enhancing its corporate image.

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According to management, there have been no dramatic increases in the frequency or duration of absenteeism, in turnover, or in levels of organizational tension or discomfort with HIV/AIDS.

However, based on current and projected HIV prevalence rates for the area, the economic impact of the disease is likely to be, in fact, rather significant to the company. As the following table shows, the AIDSCAP microeconomic model estimates the annual cost of AIDS to BDVC to be 279,870 pula (US$125,941),[2] or about 6 percent of profits. On a per-employee basis, this is a cost of 528 pula (US$237) annually. By the year 2005, the cost is estimated to grow to 304,413 pula (US$136,985) annually, or 575 pula ($258) per employee.

COST PROJECTIONS BY IMPACT CATEGORY (pula)

	1994		2005	
Cost Category	Cost	Percent of Cost	Cost	Percent of Cost
Recruitment	0	0.0	0	0.0
Health Care	4,615	1.6	4,962	1.6
Burial	54,000	19.3	54,000	17.7
HIV Absenteeism	115,833	41.4	140,030	46.0
AIDS Absenteeism	53,123	19.0	53,123	17.5
Funeral Attendance	28,962	10.3	28,962	9.5
Labor Turnover	4,086	1.5	4,086	1.3
Training	19,250	6.9	19,250	6.4
Post-training Productivity	0	0.0	0	0.0
Total	279,870	100.0	304,413	100.0

Recognizing the likely impact of HIV/AIDS, BDVC is taking no chances and has moved swiftly to establish a prevention program at the company. The company has a large investment in its workforce, as the six-month training period reflects. Once the probationary period is over, the company continues to have considerable investment in its workforce through its medical plan, life insurance scheme, and retirement benefits. In terms of production, work is performed according to deadlines, and when workers are absent, their work must be carried out by colleagues. Thus, increased absenteeism as a result of HIV/AIDS, among other potential effects, could be a costly problem in the future.

Company data on the cost of its prevention program are not available. However, an AIDSCAP program cost model estimates that

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BDVC's program probably costs 51,387 pula (US$23,124) or 98 pula (US$44) per employee annually. Thus, its prevention program costs only about one-fifth that of the present annual impact of HIV/AIDS to the company.

Company Response

The first steps toward increasing the level of HIV/AIDS awareness at BDVC were taken in early 1992 by the training and personnel departments. Managers of both departments, with encouragement from top management and with a desire to gain a better understanding of HIV/AIDS, attended an HIV/AIDS awareness seminar in Johannesburg, South Africa. Soon after the seminar, the training department invited the Ministry of Health's (MOH) Occupational Health Unit/AIDS in the Workplace Program to BDVC to speak about HIV/AIDS. Small group seminars were held, focusing on HIV/AIDS awareness.

BVDC's management then decided to hire an additional company nurse to serve as AIDS coordinator. Her job would include the establishment and coordination of an AIDS-in-the-workplace program within the training department. BDVC's AIDS coordinator attended her first peer education training session, provided by the MOH Occupational Health Unit, in 1993. She then returned to BDVC and requested that each department select two representatives to become peer educators (employees who provide information and support to their work colleagues for preventing HIV/AIDS) for their particular department. Training for the peer educators was provided by the AIDS coordinator. Curriculum materials and all other support were provided by MOH Occupational Health Unit. More than 20 peer educators had been trained at BDVC by 1994.

Once the HIV/AIDS program was developed, a letter from the personnel department was sent to all BDVC employees inviting them to attend formal department trainings (in addition to the informal peer education sessions). Although attendance is not mandatory, all employees are expected to attend. The first session was held in 1993.

Peer educators select free times that are most convenient for the department—most often at tea breaks—meeting as often as they feel necessary. By using free time, company costs in terms of lost labor are minimized. The basic content of all departmental programs is the same, covering the definitions of HIV and AIDS, transmission, symptoms and signs, and proper condom use. Brochures and handouts are provided in English, and posters are displayed throughout the building in English and Setswana.

Condoms are available in vending machines next to the men's and women's toilets at a very nominal price (10 thebe) and at no charge in the first aid room upon request. By marketing the condoms at an affordable price, the company recovers much of the cost of providing

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condoms and raises their inherent value to workers. Employees appear to prefer the condoms from the vending machines because of anonymity as well as the choice of condom. The Ministry of Health provides the condoms that are distributed at no charge.

In addition to peer education sessions, all new employees are required to undergo HIV/AIDS training as a part of the overall company orientation. While there is no formal mechanism that monitors the frequency of peer education sessions, the AIDS coordinator is quite confident that department sessions are ongoing and that people speak about HIV/AIDS very often, both formally and informally.

In 1993, BDVC's in-house drama group produced an AIDS-related video, entitled "Me Today, You Tomorrow," which was included in the HIV/AIDS training sessions. The success of the video has prompted the training department to seek funding from outside BDVC to produce and distribute copies to any interested organizations.

Employee attitudes toward HIV/AIDS are difficult to characterize, although the training and personnel departments believe that the prevention education efforts have resulted in a high level of tolerance or acceptance of HIV-positive employees. This acceptance is important to the company, for it builds productivity-enhancing team spirit and reduces the chance of the work stoppages other companies have suffered because employees were afraid of working with HIV-positive coworkers.

Company Policy

Management has supported HIV/AIDS prevention efforts from the moment that the Ministry of Health started to focus attention on HIV/AIDS in the workplace. Prevention program development preceded HIV/AIDS policy development in the organization, and there are no HIV/AIDS-specific policies. Management recognizes this as a weakness, and though there have been no specific problems regarding HIV/AIDS at the workplace, the personnel department expects to review its policies and develop official HIV/AIDS policies before any issues arise.

Though BDVC's management has yet to develop official policies for the company, its practices are well in line with those recommended by the WHO, ILO, and several business coalitions. Although all potential employees are required to undergo a general medical examination, HIV/AIDS screening is not a part of the exam, and BDVC has no plans to change this. HIV/AIDS testing is not part of the selection process for training or promotion.

Despite ambiguities between BDVC's life insurance provider's policies and its own, BDVC intends to maintain its policies. For example, the life insurance company appears to have restrictions on payments for AIDS-related deaths, but BDVC currently has no such

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exclusions and does not plan to institute them. BDVC does not plan to exclude coverage for HIV/AIDS-related death or illness for any of its employees.

Lessons Learned and Plans for the Future

Management says that development and implementation of an HIV/AIDS program have been costly, but it is a cost that they unquestionably support. Employing an AIDS coordinator to be responsible for their HIV/AIDS program is evidence of this commitment, as are the time and resources that management has approved for the HIV/AIDS program.

The training and personnel managers believe that the HIV/AIDS program has been successful, though direct measures of success are difficult to quantify. A number of companies have contacted BDVC concerning its HIV/AIDS program, wanting to learn as much as possible from BDVC's experience. BDVC also has been awarded various citations from the Botswana Ministry of Health for its workplace efforts. BDVC appreciates the positive responses from outside the organization that affirm the decision to initiate a program and demonstrate that BDVC is a responsible corporate "citizen." Comments from employees indicate that overall awareness has risen over the past two years, and many employees have duplicated the drama group video to show it at home to family and friends.

These successes, however, do not mean that the HIV/AIDS program can rest on its laurels. The AIDS coordinator strongly believes that the program must be intensified, with more time spent in department peer education sessions. She also believes that BDVC needs to focus more attention at the surrounding community level.

All staff responsible for BDVC's HIV/AIDS program agree that the senior management of other companies must become more aware of the HIV/AIDS-related workplace issues to be faced. They believe that managers need to understand that HIV/AIDS affects all levels within an organization and that management must take an active role in policy and program development. All efforts directed at HIV/AIDS in the workplace must have the support of senior management if they are to succeed.

AIDS IMPACT VS. PREVENTION PROGRAM COSTS (Annually)

Year	1994 (pula)	1994 (US$)	2005 (pula)	2005 (US$)
AIDS Impact—Total Cost	279,870	125,941	304,413	136,985
AIDS Impact—Per Employee	528	237	575	258
Prevention Program—Total Cost	51,387	23,124		
Prevention Program—Per Employee	98	44		

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BOTSWANA MEAT COMMISSION

Company Background

The Botswana Meat Commission (BMC) was established in 1966 by the Government of Botswana as a parastatal organization to coordinate the production of beef. BMC is the country's sole exporter of lean beef to markets throughout the world, particularly the European Union (EU). It has marketing subsidiaries located in the United Kingdom, Germany, Holland, and Greece; cold storage facilities in the U.K. and South Africa; and transport companies in Botswana. Eighty percent of BMC's production is exported, primarily to the EU, providing Botswana with its second largest source of foreign exchange after diamonds. BMC's turnover for 1993 was 212 million pula.

BMC is headquartered in the town of Lobatse, located 75 km from Gaborone, the nation's capital. Lobatse is, in fact, one of the major population centers of Botswana, with a population of 26,000. BMC is a major industry in the town, employing approximately 1,500 people. BMC's operations are labor-intensive, and the majority of workers are men (95 percent).

BMC's employee benefits are extensive. Employees receive medical care free of charge at on-site clinics and when referred to an outside doctor. All medical expenses for employees, their spouses, and children (legal or adopted) are paid by BMC. Though BMC offers no retirement plan, the company does allow older employees to keep working for as long as possible by making reasonable accommodations to their job responsibilities as they grow older or become infirm.

The beneficiaries of deceased employees receive a death benefit payment of four times the annual salary. The company provides funeral transportation for the body and family members, as well as 1,200 pula to the family for funeral expenses. Employees who wish to attend the funeral are provided with transportation by the company.

There are two clinics at BMC. One is inside the actual production plant, taking care of employees on duty for accidents or problems

Key Points:

- BMC provides extensive benefits, including free medical care, life insurance, and payment of burial expenses.
- Management initiated an HIV/AIDS prevention program to protect both its client base and its human resources.
- BMC offers comprehensive prevention activities, including education, STD services, condom distribution, and counseling. It keeps costs low by procuring prevention inputs at low or no cost and timing programs throughout the year around the production cycle.
- Prevention intervention are backed by supporting policies. HIV testing is completely voluntary, medical coverage is provided to all employees with HIV/AIDS, and employees with HIV/AIDS are kept on as long as they are fit to work. Adjustments are made in job responsibilities as necessary.

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that arise during the work day. The second clinic is located outside the plant—still on BMC premises—and is used by all employees not working directly in meat-handling areas, as well as by the families of employees.

Housing for BMC employees is provided on the premises of the Lobatse site, so the external clinic is more of a community health clinic than simply a workplace clinic. Given the structure of the public health system, the prevention services of the external clinic are open to the Lobatse community. Consequently, all types of health education information, including HIV/AIDS and STD materials, can reach people beyond the BMC workplace community.

The Impact of HIV/AIDS

Although there have been few direct effects felt by BMC as a result of HIV/AIDS, the epidemic will certainly become more visible to the company in the future. National AIDS sentinel surveillance surveys of male STD clinic patients and pregnant women in Lobatse that were conducted in 1993 found an HIV/AIDS infection rate ranging between 16.2 percent and 17.8 percent. Even more alarming, BMC participated in a recent surveillance program, and of the 20 BMC-related antenatal HIV tests taken, 18 of the subjects were HIV-positive. The senior nursing officer responsible for the HIV/AIDS program at BMC is certain that the prevalence of HIV infection among employees is greater than currently visible and that all professional categories are affected.

COST PROJECTIONS BY IMPACT CATEGORY (pula)

	1994		2005	
Cost Category	Cost	Percent of Cost	Cost	Percent of Cost
Recruitment	5,000	0.7	5,000	0.5
Health Care	10,066	1.2	11,289	1.3
Burial/Death Benefits	397,288	48.3	411,744	46.3
HIV Absenteeism	213,834	26.0	258,502	29.1
AIDS Absenteeism	74,334	9.0	76,414	8.6
Funeral Attendance	56,158	6.8	59,256	6.7
Labor Turnover	22,500	2.7	22,500	2.5
Training	38,906	4.7	39,546	4.5
Post-training Productivity	4,574	0.6	4,702	0.5
Total	822,661	100.0	888,954	100.0

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The senior nursing officer who runs the BMC clinics has noted an increase in absenteeism over the past few years, as well as a rise in the number of employees who are visibly ill. In many instances, without knowing HIV status, medical personnel have sufficient background and training in HIV/AIDS to sense when a person has AIDS symptoms.

Using average estimated 1994 and projected 2005 adult HIV and AIDS prevalence rates typical for Botswana urban areas[3] to project the impact of AIDS on BMC, the results are dramatic. HIV/AIDS-related costs were consuming approximately 8.8 percent of profits, or 822,661 pula (US$370,200)[4] in 1994. By the year 2005, the impact is estimated to grow to 9.5 percent of profits, or 888,954 pula (US$400,029) annually. On a per employee basis, the cost was nearly 600 pula (US$268) in 1994 and will be 644 pula (US$290) in 2005. As the table shows, the greatest costs are associated with burial/death benefits and absenteeism.

Company Response

Health education in BMC covers such topics as safety, hygiene, occupational hazards, and HIV/AIDS. HIV/AIDS prevention education and awareness training became a formal component of the company's overall health education program in 1991. Although the senior nurse had been providing HIV/AIDS-related information to antenatal and STD clients at the external clinic prior to 1991, there was no structure or regularity to such information sharing.

Three major factors contributed to the intensification of HIV/AIDS prevention training at BMC in 1991. The first was the experience and foresight of the company's senior nursing officer. She recognized the need to establish a workplace program that would reach as many employees and their families as possible. Given the resources of the Town Council, it was clear that people in Lobatse would not otherwise receive HIV/AIDS education.

Second, the executive director of BMC understood the need for a prevention program. In 1990, one of the company's European purchasers raised concerns about the possibility of HIV/AIDS at the plant and suggested that BMC screen its employees for HIV/AIDS as a condition of sales. The potential loss of a major European contract raised serious concern for the executive director, who consulted with the senior nursing officer. Although the issue was resolved, and BMC did not enact HIV/AIDS screening, top management became aware of the need to tackle HIV/AIDS in the workplace.

The last element in the implementation of systematic HIV/AIDS training was the government's establishment of an HIV/AIDS workplace prevention program and the creation of educational materials for distribution. This was accompanied by the government's explicit encouragement of all organizations to do as much as possible to prevent the spread of the virus.

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In scheduling annual health programs, including HIV/AIDS prevention efforts, the senior nurse targets times of the year when employees have the least amount of work. During peak production months, workers are on duty more than nine hours per day, while during slower periods, they may work only six hours per day at most. Using non-peak times of the year for worker education places no constraints on employee time and lowers the cost of the prevention program. Supervisors are provided with HIV/AIDS training regardless of how busy the plant is. Given that supervisors have the most contact with employees, they are told that they need to monitor, support, and encourage employees to adhere to the policies and practices presented during health and safety seminars, which include AIDS training.

HIV/AIDS training consists of hour-long lectures for groups of 50–60 workers given by the senior nurse, followed by some other health topic and an HIV/AIDS video presented later in the day. This format breaks up the presentation of materials and makes it possible for employees to digest more of the information and participate more actively in discussion after the video. Topics include HIV/AIDS prevention and transmission, signs and symptoms, acceptance of HIV-positive workers at the workplace, encouragement to speak openly, partner and relationship issues, and information on employee and family counseling services.

After each seminar, participants are asked for a written or verbal review. This feedback contributes to the ongoing development, improvement, and monitoring of HIV/AIDS training.

In addition to lectures and video presentations, HIV/AIDS prevention brochures in English and Setswana are available at the health clinics, and posters are displayed throughout the plant. Condoms are available at the clinics and in the plant in toilets, changing rooms, and shower rooms, and it is the responsibility of the Safety and Hygiene Department to keep condom dispensers well supplied.

Women within the community receive health seminars and ongoing health talks as a part of the community health services provided by the BMC clinic. Hour-long AIDS presentations are organized for women visiting the clinic, and five- to ten-minute briefings about HIV/AIDS often are presented to women during the course of medical visits.

Company Policy

Company policies are developed internally, in consultation with the union. The union has been able to negotiate agreements with management on program and policy development. For example, union representatives participate in the company's health committee.

Prospective employees are required to undergo a routine physical exam before being hired, and all meat handlers are required to undergo annual physical exams. The results of physical exams can indicate that

further medical exams and tests are needed, but at no time is HIV/AIDS included in the tests conducted during or as a result of these physicals.

As part of the corporate medical policy, all treatments for HIV/AIDS-related illnesses are covered by medical insurance. Employees or family members suspected of being HIV-positive are given extensive counseling at the clinic and then encouraged to get an HIV test. When an employee or dependent undergoes an HIV test and the results are positive, clinic workers also provide post-test counseling. However, at no time does BMC conduct mandatory HIV screening, and employees are not terminated on the basis of their HIV status.

When any employee becomes too sick from any illness to carry out his or her work responsibilities, it has been BMC's policy to find a less strenuous position for the individual in the organization (i.e., "reasonable accommodation"). Once they are too sick to go to work, they are released on medical grounds.

Lessons Learned

BMC is proud of its HIV/AIDS program, and management supports it strongly. It is clear to the senior nurse that employees have significantly increased their use of condoms since the introduction of HIV/AIDS training. The payoff of increased condom use is already demonstrated in the dramatic decrease in the number of STD cases seen by the clinics. Fewer STD cases translates into lower medical costs, less health-related absenteeism, reduced HIV transmission risk, and greater productivity.

With condoms and educational materials provided by the Ministry of Health at no cost, BMC's program is inexpensive. The prevention program model estimates the costs of the BMC program in terms of labor, STD management, and other associated expenses in 1994 was about 113,493 pula (US$51,072)—about an eighth of the estimated economic impact of HIV/AIDS to BMC in that year. Even if BMC must

AIDS IMPACT VS. PREVENTION PROGRAM COSTS (Annually)

Year	1994 (pula)	1994 (US$)	2005 (pula)	2005 (US$)
AIDS Impact—Total Cost	822,661	370,200	888,954	400,029
AIDS Impact—Per Employee	600	268	644	290
Prevention Program—Total Cost	113,493	51,072		
Prevention Program—Per Employee	82	37		

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pay for condoms and educational materials in the future, the benefits exceed the costs, and the company's management would continue the program. The benefits from the program are clear: a relatively small investment in HIV/AIDS prevention is reaping large benefits for BMC.

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QUICK PRINT, BOTSWANA

Company Background

Quick Print and Copy One—hereafter referred to as Quick Print—are two divisions of a local, privately owned company in Gaborone. The two operations were created in 1985 and are involved in printing and advertising, photocopying, and the sale of photocopy machines.

Quick Print is a labor-intensive operation that employs 53 people, most of whom are women who have no specialized training but who accumulate considerable on the job skills essential to operations. Employees involved in all but the machine operator functions are cross-trained so that they can perform most functions within the company. The operation of the six pieces of machinery that are critical to the functioning of the company, however, requires significant training. For example, in order to train an operator in the use of one of these machines, the managing director contracted a trainer from Zimbabwe for three months. The skills required for the machine operator positions are far less interchangeable.

Quick Print is considered a medium-size company in Botswana, and its owners are quite active in the local business community and Botswana's private sector organization. They are interested in the growth of local businesses, particularly those owned and operated by Botswana citizens, which perhaps accounts for their concern for and advocacy of the development of employee business skills through formal and informal training. The senior management of Quick Print views private sector-led growth as inextricably linked to the development of human resources in Botswana.

The company does not provide medical insurance, and employees therefore turn to the public health system. There is also no retirement or pension scheme. As mandated by the government, however, employees receive what is known as a "gratuity" every five years. Contributions to gratuity packages are made exclusively by the employer, based on the employee's salary, and after every five years of employment, the person is eligible to either take the cash payment in hand or leave it with the employer, who then continues to add payments. When a Quick Print employee dies, the family receives payment for any annual leave that was due to the employee as well as the amount of accumulated gratuity.

Key Points:

- Quick Print is a relatively small company that has found it feasible, cost-effective, and worthwhile to establish a HIV/AIDS workplace prevention program.
- Though HIV/AIDS awareness has increased, stigmatization of persons who are HIV-infected continues to be a problem. Lack of tolerance tends to undermine labor relations and threaten productivity. Future efforts will concentrate on reducing stigmatization.

The Impact of HIV/AIDS

The management at Quick Print is very concerned about HIV/AIDS in Botswana, not only because of its effect on people's lives, but also because of its impact on business. Management realizes that HIV/AIDS is having an impact on business operations and expects the impact to grow much more serious in the coming years. The company strongly supports HIV/AIDS prevention education in the workplace.

The frequency and duration of absenteeism at Quick Print has risen noticeably over the past few years, and managers have noticed a visible decline in the general health of many employees. The causes of increased absenteeism and general health deterioration are not confirmed; it is customary in Botswana for employees simply to state that they are ill. Managers strongly suspect, however, due to the lack of any other national public health factors, that HIV/AIDS is the cause. Given that people do not speak about health, and more specifically, do not mention anything that might be related to HIV/AIDS, it is very difficult for management to estimate the number of its employees affected by HIV/AIDS.

For the moment, the system of cross-training at Quick Print serves to alleviate any major problems that might be caused by HIV/AIDS within the workforce. Because absenteeism has been limited largely to the employees with general skills, the impact on operations has been less serious than it might have otherwise been. Another factor that has minimized the impact has been the relatively depressed state of the economy in Botswana in the early 1990s. With the lower level of business activity, rising absenteeism has not been too serious a problem. However, as management fully realizes, if higher levels of productivity become necessary, HIV- and AIDS-related absenteeism will have a serious impact on productivity.

Management knows that if absenteeism and illness begin to significantly affect the six machine operators, production would be seriously affected, and the company would experience major setbacks. They recognize that HIV/AIDS poses a very serious threat to company productivity and are attempting to address the issue while respecting the rights of employees.

To date, HIV/AIDS has had few other directly measurable impacts on the organization. Medical expenses for any possible HIV/AIDS-related illnesses are not paid by the company, and the low number of deaths has not created major funeral expenses. Because the machine operators have not yet been affected by HIV/AIDS, there have been no additional training costs to bear. However, management is not confident that these positions will continue to be unaffected.

If 1994 HIV and AIDS prevalence rates for Gaborone (approximately 22.5 percent and 1 percent, respectively) are applied to the company, the economic impact of AIDS—based on the AIDSCAP financial model—is quite substantial: as much as a quarter (38,648 pula or US$17,392)[5] of the company's profits consumed by HIV/AIDS. With

a new prevention program that is estimated to cost no more than 8,000 pula (US$3,600) annually, the program is likely to be cost-effective.

Company Response

The establishment of an HIV/AIDS prevention program at Quick Print in 1992 was the result of both the efforts of the Ministry of Health's Occupational Health Unit and management's concern about the effect HIV/AIDS might have on the company. The Occupational Health Unit has participated in Quick Print's family planning program and encountered an increasing number of questions about HIV/AIDS raised by employees. Because the unit had established an AIDS-in-the-workplace program in 1991 and could provide prevention education materials, condoms, and peer education training to interested organizations, one of the sales clerks at Quick Print approached the managing director about the possibility of establishing an HIV/AIDS workplace peer education program. Management immediately welcomed the idea and gave its full support. A peer educator was selected and given full responsibility to develop an HIV/AIDS prevention education program for the company.

The sales clerk who had raised the workplace education issue was selected by her colleagues to undergo training by Occupational Health. After completing the training, she developed a program that consisted of a formal lecture on population growth, the spread of HIV/AIDS, and condom use; distributed brochures in English and Setswana and hung posters in English; and made condoms available in toilet areas. Because these condoms "disappeared in ten minutes," the peer educator decided to keep them with her and distribute them upon request, most often during lunch breaks. Although employees were initially hesitant to come and ask for condoms for reasons of discretion and confidentiality, the peer educator quickly gained the trust of her colleagues.

Presentations last about two and one-half hours, and attendance by all members of the organization is mandatory. Time for formal presentations is given during the work day, and the peer educator is free to attend any supplemental training sessions offered by Occupational Health. Two formal sessions were presented in 1992 and one in 1993. Lunchtime is also used as an informal time at which to discuss HIV/AIDS. After the first presentation, management was very pleased and made it clear to the peer educator that they would support the program in all ways possible.

Because some employees were slow to accept the AIDS threat, in 1993 the peer educator started to use videos, supplied by Occupational Health, in her presentations. The peer educator believes that the videos have helped convince employees to take the HIV/AIDS threat seriously. The peer educator is always available to answer questions, and someone asks a question of some sort about once a week. The peer educator encourages employees to teach their children about HIV/AIDS and has

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offered to assist any employees seeking HIV/AIDS education for their children by coming to their homes, but no one had made a request by the time of this study.

All the supplies for the peer education program, including condoms, are provided free of charge by the Ministry of Health, and the Ministry is said to be responsive to requests for resupply.

Company Policy

Quick Print has few formal personnel policies and no specific HIV/AIDS-related policies. Its rate of employee turnover is very low. Employees are given 14 days of paid sick leave and 18 paid holiday days per year. These leave days are not strictly monitored, but once these 32 days have been used, time off is not paid. HIV status has no effect on continued employment with the company.

There is no funeral policy at Quick Print. Decisions about the company's provision of time, transport, and cash for funeral expenses are made by management on an individual basis. Benefits of any nature are extended only to employees, their spouses, children, and parents.

Quick Print does not plan to implement any type of HIV screening. Because management is not concerned with knowing which employees may be infected, provides no direct medical care, and does not keep medical records on its employees, confidentiality is not an issue.

Lessons Learned

Although there is no formal program monitoring, the peer educator believes that Quick Print's HIV/AIDS program has been successful in teaching people how to prevent HIV infection. Feedback is provided in the form of requests for condoms and comments about the types of condoms employees prefer. The peer educator also has noted increasing comments, especially among younger employees, about the advantages of monogamous relationships. Management believes that one possible reason why machine workers' absenteeism has not increased is their higher level of HIV/AIDS education and their seriousness about safer-sex practices.

According to the peer educator, the major shortcoming of the program is the continued lack of tolerance toward people with HIV/AIDS, which she finds greatly disturbing. Even in a relatively small organization in which employees have been working together for a number of years, rejection and stigmatization of people with HIV/AIDS continue. However, the peer educator hopes that, in time, prevention and sensitivity education sessions will lead most employees to change their attitudes and become more accepting of those living with HIV/AIDS. The company should consider formalizing and communicating its policies of nondiscrimination and nonstigmatization toward HIV-positive employees as one means of encouraging greater tolerance among workers themselves

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AUTO KENYA[6]

Company Background

Auto Kenya is a vehicle sales and service company with some 1,250 employees, 900 of whom are based in Nairobi. Though the company is a joint local- and foreign-owned corporation, nearly all of its employees are Kenyan. Eighty percent of the workforce is support staff and manual laborers. The company has a healthy balance sheet, with revenues of KSh1.64 billion (US$32.8 million)[7] and expenditures of KSh320 million (US$6.4 million) in 1992. However, like many other companies operating within an economy struggling with structural adjustment, over the next five years, the company expects the annual growth rate in expenditures (15 percent) to exceed that of revenues (10 percent). Wages account for some 25 percent of company expenditures, excluding the cost of benefits.

Auto Kenya's benefits can be considered generous, compared to those offered by many other Kenyan companies. The company provides on-site and off-site health care services to employees. Prior to July, 1993, the company relied primarily on public health clinics and a small company clinic to provide health care for its workers. However, as the quality and accessibility of public health services in the surrounding community have declined, the company has also introduced health care through a private agency, at a cost of approximately KSh2.2 million (US$44,000) annually.

In addition to medical benefits, the company offers up to three months fully paid sick leave, which exceeds the 21 working days required by Kenyan labor regulations. The company also covers many of the costs of burials for employees, including purchase of a coffin and transportation of the remains to the community of origin, at an average cost of KSh9,000 (US$180) per death. A number of workers and supervisors are also given one day of paid leave to attend the funeral of coworkers.

The Impact of HIV/AIDS

With a general adult population HIV prevalence rate for Nairobi estimated at 14 percent and growing, Auto Kenya is beginning to plan for the impact of AIDS on its operations. In line with International Labour Office (ILO) recommendations, the company does not test applicants or employees for HIV. Thus, it cannot offer any estimate of the

Key Points:

- AIDS cost Auto Kenya more than 1 million shillings (US$21,312) in 1994 and will cost more than 2.5 million shillings (US$50,074) annually by the year 2005. In comparison, an ongoing comprehensive prevention program would likely cost about KSh509,450 (US$10,189) per year.
- Company policies have drawn upon international guidelines and employee and management input.

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number of employees who are living with HIV or who have lost their lives to AIDS. However, by making the reasonable assumption that HIV rates at the company are similar to the surrounding community, this company probably has 170 infected employees, of which 15 have AIDS-related illnesses. With HIV rates in Nairobi expected to rise to 24 percent by the year 2005, some 300 employees are likely to be HIV-infected by then, unless an effective workplace prevention program is put in place.

HIV-related illnesses affect a company's balance sheet in a number of ways. On the expenditure side, costs are likely to increase in terms of medical and other worker benefits, as well as in hiring and training costs as workers are replaced. On the revenues side, absenteeism, illness or fatigue, and lower productivity of newly hired employees may affect production and hence, profits. Indirect costs of HIV/AIDS can also be significant: fear of HIV-infected coworkers or poor morale associated with policies that discriminate against HIV-positive workers can negatively affect operations.

The following table shows the estimated costs of HIV/AIDS to Auto Kenya:

COST PROJECTIONS BY IMPACT CATEGORY (KSh)

	1994		2005	
Cost Category	Cost	Percent of Cost	Cost	Percent of Cost
Recruitment	0	0.0	0	0.0
Health Care	55,785	5.2	114,675	4.6
Burial	130,572	12.3	401,760	16.0
HIV Absenteeism	527,020	49.5	903,463	36.1
AIDS Absenteeism	220,219	20.7	677,597	27.1
Funeral Attendance	20,798	2.0	63,993	2.6
Labor Turnover	42,703	4.0	131,394	5.2
Training	62,011	5.8	190,802	7.6
Post-training Productivity	6,515	0.6	20,046	0.8
Total	1,065,622	100.0	2,503,729	100.0

Company Response

The company has taken the first steps to protect itself and its workforce from HIV/AIDS. Its forward-thinking personnel manager initiated a series of prevention education sessions in 1993. Because of her previous

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work experience with HIV-positive workers, she was able to see the warning signs at Auto Kenya.

With assistance from the Ministry of Health and National AIDS Council, presentations were made to groups of 30–50 workers over the course of three weeks during special two- to three-hour lunch break sessions. The presentations were well designed and included discussion of the basic facts of the disease, measures that help prevent HIV transmission, and the company's current workplace policies, and included video presentations and an open question-and-answer session to discuss workers' feelings and concerns.

While no formal follow-up sessions have been held, prevention education films, such as "It's Not Easy" and "Sio Mimi," are occasionally shown to groups of interested workers during lunch breaks. Condoms are supplied at no cost by the Ministry of Health and are distributed free of charge in the clinic and toilets.

Company Policy

Most of the company's policies were generated internally, sometimes with input from employees and in consideration of government and ILO guidelines (which were distributed to all its 2500 members by the Federation of Kenyan Employers).

Consistent with these guidelines, the company does not test applicants or workers for HIV. The company states that it treats employees known to have HIV like any other employee with a medical illness or disability. Thus, an employee with HIV would be allowed to work as long as he or she is able, and then would be retired on medical grounds. Without prior experience, the company has not yet determined whether it would make changes in worker's duties to accommodate declining capabilities (termed "reasonable accommodation").

Medical records are private, though access to them by nonmedical management staff (upon request) means that they are not fully confidential. In the experience of some companies, lack of complete confidentiality means that some employees may not feel comfortable going to the company clinic for information or treatment about sensitive matters, such as HIV/AIDS or other sexually transmitted diseases (STDs). Thus, it could be beneficial for management to reexamine its medical confidentiality procedures.

Lessons Learned/Observations

Management at the company is hesitant to expand its prevention program efforts beyond informal video presentations. It is concerned about the cost and labor time that would be lost to education sessions. Yet, the costs of AIDS to Auto Kenya are likely to exceed the costs of prevention activities. Thus, expanded AIDS prevention efforts could be considered more of a corporate investment in productivity than an employee "benefit."

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Current financial estimates indicate that more than half a million shillings a year in profits are lost from HIV-related absenteeism alone. Unchecked, this will grow to KSh900,000 (US$18,000) by the year 2005. When other costs are factored in, including increased medical, training, and burial benefit costs, the company stands to lose over 1 million shillings (US$21,312) in revenues in 1994 and over two times that in 2005. In contrast, a comprehensive program of prevention—including education sessions, STD treatment, and condom distribution (assuming condoms are resold at cost)—is likely to cost about KSh509,450 (US$10,189) annually.

With initial HIV/AIDS prevention activities and a reasonably supportive policy framework in place, Auto Kenya is ready to take the next step: establishing an ongoing, company-financed program.

AIDS IMPACT VS. PREVENTION PROGRAM COSTS (Annually)

Year	1994 (KSh)	1994 (US$)	2005 (KSh)	2005 (US$)
AIDS Impact—Total Cost	1,065,622	21,312	2,503,729	50,074
AIDS Impact—Per Employee	859	17	2,019	40
Prevention Program—Total Cost	509,450	10,189		
Prevention Program—Per Employee	850	17		

KENYA TRANSPORT[8]

Company Background

Kenya Transport provides public transportion services primarily in Nairobi and Mombasa. Kenya Transport employs 2,200 workers. Wages represent 47 percent of the company's KSh477.7 million (US$9.6 million)[9] in gross expenditures in 1992. The company earned KSh527 million (US$10.5 million) in the same year and projects net revenues to grow at 5 percent annually for the next five years.

Good, safe, and reliable drivers, conductors, and mechanics are valuable employee attributes in Kenya, and Kenya Transport treats its employees well. In addition to an employee average wage of KSh1,715 (US$34) per week (in comparison, GNP per capita is about KSh10,750 or US$215 annually), the company operates a medical clinic, pays for medical treatment at outside clinics, offers sick leave (45 days full pay and 60 more days at half pay annually), leave for some coworkers to attend funerals, and burial benefits of approximately KSh5,000 (US$100) per death. The non-unionized management staff are also part of a more comprehensive health insurance program and pension scheme.

The Impact of HIV/AIDS

Nearly all of Kenya Transport's workers are male (99 percent), many of whom travel frequently. Experience with similar workers in the region suggests that they are a high-risk group in terms of acquiring and transmitting HIV. Thus, while the general adult population HIV prevalence rate in Nairobi is already estimated to be 14 percent, it is likely that the rate is higher among staff of Kenya Transport. Management at the company estimates roughly that the firm's general prevalence rate is 10-15 percent, with a higher rate among drivers and conductors.

Using the 14 percent rate for adults in Nairobi, about 300 Kenya Transport workers were infected with HIV as of 1994. With that city's HIV rate projected to rise to 24 percent by the year 2005, the number of employees with HIV would grow to a total of 520 in that year. At these rates of infection, based on the company's 1994 expenditures, Kenya Transport

Key Points:

- This company employs a skilled, mobile work force in which it has a high investment.
- The company's HIV/AIDS policies are generally positive, but prevention efforts within the workplace are limited.
- Misinformation about HIV/AIDS, even disbelief that it exists, results in continued high-risk behavior among employees.
- An HIV/AIDS prevention program would be a cost-effective investment in human resources. It is estimated that a prevention program would cost KSh644 per worker, while the economic cost of HIV/AIDS to the company was already KSh1,400 in 1994.

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is losing some KSh3.1 million (US$61,132) per year as a result of HIV-related illnesses. By the year 2005, the cost could reach KSh7.4 million (US$147,389). The cost projections break down as follows:

COST PROJECTIONS BY IMPACT CATEGORY (KSh)

	1994		2005	
Cost Category	Cost	Percent of Cost	Cost	Percent of Cost
Recruitment	0	0.0	0	0.0
Health Care	177,819	5.8	365,538	5.0
Burial	152,966	5.0	470,664	6.4
HIV Absenteeism	1,360,548	44.5	2,332,368	31.7
AIDS Absenteeism	568,515	18.6	1,749,276	23.7
Funeral Attendance	337,161	11.0	1,037,417	14.1
Labor Turnover	87,824	2.9	270,229	3.7
Training	282,590	9.3	869,507	11.8
Post-training Productivity	89,195	2.9	274,446	3.7
Total	3,056,618	100.0	7,369,446	100.0

As this data indicate, absenteeism associated with HIV/AIDS is the largest cost (63 percent) to Kenya Transport. Absenteeism already costs the company KSh1.9 million (US$38,581) in profits per year and will likely grow to KSh4.1 million (US$81,632) by the year 2005 if unchecked by prevention efforts.

Company Response

Management at the company is aware of the potential risk that HIV/AIDS imposes; it reports that HIV/AIDS has severely affected its sister company in Malawi. In spite of this, the company has not yet acted aggressively to address HIV/AIDS in its Kenya operation. Beyond allowing the Marie Stopes Foundation to install condom dispensing machines in the restrooms in 1988 for family planning purposes, the company has taken little action against HIV/AIDS. Marie Stopes, the Lions Club, and the Kenya Red Cross Society have occasionally conducted AIDS awareness sessions at the company, but fewer than 50 employees have attended these sessions each year.

Management has indicated a willingness to consider establishing an ongoing company HIV/AIDS prevention program. Recently the company was approached by Wellcome Trust (which has a small worker

prevention training group in Nairobi) to help set up a prevention education program. However, management is hesitant for two reasons: it is not convinced that workers are engaging in high-risk behavior, and it is concerned about the financial investment in such a program.

Company Policy

The company's policies regarding HIV/AIDS among workers are generally positive. All of the policies have been developed primarily from the recommendations of the parent company in the U.K. and modified to fit Kenyan law as necessary. While there are health-related criteria for hiring transport workers required by Kenyan law, they do not refer specifically to, or differ for, applicants with HIV. The company does not test applicants for HIV. Similarly, termination policies do not distinguish between HIV-related illnesses and other disabling illnesses that might result in medically-based retirement. Medical confidentiality of records is recognized, though it is not absolute: senior managers can get access to an employee's records if needed to make determinations for medical reimbursement or retirement. There are no specific plans to modify these policies substantially to account for the impact of HIV/AIDS, though some consideration is being given to reducing death benefits.

Observations

Though visible costs in human life have been low to date—some three known deaths to AIDS per year—the 14 percent prevalence rate within Nairobi suggests that losses will climb dramatically in the future. Because of the 7–10 years it takes for HIV infection to show itself in the form of illness, if the company waits until HIV-related illnesses are highly visible, the losses will likely be dramatic. While a prevention program cannot prevent losses of workers who are already HIV-infected, it can minimize new infections.

A focus group conducted with workers indicated that misconceptions about HIV and its transmission are widespread in the company. Some workers question the existence of AIDS altogether, while others are still confused about how it can be transmitted. In such an environment, high-risk behavior is an obvious danger. The focus group also revealed that employees would like more information about HIV/AIDS and about how the company handles cases of HIV infection among workers.

The general opinion of the group was that the company would almost certainly fire workers with HIV infection, although this is not, in fact, company policy. Workers at Kenya Transport, along with those at many other companies where focus groups were held, were uncertain of the actual company policy on termination of people infected with HIV. Because employees are unlikely to come forward for information about HIV/AIDS and to seek treatment for STDs if they are not confident

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that their jobs are safe, it is important that company policies of medical confidentiality and nonstigmatization be unambiguous and clearly communicated to employees.

Based on the information elicited from the focus group, management expressed initial interest in establishing a workplace prevention program. Even with a comprehensive program, the benefits of prevention services are likely to exceed the costs of providing those services. A rough estimate of the cost of such a program is KSh1.4 million (US$28,070), or KSh644 (US$13) per worker per year. This is below the KSh3.0 million (US$61,132) in annual costs the company is already incurring from HIV/AIDS, and well below the KSh7.4 million (US$147,389) (in 1994 shillings/dollars) cost of HIV/AIDS by the year 2005. Though a prevention program will not eliminate all HIV transmission, an annual company investment of the equivalent of less than half a week's wages per worker is a small price to pay compared to the financial and human costs AIDS could have on this company.

AIDS IMPACT VS. PREVENTION PROGRAM COSTS (Annually)

Year	1994 (KSh)	1994 (US$)	2005 (KSh)	2005 (US$)
AIDS Impact—Total Cost	3,056,618	61,132	7,369,447	147,389
AIDS Impact—Per Employee	1,403	28	3,382	68
Prevention Program—Total Cost	1,403,500	28,070		
Prevention Program—Per Employee	644	13		

MUHORONI SUGAR, KENYA

Company background

Muhoroni Sugar is a large, vertically integrated company that grows sugar cane on its estates and refines the sugar in its factories for sale by the national commodity trading board. Muhoroni Sugar is an important economic player in the Kisumu area, employing 1,200 year-round workers and another 2,000–2,500 casual workers during the cropping season. Wages average about KSh60,630 (US$1,213)[10] annually (or about 7 percent of the company's expenditures). Unfortunately, as a result of rising costs and reduced sugar prices, Muhoroni Sugar faces substantial economic uncertainty. Profits dropped from roughly KSh1.1 billion (US$22 million) annually in 1991 to near zero in 1994. Annual expenditures are expected to exceed revenues by 20 percent over the next five years.

Because the company employs a large workforce that resides in company-owned villages or towns, Muhoroni Sugar has always played a significant role in providing for the care and benefits of its employees and their families. Muhoroni Sugar operates a full-service health clinic for workers and their families and offers life insurance for those who die on the job, as well as government-required workmen's compensation, burial benefits, funeral leave, and sick leave. Though specific figures are not available, these expenses are a notable portion of the company's annual expenditures.

The Impact of HIV/AIDS

Though Muhoroni Sugar is located in rural Kenya, it is not immune to the impact of HIV/AIDS. Management is aware of at least six employees living with HIV and at least seven deaths can be attributed to AIDS in the past five years. By applying HIV prevalence rates found in this area (19 percent), a conservative estimate of the actual number of employees with HIV is more than 225.

In assessing the impact of HIV/AIDS on Muhoroni Sugar, it is important to note that senior managers, who represent 3 percent of the workforce, are particularly expensive to recruit. There is no reason to believe that managers are any less at risk of contracting HIV. Thus, at least seven senior managers may now be HIV-infected. By the year 2005

Key Points:

- Rural businesses are not immune from the impact of HIV/AIDS. The disease is costing this company a total of KSh2.9 million (US$58,303) annually, or KSh2,425 (US$49) per worker. By the year 2005, these costs could double.
- With the support of a local NGO, Muhoroni provides comprehensive HIV/AIDS prevention services which are integrated with its family planning program. These are backed by a solid set of policies.
- Funding a comprehensive program will cost about KSh1 million (US$21,467).

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(assuming employment levels remain constant), 290 employees could be living with HIV, and nine or more of them would be senior managers.

As the table below shows, recruitment costs account for more than 50 percent of the financial impact of HIV/AIDS. Hence, HIV and AIDS-related absenteeism of both senior managers and all other employees would account for approximately 25 percent of the cost of HIV/AIDS to the company.

The following table summarizes the financial impact of HIV/AIDS on Muhoroni Sugar:

COST PROJECTIONS BY IMPACT CATEGORY (KSh)

	1994		2005	
Cost Category	Cost	Percent of Cost	Cost	Percent of Cost
Recruitment	1,504,018	51.6	3,426,876	58.2
Health Care	72,507	2.5	109,963	1.9
Burial	189,916	6.5	432,720	7.4
HIV Absenteeism	692,577	23.8	874,834	14.9
AIDS Absenteeism	287,966	9.9	656,126	11.2
Funeral Attendance	88,605	3.0	201,885	3.4
Labor Turnover	43,907	1.5	100,041	1.7
Training	9,696	0.3	22,092	0.4
Post-training Productivity	25,971	0.9	59,175	1.0
Total	2,915,163	100.0	5,883,711	100.0

With a current financial cost of about KSh2.9 million (US$58,303), or KSh2,425 (US$49) per employee, HIV/AIDS has had a relatively small impact on Muhoroni Sugar, compared to total earnings. However, because Muhoroni Sugar is operating without profits, the prospect of HIV/AIDS costs doubling to more than KSh5.9 million (US$117,674), or about KSh4,895 (US$98) per employee annually, is a very serious concern.

Company Response

Management of Muhoroni Sugar is well aware of the risk HIV/AIDS poses to its operations. Though management does not believe that HIV/AIDS has yet significantly affected their operations, medical costs have already risen as a result of the disease. Recognizing the need for healthy workers and seeking a cost-effective approach to reducing the potential impact of the disease, the company initiated an HIV/AIDS

prevention program in 1991, with assistance from a local health nongovernmental organization (NGO).

For the first month, education programs were offered daily to reach the entire workforce with basic information about HIV/AIDS. Thereafter, videos provided by the NGO have been shown on a regular basis, usually during weekends as part of the general entertainment for the community. A community youth group has also begun to perform dramatic plays that include HIV/AIDS prevention messages as a way of encouraging and reinforcing prevention efforts. There are also volunteer local health committees responsible for communicating prevention education to their communities.

These prevention education messages are backed up by other prevention intervention services, including condom distribution, STD diagnosis and treatment, and some counseling services. Voluntary HIV testing is also available by referral to neighboring medical facilities. STD services are available on a daily basis at the health clinic. Condoms are distributed free of charge at five distribution points, with dispensers in the factory toilets and the health clinic. The company would like to enhance its counseling services through increased formal training.

Another positive element of the prevention program is that it is integrated with the family planning services that were already provided by the company through the same NGO. Family planning and HIV/AIDS prevention messages are generally complementary and reinforcing. Both encourage safer sexual practices, which reduce the risk of HIV transmission and other STDs. Contraceptive devices are recommended on the basis of both the risk factors of the clients and their desires about increasing their family size. The field health educators who visit residents in the villages offer education and services for both family planning and HIV/AIDS.

Company Policy

Muhoroni Sugar's policies state that employees with HIV/AIDS are treated like any other employee with a life-threatening illness. Employees and applicants are not tested for HIV and are allowed to work as long as they are medically fit. Medical treatment is provided as long as possible to help prolong the life of HIV-infected employees and/or their families. Workers known to have HIV infection or AIDS symptoms presently are all still actively employed by the company. Medical information on workers is kept confidential. These policies, combined with HIV/AIDS prevention information, tend to reduce the possibility of labor disruptions that might otherwise arise from fears of working with HIV-positive coworkers. These policies also tend to increase worker confidence that management will not discriminate against them if they seek health-related information or assistance. This may well explain the high condom demand at the company, averaging 120 condoms per employee annually.

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Observations

Muhoroni Sugar is clearly a forerunner in corporate responses to HIV/AIDS in the workplace. The challenge to Muhoroni Sugar is how to maintain its prevention programs and policies in the face of a growing financial crisis that is unrelated to the impact of HIV/AIDS. Prevention program costs to the company have been relatively low to date because the local NGO provided most of the materials and technical assistance free of cost. However, the company has been responsible for the salary of the clinical officer managing the HIV/AIDS program. The local NGO began withdrawing its assistance in 1994, and the company is now maintaining much of the program at its own cost. As expenditures continue to rise and revenues decline at the company, management will be forced to seek new ways to afford the program.

Initial estimates on operating a comprehensive prevention program at company expense indicate that it would be reasonable, relative to the impact of HIV/AIDS on Muhoroni Sugar. The first-year cost (including start-up costs) of a prevention program would be KSh1.5 million (US$30,149), or KSh1,250 (US$25) per employee. The recurrent annual cost would then drop to approximately KSh1 million (US$21,647), or KSh900 (US$18) per employee. Thus, the program costs are about one-third that of the present annual impact of HIV/AIDS and about one-sixth that of the projected impact in the year 2005 in the absence of an effective program.

As one possibility for containing the costs of the program, Muhoroni Sugar is implementing some cost-recovery elements into the prevention program. The cost estimates noted above include installation of condom machines, which would allow the company to recoup the costs of providing more than 12,000 condoms per month to its workforce (especially if Muhoroni Sugar were to receive condoms on a subsidized basis). However, efforts to introduce cost recovery will need to be carefully balanced against wage levels and the ability of employees to pay for services.

AIDS IMPACT VS. PREVENTION PROGRAM COSTS (Annually)

Year	1994 (KSh)	1994 (US$)	2005 (KSh)	2005 (US$)
AIDS Impact—Total Cost	2,915,163	58,303	5,883,711	117,674
AIDS Impact—Per Employee	2,425	49	489,598	
Prevention Program—Total Cost	1,082,350	21,647		
Prevention Program—Per Employee	900	18		

WESTERN WOOD, KENYA

Company Background

Western Wood is a wood processing manufacturer based in the Great Rift Valley of western Kenya. In 1992, there were revenues of KSh400 million (US$8 million)[11] and expenditures of KSh270 million (US$5.4 million), resulting in some KSh130 million (US$2.6 million) in profits. Western Wood employs some 1,600 workers, many of whom are union members. Most of the workers (80 percent) are male manual laborers earning an average of KSh1,500 (US$30) per week. However, there is also a significant base of highly skilled machine operators (40), supervisors (100), and senior managers (40) whose earnings range from KSh1,900 to KSh15,000 (US$38 to US$300) per week. In total, wages account for 68 percent of the company's expenditures.

The company has not felt it necessary to operate its own clinic, and instead, pays for the treatment of management and unionized staff at the municipal council clinic. However, as medical costs increase, Western Wood is planning to establish a private health insurance scheme to cover its employees.

The company also has a retirement benefit for management and workers with ten years or more of service. Like many other East African companies, Western Wood also provides a free coffin, transport to the burial site, and a death benefit to the families of deceased employees. The standard workmen's compensation benefits required under Kenya labor laws are offered to disabled employees.

The Impact of HIV/AIDS

Adult HIV prevalence estimates for the Great Rift Valley region is 8 percent as of about 1994 and is projected to rise to approximately 14 percent by the year 2000. Applying these rates to the company, some 129 Western Wood workers would be HIV-infected. Unchecked, this is expected to grow to 225 workers by the year 2005, with 34 of them having symptoms of AIDS. Unless there is a program to reduce the risk, HIV/AIDS is expected to hit Western Wood relatively hard. HIV/AIDS-associated absenteeism and the eventual deaths of such highly skilled workers as the machine operators—who require 18 months of training and are not easily replaced—will have a significant impact on the company. Of course, unexpected absenteeism among other workers

Key Points:

- This company shows that not only companies based in urban centers need to worry about the impact of AIDS—the disease will have a significant effect on this rural manufacturer.
- Approximately 1.5 percent of profits are already consumed by AIDS-related costs, and this may grow to almost four percent by the year 2005.

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and its effect on production will also be noticeable. For example, while wages are generally lower for workers in the wood cutting, transport, and shipping departments, widespread, frequent, or unexpected absences in these areas will all significantly reduce production.

Concerned about the likely impact of HIV/AIDS on their operations, management agreed to participate in a financial impact analysis. Based on the salary, benefits, training expenses for the company, and HIV prevalence rate estimates, HIV/AIDS is having the following financial impact on Western Wood:

COST PROJECTIONS BY IMPACT CATEGORY (KSh)

	1994		2005	
Cost Category	Cost	Percent of Cost	Cost	Percent of Cost
Recruitment	0	0.0	0	0.0
Health Care	258,003	12.7	650,871	12.7
Burial	107,870	5.3	338,100	6.6
HIV Absenteeism	729,040	35.9	1,275,820	24.9
AIDS Absenteeism	305,286	15.0	956,865	18.7
Funeral Attendance	9,393	0.5	29,442	0.6
Labor Turnover	321,902	15.8	1,008,945	19.7
Training	298,230	14.7	934,752	18.2
Post-training Productivity	2,621	0.1	8,215	0.2
Total	2,031,518	100.0	5,124,970	100.0

Comparing these costs to the profit estimates, HIV/AIDS consumed 1.5 percent of profits in 1994, and this may rise to 3.7 percent by the year 2005. Currently, the most notable expenses are health care, HIV/AIDS-related absenteeism, labor turnover, and training costs, in that order. These also remain the most significant expenses in the 2005 projection.

Company Response

Western Wood has responded tentatively to the risk HIV/AIDS poses to its operations. In 1993, the personnel manager introduced a condom distribution program and put up posters with the assistance of Population Health Services (PHS). Management is also planning to begin showing HIV/AIDS prevention videos.

Though workers have not voiced a desire for information on HIV/AIDS, the response to making condoms available has been extremely positive, and the demand for them is high. Approximately 3,000 condoms are distributed each week in the toilets. Though PHS provides the condoms free of charge, the cost to Western Wood to provide them would be modest: roughly KSh50,000 (US$1,000) annually, most of which would be recouped if the company sold them at cost. At this rate of condom distribution, it also seems likely that condom use among workers is very high. This suggests that the rate of HIV and other STDs contraction is likely to decrease significantly among the workforce. In the future, this may save much of the KSh2.5 million (US$50,000) already being lost annually to HIV/AIDS.

Company Policy

Western Wood has no specific policies on HIV/AIDS. It does not test workers nor applicants for HIV, and it does not keep medical information, since it does not have a medical clinic. Though management has not yet developed a policy on HIV/AIDS, workers with HIV/AIDS would likely be kept on as long as they are medically fit and then retired on medical grounds with whatever benefits would normally be offered.

Though these practices are generally consistent with those recommended by the World Health Organization, the International Labour Office, and several business coalitions around the world, they are more the result of a lack of policy consideration about HIV/AIDS on the part of management than out of a reasoned commitment to these particular practices. These practices may not survive in the future unless the company gives careful thought to the impact of HIV/AIDS and how to respond appropriately.

Observations

Western Wood has taken some important steps to address the real risk HIV/AIDS poses to its business. The decision to distribute condoms has been well received, and the high demand for them indicates both the risk HIV/AIDS poses to those who do not take precautions and the positive response that can be generated through corporate action.

Enactment of other prevention interventions—including HIV/AIDS education and STD diagnosis and treatment—would likely be cost-effective for Western Wood. Estimates for a company-wide, comprehensive HIV/AIDS prevention program are KSh 2.1 million (US$42,395) in the first year and KSh 1.6 million (US$31,885) annually thereafter. With 1,610 workers, the recurrent operating cost of prevention per worker is then KSh1,000 (US$20). In contrast, the financial impact on a per worker basis was KSh1,262 (US$25) in 1994, and will grow to KSh3,183 (US$64) annually in the year 2005.

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AIDS IMPACT VS. PREVENTION PROGRAM COSTS (Annually)

Year	1994 (KSh)	1994 (US$)	2005 (KSh)	2005 (US$)
AIDS Impact—Total Cost	2,031,518	40,630	5,124,970	102,449
AIDS Impact—Per Employee	1,262	25	3,183	64
Prevention Program—Total Cost	1,594,250	31,885		
Prevention Program—Per Employee	1,000	20		

LA COMPAGNIE SÉNÉGALAISE DES PHOSPHATES DE TAIBA, SENEGAL

Company Background

La Compagnie Sénégalaise des Phosphates de Taiba (CSPT) is Senegal's largest mining company, producing close to two million tons of phosphate per year. It mines and treats phosphate, the country's primary mineral resource. CSPT is an important contributor to the country's foreign exchange and government revenues. Founded in 1957, CSPT is one of the ten largest companies in Senegal, in terms of number of employees (1330, including 28 women), working capital (12 billion CFA or US$22.2 million),[12] and annual earnings (27 billion CFA or US$50 million).

In the late 1990s, CSPT will merge with the Industries Chimiques du Sénégal (ICS) which, among other activities, currently runs a nearby processing plant that employs 200 people. CSPT is a *société d'économie mixte* (privately managed parastatal company), in which the government holds a majority of shares (50 percent) and the remaining shares are privately owned (in this case, mostly by French interests). Managed primarily by Senegalese nationals, the headquarters is located in the capital, Dakar, with a sales office in Paris.

The company's mining facilities are situated at Taiba, in the region of Thies, 120 kilometers from Dakar. This is a rural area, isolated from major educational, social, cultural, and health structures. More than 90 percent of the company's employees work at this site. The workforce is predominantly male (98 percent) and is composed of persons from all regions of Senegal. Mining and processing activities continue nonstop throughout the year.

CSPT contributes to improving the quality of life in the region. The jobs created by the mine help slow the rural exodus and require significant efforts in the areas of recruitment, training, and upgrading of skills. Local towns and villages benefit from the company's participation in the creation of housing, schools, recreation facilities, water services (wells, bore holes, and water points), and health centers.

Benefits and Health Policies

CSPT's human relations, training, and medical structures are committed to the smooth integration of all personnel into the company.

Key Points:

- Management is not in full agreement on the risks of HIV/AIDS at this company. Head Office managers are not convinced that there is a danger, while the company doctor is certain that the organization needs to address AIDS.
- As of 1994, two HIV-positive cases were reported from a small volunteer surveillance study done of 1/10th of the workforce.

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Housing is provided by the company for most of the employees and their families in three company-built housing sites. Because of the isolation of these sites and the lack of employment opportunities for spouses, some families choose to live elsewhere.

The company supplies staple goods through a cooperative store. Health services, as well as cultural, sports, and socio-educational facilities, are provided for workers and their families.

Recruiting and employment policies follow Senegalese law (Work Code, Social Security Code, Health Code, etc.), as do policies about medical coverage for illness, handicaps and accidents, the confidentiality of medical records, and non-discrimination.

- Medical costs are covered in part by the company's private health plan (IPM). Sixty percent of the cost of external medical consultations and prescription drugs, as well as 40 percent of hospitalization costs, are covered. The IPM provides the employee with a letter of guarantee making it possible to receive medical services without having to pay up front. The percentage of expenses not covered by the IPM is then deducted from the employee's paycheck. The IPM is funded by the company (50 percent) and the employees (50 percent), with each contributing 3,000 CFA (US$15.50) per month.

  The cost of running the IPM has been climbing rapidly since 1991: 68 million CFA (US$126,000) in 1991, 150 million (US$278,000) in 1992, and 180 million (US$333,000) in 1993. According to the company, this trend can be explained by increases in the cost of living and significant increases in the cost of medicines. These figures do not reflect the dramatic increase in costs associated with the devaluation of the CFA in 1994.

- Medical assistance for work-related illnesses and accidents is covered by Senegalese Social Security.

- All employees receive retirement benefits.

- Funeral expenses are paid by the company.

- Financial assistance for families of deceased employees is provided for a period of four months: 15,000 CFA (US$28) per month plus necessary staple goods (rice, oil, sugar, and soap).

To ensure employee fidelity to the company, management also benefits from:

- Full health coverage, the cost of which has also risen in the last few years from 42 million CFA in 1991 to 65 million CFA in 1993 (from US$78,000 to US$ 120,000).

- A life insurance plan, offering complimentary retirement, death, and disability coverage; CSPT pays for two-thirds of the premiums, and the employee pays for one-third.

The Impact of HIV/AIDS

For the moment, CSPT's management does not consider the HIV/AIDS epidemic as a problem that needs to be addressed by the company. There are several reasons for this: (1) the small number of cases currently recorded, (2) lack of information about the rising prevalence rate of HIV/AIDS in Senegal, and (3) management's preoccupation with production. Managers feel CSPT would not be affected by a loss of personnel because there is an abundance of unskilled laborers looking for work. There are also training and provisional management policies within the company that allow for filling of vacated posts internally.

On the other hand, if the combined prevalence of HIV-1 and HIV-2 is estimated at approximately 1–2 percent currently, then some 13 to 27 workers are currently infected with HIV. By the year 2005, using a conservative 5 percent HIV prevalence rate, more than 65 employees will be HIV-positive. In the context of the company's commitment to providing full health care coverage, funeral expenses, and retirement benefits to all employees, the costs of HIV/AIDS could be significant. It is also important to note that not all workers are easily replaced (e.g., technicians, mining engineers, managers), nor are losses of lower-skilled workers in a complex production process easily absorbed.

Though most senior managers are not yet aware of the risk, the company doctor is well aware of the danger HIV/AIDS poses to the company and has initiated some prevention activities in the context of a family health program. This program was started in 1987 and is supported by management. Employees have expressed the desire to be more fully informed about HIV/AIDS and, as a result, some prevention activities are now offered through the initiative of the medical unit. The doctor is planning to expand and formalize the company's HIV/AIDS prevention education program. Actions taken thus far include the following:

- A small epidemiological study of major infections was conducted in 1992 by the company physician during a blood donor drive. To conduct the study, he first organized an information campaign targeting management and employee representatives. Of the blood donors, 145 volunteered to take part in the study. The results led to the diagnosis of one case of syphilis, two HIV-positive cases, and 20 cases of hepatitis.

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The results of the study were discussed during a weekly meeting with the department heads. The company physician pointed out that the plant does not exist in a vacuum. Many employees are single or living away from their families and may participate in unsafe sexual activities outside the plant in their free time.

- Approximately 3,000 condoms are distributed free each month.

- STD consultations are offered (initially part of the family health program). It should be noted that STD treatment represents approximately 25 percent of the total number of consultations. High STD rates are associated with much higher risk of HIV transmission during unprotected sexual encounters.

- Materials in the form of illustrated and nonillustrated booklets are distributed, and there are also occasional informational meetings about HIV/AIDS. However, no educational materials are distributed that specifically address HIV/AIDS.

The company physician will soon attend a seminar for business management personnel and health officers, organized by the national AIDS control program. He wants to be better informed about all aspects of HIV/AIDS education, counseling, and clinical treatment. In fact, he believes that it is unsuitable to perform prevention activities if he cannot assist employees already infected by the HIV virus.

Observations

CSPT has the infrastructure (e.g., buildings and equipment), resources, and qualified personnel necessary for carrying out an HIV/AIDS prevention program. In addition, the medical unit has a successful family health program, and management has noted the benefits such programs can bring.

The medical unit plans to expand and formalize its HIV/AIDS prevention program. It is the medical staff's view that this program could become broader and more effective if management can be made more aware of the importance of such a program and their full backing is secured. One strategy to accomplish this would be for the company physician to include other senior managers in the design and implementation of the prevention program. Initial support might be won by holding a series of meetings with managers to review the benefits to the company of the existing family health program. Economic impact and prevention program cost estimates, using internal company data, can focus attention on specific concerns for the company.

PARKE DAVIS, SENEGAL

Company Background

Parke Davis is the subsidiary of a large multinational pharmaceutical manufacturing and packaging company. Parke Davis is one of the world's largest drug companies, employing more than 30,000 employees in 130 countries.

The products produced at this facility are primarily for export (85 percent) to 20 African countries and to France. Competition for these products comes from French pharmaceutical companies who export to Africa. The modern plant is staffed by 68 employees (40 women and 28 men), most of whom are skilled. Working conditions are so good, in fact, that there is a great level of stability in the workforce, with virtually no turnover in the past several years.

All employment procedures were designed to conform with the country's labor regulations and with the parent company's human resources policies. These procedures are nondiscriminatory in matters of recruitment and the social and medical coverage of employees.

Employees and their families benefit from private health insurance, which costs the company 18 million CFA (US$33,300)[13] per year. Certain health services are provided on-site at the plant. In 1992, a total of 60 work days were lost because of illness. Parke Davis has an infirmary at the plant that is used for visits by the consulting physician or by the pharmacists for first aid. The company's medical service provides for basic health care, annual check-ups, and periodic vaccination campaigns during epidemics. Medical treatment for STDs is also provided.

The Impact of HIV/AIDS

No cases of HIV infection have yet been discovered at Parke Davis. However, concern about the epidemic does exist, and employees increasingly ask for information about HIV/AIDS, such as the modes of transmission and how to protect oneself.

Company Response

As one answer to these requests, the company called on SWAA (the Society for Women and AIDS in Africa) to organize a conference to increase awareness about the problem. All personnel were invited to attend. The panel of speakers included a physician, the head of the department of infectious diseases at one of Dakar's major hospitals, a member of the

Key Points:

- The company is well positioned to establish an HIV/AIDS program. It has a significant investment in benefits and training and has the resources to initiate a prevention program.

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national AIDS control program, and one of Senegal's top AIDS experts.

Currently, the company does not plan to put in place an HIV/AIDS prevention education program, but neither does it exclude the possibility. If such a program were to be developed, outside specialists would be called upon for assistance.

Company Policy

Management has clear personnel policies that would apply to HIV/AIDS. Employees contracting the virus will be kept on the job and will keep the benefits associated with their posts. If an employee is unable to fulfill his or her job tasks, reassignment will be offered whenever possible. If job reassignment is not appropriate, the employee will be laid off and any accrued retirement benefits will be awarded, in compliance with the country's work legislation and Parke Davis headquarters' social policies.

Confidentiality is strictly observed for medical records. These records are controlled by the company physician, who is the only person with access to them.

Observations

Parke Davis has strong reasons to consider establishing an HIV/AIDS prevention program. The company's existing policies reflect its strong commitment to, and investment in, maintaining a healthy and satisfied workforce. Though no cases of HIV have yet been discovered at Parke Davis, the growing prevalence of HIV/AIDS in the country suggests that a prevention program would be a prudent investment well within its financial means.

PORT AUTONOME DE DAKAR, SENEGAL

Company Background

The Port Autonome de Dakar, or Port Authority of Dakar (PAD), creates, maintains, improves, and operates all the port facilities of Dakar. The work of PAD is largely capital-intensive. The company has 542 employees, of which 70 are women. They include engineers, technicians, sailors, laborers, and administrators. PAD does not manage the approximately 1,500 professional and temporary dock workers, who also form part of the port population.

In existence since 1856, the Port Authority became a national company, or société nationale, in 1987, with 5 billion CFA (US$9.3 million)[14] in capital. Capital for the société nationale in Senegal is provided by the state, but the enterprise is managed as a private company. As such, PAD's financial and administrative systems are autonomous. Also, as a société nationale, the Port Authority must balance its receipts and outlays as would any private company. Operating costs are entirely financed by the Port Authority of Dakar, principally from port duties, leasing of buildings and equipment, and so on.

After losing much ground in recent years to competition in the area of maritime transport, Dakar is making great efforts now to regain its competitiveness in western Africa. This comes at a time when the big maritime companies are reducing their ports of call in the trade between Europe and Africa. It is expected that in the near future, a small number of large African ports will control most of the transcontinental traffic, among them the ports of Banjul, Abidjan, and Nouakchott.

Charged by the President of Senegal "to clean house," the new director of PAD has reduced the number of employees by 90, fought against the bureaucracy, and terminated investment programs judged to be unnecessary in the second half of 1993. These measures were a prerequisite of the program for reviving the port of Dakar.

PAD is currently recovering from economic losses caused by a decline in earnings, enormous difficulties in collecting fees, a decline in worldwide traffic, a collapse in the market for loading and off-loading operations, and a loss of business when some shipping clients shifted to more attractive ports.

Key points:

- PAD is an example of the difficult situation many parastatal companies face: high overhead and a lack of competitiveness in the international market. This company seeks to maintain employee benefits while also trying to reduce costs, improve efficiency, and expand its market.
- The risk of HIV transmission is greater among a mobile, relatively well-paid, and skilled, port workforce. Thus, creating an HIV/AIDS prevention program is an important consideration, even as efforts are under way to cut costs.

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PAD takes education of its employees very seriously. PAD has a three-year training program, carried out by the Service for Training and Management Planning. PAD also organizes seminars for the benefit of its employees. For these purposes, PAD has a classroom completely equipped with teaching and audiovisual equipment for in-house training. There are also various training agreements signed with other ports, such as the Hague, Dunkirk, and Anvere, to meet PAD's various training needs. PAD reimburses the fees of employees registered in national and foreign training institutes. Furthermore, study grants are available to employees of PAD. Finally, literacy courses have been offered since 1988.

Company Benefits

PAD provides a considerable number of employee benefits, such as:

- Full coverage of medical expenses for employees treated at the clinic and 80 percent coverage of expenses for employees seeking external services.
- Disability payments to employees who are accident victims.
- Contributions toward the cost of a medical evacuation.
- Housing loans equivalent to the personal down payment required by the bank.
- Contributions toward funeral expenses of a deceased employee.
- Gifts of basic commodities (oil, sugar, soap) to ease the difficult transition between the date of retirement and the date of the first payment from Social Security.
- Promotion of soon-to-be retirees two levels, 13 months before retirement.
- Various subsidies to unions, the association of women of PAD, and the mutual benefit society of the employees of PAD.

Company Medical Services

PAD provides extensive medical services for its employees and their families. PAD's clinic employs ten, including a physician, a midwife, a nurse, a health worker, two nurse's aides, two accounting aides, a secretary, and an ambulance driver. The clinic has an observation room, a vaccination room, an infirmary, a pharmacy, rooms for family planning and prenatal consultations, and so on. The pharmacy is completely

managed and stocked by the company. The clinic also has a building used for information, education, and communication (IEC) programs.

Unlike a number of midsized and large companies in Senegal, PAD has not established a private health plan. The company covers the costs of the medical services dispensed. Most patients are treated for their illnesses at the clinic; certain patients who need specialized treatment are sent elsewhere. Care is provided to employees and their families and the port population. For humanitarian reasons, some retirees are also treated. The medical service provides services for a population of 10,000 persons per year. It averages 50 consultations per day. The costs associated with this care reach 75 million CFA (US$139,000) annually. The medical service's annual budget (small equipment and pharmacy) reaches 25 million CFA (US$46,300), with the possibility of supplemental funding.

During medical consultations, employees sometimes ask for information about HIV/AIDS. This is usually during consultations for STDs, recurring infections, or diarrhea, or when wives are concerned about their husband's genital infections. The doctor explains the basic facts to those who ask, but consultations on HIV/AIDS are limited to these specific, isolated cases because the doctor has not seen anyone sick with AIDS or any employees testing positive for HIV. Thus, the company generally still underestimates the degree of illness. This could be why the company has no program of education for the prevention of AIDS as such.

However, the roots of an HIV/AIDS prevention program are already in place. The medical service emphasizes prevention, in keeping with the desire of management who believe that prevention is the best way to maintain healthy workers to fulfill production objectives in the current economic slowdown. As a result, the medical service works to eliminate work-related risks and carries out vaccination campaigns for employees and their families within the framework of the broad national vaccination program (the vaccines are provided by UNICEF through the Ministry of Health).

In addition to the general medicine and preventive medicine components of their medical activities, PAD has a family health program initiated in 1988 with the support of the private and parastatal sector of the Project for Family Health and Population of ISTI, financed by the United States Agency for International Development. This program permits PAD to resolve both medical and economic problems: spacing of pregnancies, improved health for women, reducing costs due to pregnancies, and so on. PAD offers some medical services concerning HIV/AIDS within the framework of this family health program. These services include free distribution of condoms (provided by a local nongovernmental organization) and diagnosis and treatment of STDs.

The employees of PAD, and the population of the port in general, appear satisfied with the medical services offered.

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The Impact of HIV/AIDS

There have been no reported cases of HIV or AIDS within the company. However, the environment around PAD favors the acceleration of transmission of the virus. The doctor recognizes the necessity of coordinating information with his colleagues at the port and is working to do so.

In spite of these positive steps by the physician, a more comprehensive and focused HIV/AIDS prevention program has yet to be considered by PAD's management. The management of PAD has yet to fully consider:

- The seriousness of the illness.
- The spread of the epidemic in Senegal.
- The characteristics of the port environment that favor the spread of the illness.
- The impact HIV/AIDS will have on the company's operations and the health of its workforce (e.g., increased absenteeism and lowered productivity).
- The costs of the illness (in overtime, replacements, costs of treatment).
- The benefits to the company from education and prevention when compared to costs of treating an infected employee.

Company Policy

PAD's health/medical policies are not unique to the company, but conform to Senegal's Work Code, Social Security Code, Health Code, and Decree No. 1329, which require medical examinations for all potential hires. HIV screening is not included in this exam, and HIV tests are only given to put together the medical file of an employee who leaves for training abroad.

The doctor maintains a file where all medical information is kept confidential. Management can, nevertheless, be given this information in order to make a decision concerning medical expenses incurred for a patient or to justify actions taken by the company physician.

If an employee were to be diagnosed with HIV/AIDS, employment and benefits would be maintained as long as the employee was able to fulfill his functions and any risks of transmission were controlled.

Plans for the Future

The company doctor foresees establishing an HIV/AIDS prevention

program in the near future, including training, education to change attitudes, and counseling to provide care for employees who are sick. He is thinking of doing this with outside help on technical, financial, and training matters.

How this effort would be perceived within the company and how much it would cost are the critical unanswered questions that must be considered by the company doctor. The managing director, the labor unions, and the director of human resources will also be involved in the decision to establish a prevention education program. The doctor also plans to send the head nurse to the Institut Pasteur in Dakar for an internship.

If management becomes convinced that the epidemic poses a significant risk, it is likely that the company would be willing to pay for all aspects of a program, including financing materials and services for prevention and training personnel, with possible technical assistance from local organizations.

There also is an opportunity to coordinate PAD's future program with other organizations. For example:

- The association to which middle managers of the company belong, the association of women, and the religious associations could relay prevention messages and take charge of the awareness campaign.

- Other companies working in the same sector, such as Dakar Marine, fishing companies, and ship handlers, have doctors with whom prevention activities could be coordinated.

- The sanitation control service of the port of Dakar could help to better understand and avoid the spread of the epidemic in the port zone.

Such coordination could both promote the effectiveness and efficiency of the programs and reduce administrative costs to each organization.

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AFRICA BEVERAGE CO., SOUTHERN AFRICA[15]

Company Background

"Africa Beverage Company" (ABC) is a joint public- and private-sector brewery and soft drink venture based in southern Africa. Production and warehouse facilities are located in one of the country's major cities, and stock depots are situated throughout the country. ABC employs approximately 800 people, the majority of whom are male. Roughly 500 employees are based at the central production and warehouse facilities. Significant investments have been made in employee training and development because specialized skills are required for brewery operations.

Private medical insurance is available for all employees who wish to subscribe to the group policy. HIV testing and screening are not of interest to ABC's management, and HIV status does not affect an employee's position. For all employees, ABC pays 50 percent of the subscription fee, and the insurance company reimburses the employee 90 percent of all medical and prescription costs incurred. When an employee reaches retirement, ABC pays 100 percent of the medical insurance subscription fee.

Upon hire, employees are automatically enrolled in the company's group life and accident insurance plan. ABC also provides certain funeral benefits to employees, covering the cost of transportation, the casket, and food for the funeral. While many employees live in major urban areas, they often consider their actual home to be the village from which they come. Thus all types of ceremonies, including funerals, often require long-distance travel. To date, most funerals are scheduled on the weekend so that people do not lose time from their jobs because of travel. As such, ABC has not experienced significant employee absenteeism due to funerals, although it is widely accepted that the increasing rate of deaths due to AIDS in the coming years will have a major impact on the leave taken due to funerals.

Key Points:

- Management considers HIV/AIDS prevention education essential, given the level of HIV prevalence in the country and the difficulty of replacing trained employees.
- Though ABC provides extensive medical, life, and accident insurance benefits for its employees, management is committed to *not* screening employees for HIV, believing it would undermine morale, cost too much, and fail as an indicator of employee productivity.
- ABC was one of the first companies in the country to establish a prevention program. While it received initial government assistance to establish the program, the company finds that prevention is worth the investment in staff and resources.

The Impact of HIV/AIDS

To date, the company reports little noticeable financial impact as a result of HIV/AIDS. Employee turnover at ABC is very low

(3 percent annually) and remains so, even with the onset of the HIV/AIDS epidemic. There appears to be no significant increase so far in the frequency or duration of absenteeism, which might affect production. The large size of the organization and the fact that its workforce is dispersed have reduced the visible impact of the disease.

However, HIV/AIDS does exist at ABC, and it has affected employees. Management knows that the effects on the company will not remain invisible for much longer. Assuming current HIV prevalence rates in the country prevail at ABC, between 150 and 300 employees may be infected. As the number of employees who die without an official cause of death rises, it is increasingly suspected that AIDS is the cause.

There is a great deal of interaction among ABC employees in the workplace and within the community. Employees often socialize with each other, helping to create an atmosphere at ABC of openness and communication. People know about and are involved in each other's personal lives. The training manager believes that this level of interaction contributes to the creation of a more cohesive work environment, which may help people within the organization become more tolerant and supportive of coworkers living with HIV/AIDS. Management hopes that the company's HIV/AIDS program will promote this kind of reaction and maintain a positive work environment and productivity.

Company Response

ABC has always been very active in the area of occupational health and safety. When the Ministry of Health established an HIV/AIDS prevention program, ABC was one of the first companies to participate, acting as a pilot organization in which to test the new program. Senior management is supportive of the HIV/AIDS program and wants to be kept abreast of all developments concerning the program.

Formal training sessions and informal peer education take place primarily during afternoon tea breaks. This is not because management refuses to allow employees to use company time for HIV/AIDS training, but rather because employees are released from the production floor during tea breaks without creating a major disruption in production operations. Since afternoon tea break is an established time at which employees come off the production floor, it is a good time to conduct training sessions.

The training sessions include prevention of HIV/AIDS and STDs as well as instruction on condom use. Workplace safety issues are included in discussions to teach workers how to handle workplace accidents and to dispel fears about HIV transmission during such incidents. All information is presented in the local language. Workers have responded well to the peer educators, speaking openly about their experiences and practices as well as what they think might be symptoms

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of an STD. They speak about seeing the doctor for STD treatment and are very open about asking for condoms from the peer educators. The men appear to have no problem asking female peer educators for condoms.

Lessons Learned and Plans for the Future

Management reports that the AIDS program costs virtually nothing. Should the training manager choose to purchase any additional materials, such as videos, or other AIDS training packages, the costs are considered insignificant.

In the future, the training manager plans to include an HIV/AIDS component at the end of every type of training course provided by the company. To increase employee comfort with formal education sessions, the training manager has decided to hire an external trainer to conduct these sessions. There are also plans to develop afternoon video sessions so that when production workers have completed work, they can request that various HIV/AIDS training videos be shown to them in small groups.

ABC strongly believes that all companies in the country should develop HIV/AIDS prevention programs. People spend a large portion of their time at the workplace making it a potentially effective venue for AIDS education. It is expensive to recruit new employees—especially in skilled industries like ABC—and many companies have large employee training budgets. As ABC has learned, it is very costly to replace people, and organizations in Africa cannot afford to lose the skilled manpower they possess.

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COMMUNICATION TECHNOLOGIES INC., WESTERN AFRICA[16]

Company Background

"Communication Technologies Incorporated" (CTI) is a national telecommunications company with capital of 50 billion CFA (US$93 million)[17] and annual earnings of about 35 billion CFA (US$65 million). CTI currently is the largest provider of telephone, telex, telegraph, and fax services in this western African country. CTI's installations are modern and efficient, and its personnel well trained, thus enabling the company to offer reliable and competitively priced telecommunications services. It is one of the leaders in the region in this field, and the expertise of its engineers and technicians is unquestionable.

CTI's 1,851 employees (including 324 women) work throughout the country. The investment by CTI in human resources is reflected in its training plan and benefits package. The training plan is designed to meet the anticipated in-service training needs of workers, so that they are prepared for the rapidly evolving technologies they encounter as part of the company's development program. The training budget for 1994 is 300 million CFA (US$555,500), more than 3 percent of the company's salary costs. This amount is judged insufficient by management, and the company hopes to increase it to 5 percent of salary costs.

CTI offers two major types of training: short courses offered either in-house or outside to meet specific needs that arise, and long-term training at foreign telecommunications schools. During long-term training, the company pays for transportation, training costs, and the employee's normal salary, plus 400,000 CFA (US$740) a month for living expenses.

CTI currently has a relatively small center that hosts training and seminars. The company plans to build a large training center in association with a government-sponsored "technopole" (a complex for innovative technology design and applied research to increase productivity and promote development).

Social Policies and Practices

The personnel and employment policies of CTI are largely determined by the country's social legislation that requires the employer's

Key Points:

- This company is a high-technology, service-oriented firm with some of the most extenive labor benefits and policies in the region. Comprehensive medical services are provided, including family planning services, preventive health, free condom distribution, and STD services.
- CTI has a large investment in staff, including a 163,000 CFA (US$300) per worker annual investment in training.
- Though the company does not yet have an HIV/AIDS prevention program, the director of human resources is planning one.

participation in a retirement plan, private health plan, disability coverage, contribution towards funeral costs, nondiscrimination between men and women on the job, and the practice of job reassignment in the case of incapacity.

CTI has put in place some of the country's most extensive social policies and training and health programs. These policies and programs have been designed and are implemented with the participation of personnel representatives and are written into the company agreements.

Health policies have an important place in the social framework of the company, as do housing policies. Health coverage for all employees is provided by the company's private health plan, which was put in place with input from the labor unions and in accord with the company agreements. The company contributes 6,000 CFA (US$11) per month per employee, and employees contribute 6,000 CFA if they are part of management or 4,000 CFA (US$7.50) if they are not.

Health care is provided in the various health facilities run by CTI's Department of Work-related Medicine, or in outside clinics/hospitals or by private physicians chosen by the employee. These physicians and establishments are recognized and covered by the company's health insurance. CTI's health insurance covers more costs than are mandated by law. Consultation expenses are reimbursed at a rate of 100 percent for employees and 70 percent for their family members. Drug costs are covered at a rate of 70 percent for everyone.

In the other areas of its social policy, CTI offers a wide range of benefits to its employees, including financial assistance for housing purchases, car loans, and school fees and supplies.

Company Health Services

Medical services are provided by CTI's Department of Work-related Medicine. Beneficiaries include employees, members of their families, and residents of the surrounding areas introduced to the service by an employee.

To carry out its functions, the Department of Work-related Medicine runs several clinics. These centers are completely functional and well equipped. They are staffed by approximately 15 people, including five physicians, a midwife, four nurses, and several other medical aides.

The annual budget for medical services is more than 61 million CFA (US$112,963), including medicines, staff, and equipment. Services and medication are provided to employees free of charge.

The activities of the Department of Work-related Medicine are divided into two components, general medicine and work-related medicine. Along with these activities, the service also runs a family health program, started in 1990 and financed in part by the company and in part by a local NGO. Among other things, this program offers

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free distribution of condoms and STD diagnosis and treatment upon request and during annual physicals and other medical consultations. Several outside organizations provide audiovisual materials, equipment, medicines, condoms, birth control pills, IUDs, and in-service training for the physicians, midwife, and family planning counselors.

The Impact of HIV/AIDS

The company does not currently have an HIV/AIDS prevention education program, but the head physician plans to start one because cases are beginning to appear at the company. The company has no estimate of the number of employees who have HIV or AIDS, though management knows of at least two employees living with HIV. Based on national estimates of HIV prevalence, CTI probably has between 18 and 37 HIV-positive employees. CTI has an extensive investment in staff in terms of medical and other benefits, let alone its training investment of approximately 163,000 CFA (US$300) per employee annually. Thus, the company can ill afford human resource losses from HIV/AIDS or any other debilitating disease.

In addition to the direct financial impact that HIV/AIDS may eventually have on the company, there are other more immediate impacts that can also undermine productivity. Recently an employee died from tuberculosis, which led to an indignant outcry among coworkers afraid of infection. Experience elsewhere suggests that unless workers are educated about the methods of HIV transmission, similar and even more disruptive labor relations breakdowns can result if workers fear infection from coworkers who are, or are believed to be, HIV-positive. Management is aware of this danger but has yet to take action to raise awareness about HIV/AIDS.

Observations

According to the director of human resources, the question of HIV/AIDS can no longer be avoided, considering the potential impact on the company's productivity and profitability. To increase management's awareness, information about the specific risks for the company is necessary.

The director believes that implementing a prevention program would be beneficial and that an important part of the program should deal with employee attitudes toward the epidemic and toward colleagues who are infected with HIV. The planned approach is to first publish an article in the company newspaper in order to raise awareness. Next, a questionnaire about HIV/AIDS and family planning will be prepared to determine the degree of employee interest in the topic. Then, work will begin with the Health and Safety Committee to train people from the different workshops to serve as health agents and to organize information, education, and communication (IEC) sessions.

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The medical team is also aware that it is not alone in its efforts, and assistance is available to help them move ahead. Local NGOs and government agencies, like the National AIDS Control Program, will be able to provide CTI with the technical assistance it needs to develop an effective HIV/AIDS prevention program.

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SUGAR INDUSTRIES INC., WESTERN AFRICA[18]

Company Background

"Sugar Industries Inc." (SII) is an agriculture-based company with capital of 13.6 billion CFA (US$ 25.2 million).[19] The majority of SII (87 percent) is owned by an African- and European-based conglomerate. This conglomerate is one of the country's largest employers and is very active in other business sectors. SII owns and operates a sugar processing plant with a capacity of 500 tons of sugar a day. Each year, more than 800,000 tons of sugar cane are harvested and processed to produce 83,000 tons of sugar to be sold on the local market. The company has approximately 4,000 permanent employees (including 70 women) and 2,500 seasonal workers.

The personnel, employment, health, and social policies of SII are largely determined by the country's existing labor laws. These laws mandate the employer's participation in a retirement plan, a private health plan, disability coverage, payment of funeral costs, nondiscrimination between men and women on the job, and the practice of job reassignment in the case of incapacity.

In the past, SII distributed considerable funds for social services for employees and the community in a haphazard manner. Today, the company is attempting to formalize its management of social service funds.

Department heads are housed by the company in its housing estate. All employees benefit from access to subsidized staple goods available from the company's cooperative.

Health is the largest component covered today by SII's social policies. Health care is provided at the company's clinic or at other health facilities such as the regional hospital. Employee health care costs are covered by the company's private health plan.

SII is currently restructuring its operations. A training department was created one year ago, and a social services department has just been created that will be joined with the existing medical service in two years.

Company Health Services

Medical services are dispensed in SII's two

Key Points:

- A family health program was introduced in 1989 and includes socially marketed condom distribution, STD treatment, and information and education about STDs.
- Since the program's inception, STDs have dropped from being the most common to being the third most common illness treated at the clinic. This has yielded a significant corporate financial benefit through declining absenteeism.
- The medical staff believes that integrating HIV prevention activities into the existing family health program would be greatly beneficial and is planning to do so. HIV is present in the organization, yet employees have little understanding of its risks or means of transmission. Already, miscommunication about AIDS has led to heightened labor tensions in the organization.

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clinic buildings (one is for curative care and the other for all work-related medical activities). The beneficiaries of the company's medical services include all employees and their families, retired employees and their families, and persons from the area who have been brought to the clinic by an employee. These outside patients are more and more numerous because they receive better treatment and follow-up at the SII clinic than in the government health posts. A total of approximately 50,000 people benefit from the medical services offered by the company.

The clinic provides an average of 180 consultations per day, and if necessary, can keep patients under observation for 48 to 72 hours before sending them to the regional hospital, 100 kilometers away. Physicians at the hospital are in close touch with SII's clinic staff and come every Thursday to consult.

The company covers 60 percent of hospital and medication costs for its employees. The remaining 40 percent can be financed by the company, with employees reimbursing SII through paycheck deductions over a period of months.

The physicians make periodic rounds through the different sections of the company to determine health risks and to check that health and safety measures are being applied. Employees are satisfied with the medical services offered, as are the usually vocal labor unions, which have voiced no criticism about this aspect of the company's operations.

Since 1989, SII has offered a family health program funded, in part, by the company itself and, in part, by a local nongovernmental organization (NGO). As part of this program, the medical staff at the clinic provides:

- Condoms, which are sold for 100 CFA (US$0.19) per ten. Each person's purchase is limited to ten condoms per week to avoid resale. When condoms were distributed free of charge, there was less of a demand than when they are sold now.

- Diagnosis and treatment of STDs.

- Information, education, and communication (IEC) activities about STDs.

The occurrence of STDs is high among single workers and workers living far from their families. Most of those with STDs come in for treatment two to three weeks after being paid on the eighth of the month. STDs are the third most common type of illness treated at the clinic after lumbago (a work-related affliction) and parasitic diseases. In 1987, gonorrhea was the most commonly treated illness. Its decline can be attributed to increased condom use by residents in the area.

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The clinic does not yet offer much prevention training because only recently have two staff members been trained by the NGO. More efforts are needed to get the prevention messages across.

The Impact of HIV/AIDS

The head physician perceives that HIV/AIDS is already a problem for the company: "I feel that it is here." Many SII employees live far from their spouses and are sexually active with multiple partners. The risks of the spread of HIV are great given an environment that offers many possibilities for its spread:

- Salaried employees start spending their money when paid on the eighth of every month and attract prostitutes from all over the country.

- Every year thousands of migrant workers come to work temporarily for six months and then leave. Migrant workers tend to be at greater risk of engaging in risk behavior. Moreover, the company does not keep track of temporary employees after the cutting season, and hence, they are not targeted for ongoing prevention or care and support services if they are HIV-positive.

Three cases of seropositivity have been recorded, all of which involved temporary workers who were no longer in contact with the medical service. One of the company physicians believes the HIV/AIDS situation at SII is serious and that "there are many workers already infected, even if we don't have the means to make a precise measurement or the possibility of conducting such an investigation."

AIDS remains a sensitive issue. For World AIDS Day, the national television network produced a report about STDs and AIDS that included interviews with SII workers. When they watched the report, the interviewed workers erroneously believed that they were themselves infected by the HIV virus. Understandably, this created serious confusion and, ultimately, led to a loud outcry by the labor unions.

Plans for the Future

As of 1994, SII had no prevention education program. The head physician feels that the company can best respond to the epidemic by promoting prevention through the distribution of condoms, educational activities such as showing videos in the clinic waiting room, and other awareness-raising activities being planned by the newly created health and safety committee.

Prevention measures have already been taken against other STDs and bilharzia. Thanks to the measures taken, high levels of costly absenteeism have been reduced to an acceptable level. Because of this

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past experience with corporate prevention initiatives, establishing an HIV/AIDS program is a matter of demonstrating to management that the disease represents a similarly significant threat to the company. This should be possible through the concerted efforts of the company's medical staff and the growing profile of HIV/AIDS prevention efforts on the part of the government, media, and other influential actors.

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WEST AFRICAN RAILWAYS INTERNATIONAL[20]

Company Background

"West African Railways International" (WARI) is this country's primary provider of passenger and freight rail services. The company's revenues in 1992 equaled 11 billion CFA (US$20.5 million),[21] while expenses totaled 12.8 billion CFA (US$24 million). Like other large companies in the country, financial difficulties have led to a freeze in investments and a reduction in the payroll. Today, WARI employs 1,450 persons, of whom 52 are women. An average of 78 employees leave the company each year through death or retirement. The company currently is not recruiting any new employees, and vacated positions are filled through internal promotions or transfers.

Training policies have always sought to improve the technical capacities of personnel. In-service training is offered at the company's training centers, and specialized professional training has been offered abroad. Wide-scale internal promotion has also enhanced the technical abilities of the staff. This high level of preparedness is paying off, since rail services are maintained by a staff significantly reduced from prior years.

Health Services and Benefits

Despite the fact that the company has had to reduce the social benefits offered to its employees (see below), the current managing director, like his predecessor, is very concerned about the lives and well-being of employees and their families.

The largest component of the company's social services is the medical services offered free of charge to all current and retired employees and their families (approximately 13,050 people). Besides free treatment at the company's clinic, the company pays for all outside medical consultations with specialists and for two-thirds of all hospitalization costs (the remaining third is paid by the employee). In addition, management level personnel with long-term illnesses receive their full salaries for a one-year period.

To ensure primary health care, WARI provides its employees with a large medical clinic (including a maternal and child care center), two infirmaries, and a national network of physicians and nurses who receive an indemnity for treating railway workers to ensure that rail traffic is not hindered. The medical service manages all

Key Points:

- WARI employs a highly skilled migrant workforce that is at relatively high risk for HIV transmission. Previous experience with its family health program suggests that an HIV/AIDS prevention program would be cost-effective and well received by staff.
- Should WARI overcome its immediate financial crisis, its management is likely to move quickly to establish a workplace program.

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health-related activities and is directed by the head physician, a woman who has served the company full-time since 1967 and who has an excellent knowledge of most of the railway employees and their families.

The service's annual budget is 9.9 million CFA (US$18,333) for the purchase of medicines, first aid supplies, and laboratory products. However, the financial crisis hitting WARI has meant that the company no longer has the funds to actually finance the medical service.

The center receives an average of 50 to 60 clients per day during the dry season, and between 120 and 150 during the four-month rainy season. In 1993, 29,754 consultations were carried out for employees, retirees, and their family members. The cost of medical services was 94 million CFA (US$174,074), including 60 million CFA (US$111,000) for hospitalization and 9.9 million CFA (US$18,333) for medicine.

Current activities at the medical/social center include:

- Primary health care;
- Vaccinations;
- Maternal and child health care; and
- The four components of the family health program: family planning, diagnosis and treatment of STDs, treatment of sterility, and family life education.

Many companies in the private sector have a tradition of providing death benefits to the families of deceased employees. WARI follows this tradition, offering 50,000 CFA (US$92.60) to these families and to retired personnel. In 1992, approximately 50 families benefited from this payment.

Paid leave is offered to employees who wish to attend funerals. During a 12-month period between 1993–94, a total of 108 days off were granted to employees to attend funerals.

Employees who are no longer able to carry out their normal job functions are transferred to less demanding posts whenever possible. This practice reflects national law as well as the organization's policy of employment maintenance. All employees are covered by a retirement plan once they are no longer able to work.

History of Family Health Program

For a long time, medical services have included ad hoc small-scale family planning advice provided by the physician or midwife. This has been offered either in response to the request of railway agents or their spouses, or when a serious medical problem made such family planning counseling necessary. But these services only touched a small fraction of company employees.

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Prior to 1987, there were 4,627 railway agents, 11,568 women of child-bearing age, and 37,016 children under the care of the medical services. The economic effects of the company's high birth rate were significant, particularly the absenteeism of female employees due to frequent maternity leave, pregnancy-related hospitalization, and appointments with medical specialists.

In 1987, WARI's senior management was convinced by an United States Agency for International Development (USAID)-funded nongovernmental organization (NGO) to undertake a family health project. The program promised to reduce medical/social expenditures through family planning. Two years of funding was provided by the NGO, after which the company paid for the program from the reduced expenditures for maternity-related expenses. The company has been very satisfied with the program.

The Impact of HIV/AIDS

The medical service has identified two HIV-positive persons, including one technician who died from AIDS. The head physician considers the HIV/AIDS epidemic to be a concern for the company and realizes that there is a serious need for prevention and education activities, even if the possibilities for such programs are limited because of the current financial crisis.

In fact, railway staff are particularly at risk for two reasons: the high HIV prevalence in locations to which they travel, and frequent absence from home for up to a week at a time and risk of exposure to HIV if they have unprotected sexual encounters with occasional partners.

Company Response

WARI does not have a formal HIV/AIDS prevention program. However, the medical services provided to employees contributes to the prevention of the disease. These include:

- "Open house" meetings about HIV/AIDS and its prevention;
- Promoting STD services for employees and their spouses;
- Free distribution of condoms;
- Voluntary and confidential tests for HIV (between 50 and 100 persons have already been tested).

Plans for the Future

It is difficult to predict the possibility of implementing an HIV/AIDS prevention education program at WARI in the near future. Though the medical service is aware of the threat, the managing director and

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personnel manager desire more information and statistics about the gravity of the epidemic. There is also the immediate problem of a lack of financial resources to support a prevention program. On the other hand, management had a very positive experience with the family health project and would likely support a complementary HIV/AIDS prevention project once funds are available. Not only would the program benefit a valuable and relatively highly trained work force that is at high risk, but it would also have a positive impact on the surrounding community.

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DAVID WHITEHEAD TEXTILES, ZIMBABWE[22]

Company Background

David Whitehead Textiles—a subsidiary of the Lonrho conglomerate—employs nearly 4,500 people at its three factories in the towns of Kadoma (2,544 employees), Chegutu (1,764 employees), and Gweru (175 employees) in Zimbabwe. More than 90 percent of the company's employees are male. Most of the men live in town with their wives and families, although some couples are separated for long intervals when wives return to their villages to cultivate the fields. A health clinic at each factory provides free health care to company employees.

The Impact of HIV/AIDS

David Whitehead Textiles has seen its share of deaths from AIDS. Since the end of 1989, the company's Kadoma factory has posted the number of AIDS deaths each month on notice boards outside the factory clinic and canteen. By the end of 1994, the company clinic had recorded 131 AIDS deaths among the workforce at Kadoma, and the death rate was increasing every year.

In the 1990s, the level of AIDS awareness has grown among David Whitehead's workforce, largely because of management's strong commitment to AIDS prevention over the past few years and employees' active involvement in AIDS education activities.

Company Response

David Whitehead Textiles has been at the forefront of industry's response to the AIDS epidemic in Zimbabwe since 1989, when the company launched its AIDS Awareness Campaign. Company management first realized the need for an AIDS prevention program and policy in 1988, when the Blood Transfusion Service discovered that 21 percent of blood donors at the company's factories in Kadoma and Chegutu were HIV-positive. In response to this disturbing news, the company's public relations manager and the company doctor—with strong support from the chief executive officer—initiated an AIDS Awareness Campaign targeting employees, their dependents, and the surrounding communities. These were the company's objectives:

Key Points:

- HIV/AIDS awareness has grown substantiallly at the company since management made a strong commitment to prevention activities.
- The company has collaborated closely with international, national, and local organizations to establish an effective program that uses a diverse range of interventions.
- The program costs have been modest, and management considers them to be a worthwhile investment. For example, STD cases have dropped 75 percent since the introduction of the AIDS Awareness Campaign.

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- To establish an understanding of HIV/AIDS among the entire population of David Whitehead Textiles to ensure that all employees understand that AIDS is a threat to their own lives and what actions can be taken to avoid HIV infection.

- To maintain stability within the workforce so that such costs as training, medical, and funeral expenses are kept to a minimum.

- To show the workforce (and Zimbabwe as a whole) that the company cares.

- To determine the present situation within the company, and to develop strategies for awareness by all employees, for treatment of people with HIV/AIDS, and for ongoing back-up services.

- To provide medical and counseling services to people with HIV and AIDS within the workforce.

- To publicize the campaign nationwide so that other companies would follow suit.

In designing its HIV/AIDS education program, the company sought guidance and assistance from such outside organizations as the Zimbabwe Ministry of Health, the National AIDS Coordination Programme, the World Health Organization, and local AIDS service organizations. It was decided that the campaign would use a number of communication channels, including drama, printed information materials, and group discussions, as well as interpersonal communication to reach its target audiences effectively.

The company doctor and Ministry of Health staff provided training about HIV and other sexually transmitted diseases (STDs) to all 64 Health and Safety representatives from the three Whitehead factories. Six years later, the trained representatives continue to serve as AIDS information officers, answering questions, and providing life-saving information and advice to groups and individuals at work.

A local theater group performed a play about AIDS in Shona, the major local language. The company also developed a comic book entitled, *AIDS: Toward a Greater Understanding*, in collaboration with the National AIDS Coordination Programme. Twenty thousand copies were published in Shona, Ndebele, and English.

The high profile campaign launch took place in November 1989, with meetings held in factory canteens, theaters, nightclubs, and school halls. The meetings, attended by David Whitehead employees, their families, and people from the local communities featured an explanation of the campaign, a presentation by the company doctor on basic facts

about HIV/AIDS, and a performance of the play, "Me and My AIDS," followed by questions from the audience. Members of the audience received copies of the comic book and were advised that the company would provide free condoms to its employees.

After the campaign launch, workers could turn to the AIDS information officers at the work site to answer their questions. Some AIDS information officers also went to bars and beer halls after working hours to talk about AIDS with sex workers and their clients and to promote condom use.

Employees at the Kadoma factory even wrote their own play about AIDS for World AIDS Day in 1991. Since then, the group has performed the play at an Army barracks, an Air Force base, commercial farms, community halls, in the city square, at football matches, and for many other companies, and continues to perform as needed.

The company set up condom dispensing machines in all three of its factories in 1989 and incurs the cost of supplying condoms free to its employees. At the Chegutu factory, an average of 1,776 condoms were distributed from the clinic, the Health and Safety Officer's Office, and the canteen each month in 1992.

Costs and Benefits

The company is very encouraged by the mounting evidence of sexual behavior change among its workforce members since initiating the AIDS Awareness Campaign. The number of STD cases treated at company clinics has dropped significantly since the start of the campaign. At the Kadoma factory clinic, for example, the number of patients treated for STDs fell by 72 percent, from 959 in 1989 to 261 in 1994. The decrease in the number of STD cases treated was even more dramatic at the Chegutu factory clinic: from 1,628 cases in 1989 to 273 in 1994, a decrease of 83 percent.

The tremendous increase in the number of condoms distributed to employees also points to sexual behavior change. Before the program began in 1989, no condoms were distributed. In 1992, 15,324 condoms were distributed at the Kadoma factory and 21,312 at the Chegutu factory. While no surveys have been conducted among the workforce, it seems that many employees, particularly married men, are now choosing monogamy over having several sexual partners as before. The benefits of the campaign are clear. Company employees and their partners can now make an informed choice about avoiding HIV and other STDs.

The costs to the company of running an AIDS prevention program have included the costs of publishing the comic book (Z$12,400 or US$2,435),[23] performing the play 21 times (Z$5,250 or US$1,030), and supplying condoms (while no estimates were provided, the cost probably did not exceed Z$17,850 or US$3,500).[24] The costs of medical

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treatment of AIDS patients cannot be specified, as the figure is included within the overall health budget of the company.

Company Policy

The company maintains a policy of not screening job applicants or existing employees for HIV. Procedures have been established, however, for employees to be referred to government hospitals for HIV tests on purely clinical grounds, with their informed consent. All nursing and medical staff at the company clinics have been trained in pre- and post-test counseling techniques. The company doctor treats the results of all these tests as confidential.

Lessons Learned

The experience of David Whitehead Textiles demonstrates the importance of a strong and ongoing commitment of both time and financial resources to an HIV/AIDS prevention program on the part of management. The active involvement of employees in educational activities was also critical to the program's success. The company also found that calling attention to the number of AIDS deaths within its own workforce helped convince employees to take AIDS more seriously.

EASTERN HIGHLANDS PLANTATIONS, ZIMBABWE[25]

Company Background

Situated in Manicaland Province bordering Mozambique, Eastern Highlands Plantations Limited (EHPL) is a large tea, coffee, and timber producer. EHPL employs between 2,500 and 3,000 men and women, 60 percent of whom are contract or seasonal workers. The estate includes 14 village communities with a population totaling 7,000.

Though many might consider most of the workers to be low-skilled and easily replaced because of their relatively low wages, Eastern Highlands' personnel manager doesn't think so. According to Webster Zizhou,

> People think tea-plucking is an unskilled job...but I disagree. I think it's a highly skilled job. It's easier to hire a trained motor mechanic than a good tea-plucker. The work is also very labor-intensive, and AIDS will have an impact on our labor supply. Turnover among tea-pluckers is already quite high.

The company is responsible for the welfare of these workers and their families. In addition to providing free health care, EHPL operates four primary schools with a total enrollment of more than 800 pupils, a baby care center for children up to three years old, and a preschool for children between the ages of three and five.

The Impact of HIV/AIDS

As the personnel manager notes, HIV/AIDS is taking its toll on the company. As of 1992, the national HIV prevalence rate of Zimbabwe was estimated to be at least 15 percent. Though the company does not test for HIV, the clinic's medical staff offer counseling for those with HIV/AIDS. Between 1988 and 1993, more than 200 people within the estate community were known to have HIV/AIDS.

Company Response

Recognizing the rapidly growing impact of the disease, the company launched its HIV/AIDS prevention program in September 1991. The clinic staff trained 48 supervisors, foremen, and other influential members of the workforce as

Key Points:

- Even low-waged workers are highly skilled and hard to replace.
- An innovative range of HIV/AIDS prevention activities are offered, including courses for new workers, peer education sessions at work sites, and campfire sessions after work.
- EHPL's prevention efforts have reduced STD rates by 50 percent.

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AIDS educators. These peer educators have subsequently served important roles in raising awareness of AIDS and encouraging behavior change among the workforce. The company nurses regularly conduct education sessions on AIDS and other STDs with groups of employees, at the clinic, and in the village on the estate. HIV/AIDS education is now also included in the two-day orientation course for new employees and during worker education days held throughout the year.

The company's industrial relations officer and community leaders also launched an education program called "campfire counseling." These meetings are regularly held around campfires and give married and unmarried couples the opportunity to talk about social and family problems and health issues, including HIV/AIDS.

Condoms are distributed free of charge at company offices, beer halls, and clinics. Demand for condoms has increased rapidly, with an average of 3,600 condoms distributed each month in 1992. Unfortunately, condom distribution has fluctuated and declined as a result of difficulties in obtaining condoms from the National Family Planning Council. In the future, EHPL may need to consider procuring condoms from other sources, even if it means that the company must pay for them.

There is no cure for HIV or AIDS, and once someone is infected with HIV, they will inevitably contract AIDS. Many of the workers and their partners contracted HIV before the program began, and it will be several years before the community's HIV prevalence rates decline.

However, STD rates respond more quickly to changes in risk behavior, and these have changed dramatically since the introduction of the program in September, 1991. In the second half of 1991, there had been 214 cases of STDs treated. The number of cases then declined to 146 cases in the second half of 1992, and there were only 100 cases as of June, 1993 (the latest period for which there is information). These changes in the STD rates indicate the effectiveness of the prevention program introduced by the company. With this performance record, the company is pleased with its decision to establish an HIV/AIDS program and plans to continue it indefinitely.

RIO TINTO ZIMBABWE[26]

Company Background

Rio Tinto Zimbabwe is a mining company employing 2,600 people at six locations around Zimbabwe. Four of these locations are involved in mining/refining and one in engineering, and the sixth is the head office in Harare. With the exception of the Harare-based staff, almost all of the company's employees live in mine townships where housing is provided by the company for its employees and their families. The company operates health clinics at its Renco, Eiffel Flats, Patchway, and Brompton sites.

The Impact of HIV/AIDS

Like other mining companies in Africa, the productivity of Rio Tinto Zimbabwe operations is threatened by AIDS. The number of HIV-related deaths is slowly increasing, but is not yet at a crisis level, according to the company's group personnel and training manager. From 1990 to 1992, a total of 234 Rio Tinto employees, their spouses, and other family members from three sites near Kadoma tested HIV-positive: about 2 percent of the total population. In the same period, there were also 14 known AIDS deaths of employees, of whom all but one died in service rather than take illness retirement. The personnel manager estimates that there are about two HIV-related employee deaths per month, or about 1 percent annually, and that they "haven't seen the worst yet." In addition to new infections, there are probably many asymptomatic people who were infected before the launching of the prevention campaign.

The company's chairman wrote in the 1993 annual report:

> It is again my sad duty to report that 30 employees died in service during the year. This is similar to the number reported for the past three years. Regrettably, AIDS-related infections are increasingly evident as a cause of death.

Company Response

Rio Tinto launched an HIV/AIDS prevention program in its mining operations in 1990. The program—now dormant—ran successfully for

Key Points:

- Initiation of an intensive HIV/AIDS prevention campaign among workers and the surrounding community increased condom distribution tenfold in less than three years.
- With increased condom use and general prevention awareness, STD cases dropped between 47 and 78 percent in the same time frame, greatly reducing the costs of STD drugs and absenteeism to the company.
- Even the most successful program must continue to evolve and be innovative to remain vibrant. This program gradually faded out because of repetitive prevention activities. A new program will be planned.

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three years. The company hired a Harare-based agency to train volunteers at each of its sites in basic AIDS awareness and health promotion skills to prepare them to design and run a variety of AIDS awareness activities among workers and their families. The trainers, two nurses, held three-day workshops for six volunteers at each site and returned nine months later for a follow-up visit to offer further assistance. The volunteers were required to be bilingual and respected members of the community.

The trained volunteers formed AIDS Action Groups to serve as peer educators in the workplace and throughout the community. The groups elected their own leaders; each group included the nurse in charge of the clinic. Through drama, music, poetry, posters, quizzes, discussions, and videos, the AIDS Action Groups communicated two primary messages, depending on the particular target audience: "Stay faithful to one sexual partner" and "Use condoms if you have more than one partner." The groups talked with their coworkers, individually and in groups, in offices, workshops, mines, and the company clinic. The groups also met with the families of mine workers at churches, football matches, women's clubs, and community centers; they talked with men and women at bars, beer halls, and social clubs, popular entertainment centers in the mine townships. Schoolchildren were also part of the prevention effort. AIDS Action Groups visited schools, using plays, songs, and poetry composed by the children to encourage sexually responsible attitudes and behavior.

Condom distribution was an important component of the AIDS Action Groups' activities. While condoms were available from company clinics prior to the creation of the AIDS Action Groups, they were not popular. Only 500 condoms were distributed in 1989 by the three company clinics serving three Rio Tinto sites near Kadoma. With the initiation of the AIDS Action Groups, group members distributed condoms in the workplace and company clinics and ensured that condoms were available free of charge in changing rooms and at bars, beer halls, and social clubs on company premises. In 1992, nearly 56,000 condoms were distributed through company clinics and other outlets in the same three places.

Company Policy

The company does not conduct routine HIV screening of job applicants or testing of its employees for HIV unless requested by the worker, which is rare. Sometimes other medical checks indicate that a worker may be HIV-positive. A worker may be tested for HIV on purely medical grounds, but only after counseling by clinic staff and with his or her informed consent. The clinic staff treats information about sexually transmitted diseases, including HIV infection, as confidential.

HIV-positive workers are permitted to continue working for as long as they are able. A worker with AIDS who is still able to work receives

all the normal medical treatment available either under the voluntary Group Medical Benefit Society or from the mine clinics. When an employee can no longer work, he or she can still receive income under the company's Disability Income Benefit Fund. The fund was introduced more than two years ago to provide income to employees who are disabled through accident or illness. The benefit amounts to 66 percent of basic salary, tax free. Although the fund was not specifically designed for employees with AIDS, it does cover them.

Lessons Learned

Perhaps the most critical lesson the company has learned is that starting the HIV/AIDS awareness program in 1990 was the right thing to do, but that it should have happened even earlier.

The personnel manager has said: "I think we were waiting for a lead from the Ministry of Health, but it never came. Even today the government is not active enough in this field, and so it is up to the private sector to go their own way."

The company successfully ran an HIV/AIDS prevention program for three years at very little cost. Each training course cost the company about Z$3,000 or US$590.[27] Condoms were donated by the United States Agency for International Development (USAID). The members of the AIDS Action Groups were all volunteers. The company provided them with support in terms of supplies, transport, and days off work to carry out prevention activities, though most of their activities were conducted on their own time in the evenings and on weekends.

The company attributes the program's success to two factors: AIDS Action Group workers were volunteers, and each group included the nurse in charge of the clinic, the natural choice for leader.

Apart from submitting a monthly report to the head office, the AIDS Action Groups were mostly autonomous. While management supported their activities, it did not restrict their actions in any way. This gave ownership of the program to the workers themselves. The volunteers in the groups tended to be workers who had the respect of their peers. This proved to be more effective than selecting only those with seniority in the company.

While other companies in Zimbabwe have offered AIDS prevention programs to their workers, Rio Tinto was one of the first to effectively reach out to the workers' families and the wider community. This was possible because the mine townships are self-contained units providing a "captive audience." For a Harare-based company whose workers live in the numerous residential suburbs of Harare, it would not have been as easy to reach the families.

An HIV/AIDS prevention program in the workplace can be successful in informing workers and their families about AIDS and in changing sexual attitudes and behavior. In the case of Rio Tinto, the

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success of the program can be seen in the dramatic decrease in STD cases treated at company clinics between 1990 and 1992 and the significant increase in the number of condoms distributed during that same time period. While the number of employees remained the same, the number of STD cases treated at the four company clinics fell by between 47 and 78 percent from 1990 to 1992. The number of condoms distributed at the four sites increased significantly by an average of 63 percent during that period. Unfortunately, the company has had to stop distributing the condoms in public places (bars, beer halls, social clubs) because in some places, people were abusing this service by taking far more condoms than they actually needed. The condoms are still available on request from the company clinics.

Even the most successful HIV/AIDS prevention effort can run out of steam. Despite the efforts of the AIDS Action Groups to keep devising new, creative ways of communicating the same prevention messages, after three years, the community started getting tired of hearing the same thing, and the program slowly fizzled out. Until they create a new initiative that will spark the interest of the community, the AIDS Action Groups are discontinuing the program. As a stopgap, the company will be holding an AIDS poster competition open to all employees. Cash prizes will be offered to attract as much interest as possible.

As the epidemic evolves, the workers' needs are also changing. Workers infected with HIV before the awareness campaign will soon be developing symptoms. The company recognizes that future efforts will also have to foster acceptance of coworkers with AIDS and of community members living with HIV/AIDS.

Endnotes

1. These and other materials are available from Family Health International/ AIDSCAP, 2101 Wilson Boulevard, Suite 700, Arlington, Virginia U.S.A. 22201; tel: 703/516-9779, fax: 703/516-9781.
2. An exchange rate of 45 U.S. dollars per Botswana pula is used here.
3. Adult AIDS prevalence rate 1.04 percent, 22.5 percent HIV prevalence rate in 1994; 1.05 percent AIDS prevalence rate, 27.2 percent HIV prevalence rate projected for 2005.
4. An exchange rate of 45 U.S. dollars per Botswana pula is used here.
5. An exchange rate of 45 U.S. dollars per Botswana pula is used here.
6. A ficticious name.
7. Because of wide fluctuations in the exchange rate between Kenyan shillings and U.S. dollars during this time period, a standard rate of 50 shillings to the dollar is used here. At this rate, one Kenyan shilling is equivalent to approximately 10.7 CFA.
8. A ficticious company name.
9. Because of wide fluctuations in the exchange rate between Kenyan shillings and U.S. dollars during this time period, a standard rate of 50 shillings to the dollar is used here. At this rate, one Kenyan shilling is equivalent to approximately 10.7 CFA.

10. Because of wide fluctuations in the exchange rate between Kenyan shillings and U.S. dollars during this time period, a standard rate of 50 shillings to the dollar is used here. At this rate, one Kenyan shilling is equivalent to approximately 10.7 CFA.
11. Because of wide fluctuations in the exchange rate between Kenyan shillings and U.S. dollars during this time period, a standard rate of 50 shillings to the dollar is used here. At this rate, one Kenyan shilling is equivalent to approximately 10.7 CFA.
12. In 1994, 540 CFA averaged approximately one U.S. dollar. One CFA thus equaled approximately .00185 U.S. dollar and .093 Kenyan shillings.
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14. In 1994, 540 CFA averaged approximately one U.S. dollar. One CFA thus equaled approximately .00185 U.S. dollar and .093 Kenyan shillings.
15. A fictitious company name. All other information is accurate.
16. A fictitious company name. All other information is accurate.
17. In 1994, 540 CFA averaged approximately one U.S. dollar. One CFA thus equaled approximately .00185 U.S. dollar and .093 Kenyan shillings.
18. A fictitious company name. All other information is accurate.
19. In 1994, 540 CFA averaged approximately one U.S. dollar. One CFA thus equaled approximately .00185 U.S. dollar and .093 Kenyan shillings.
20. A fictitious company name. All other information is accurate.
21. In 1994, 540 CFA averaged approximately one U.S. dollar. One CFA thus equaled approximately .00185 U.S. dollar and .093 Kenyan shillings.
22. This case study is based on a chapter of the book, *Work Against AIDS: Workplace-based AIDS Initiatives in Zimbabwe*, by Glen Williams and Sunanda Ray, published by ACTIONAID, London in 1993. The book is available from TALC, P.O. Box 49, St. Albans AL1 4AX, U.K.
23. In 1992, one Zimbabwe dollar equaled 1963 U.S. dollars, 6.3 Kenyan shillings, 52 CFA, and .092 Botswana pula.
24. Approximately 86,000 condoms were distributed between 1989 and 1992. According to one condom management organization, at this time, condoms probably cost no more than US$.035 each in bulk in Zimbabwe.
25. This case study is based on a chapter of the book, *Work Against AIDS: Workplace-based AIDS Initiatives in Zimbabwe*, by Glen Williams and Sunanda Ray, published by ACTIONAID, London in 1993. The book is available from TALC, P.O. Box 49, St. Albans AL1 4AX, U.K.
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27. In 1992, one Zimbabwe dollar equaled 1963 U.S. dollars, 6.3 Kenyan shillings, 52 CFA, and .092 Botswana pula.

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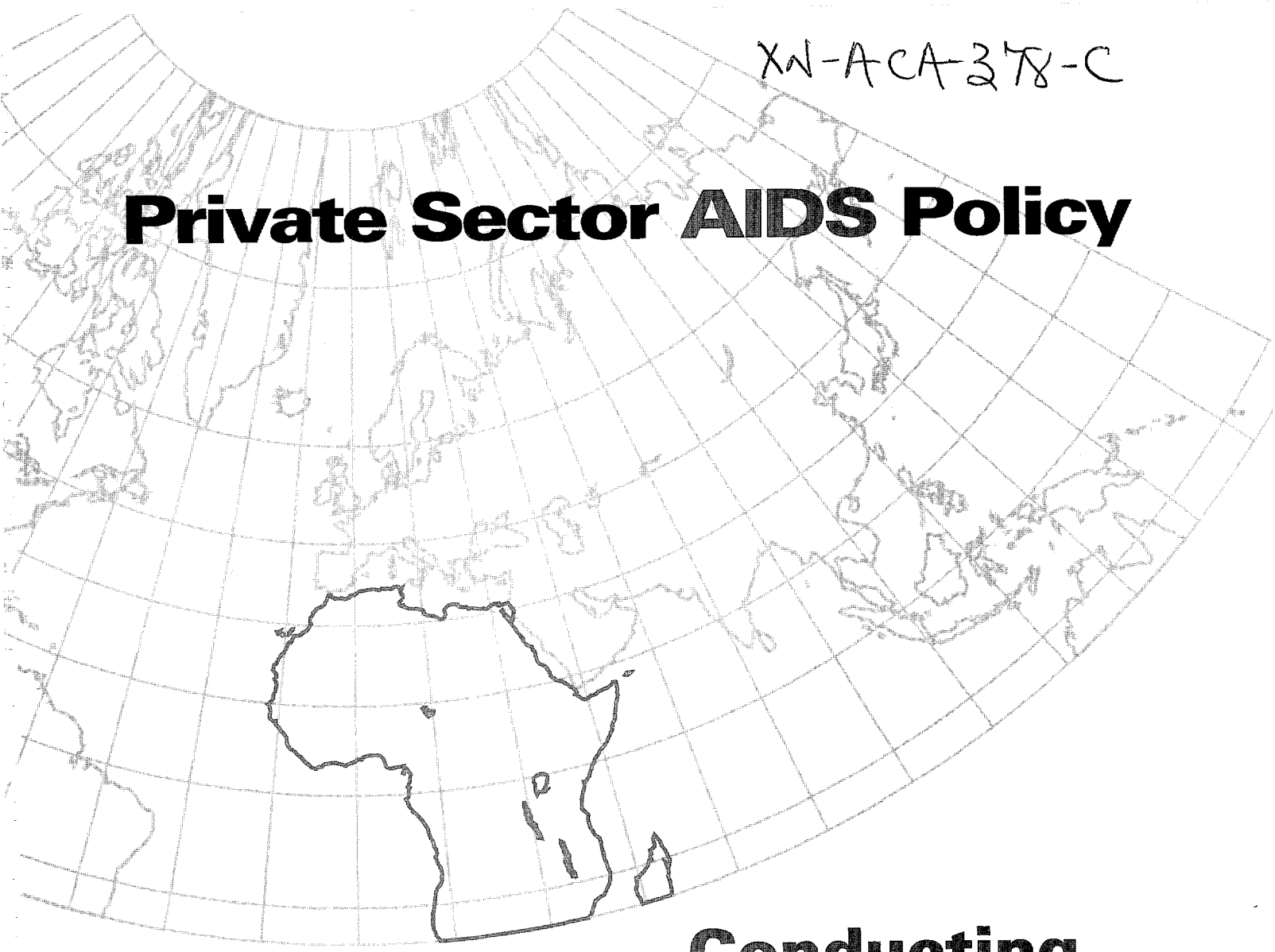
Private Sector AIDS Policy



Conducting a Workplace HIV/AIDS Policy Needs Assessment:

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A USER'S GUIDE

Developed by Family Health International's AIDSCAP Project (No. 936-5972.31-4692046) as part of the **Private Sector AIDS Policy Presentation** (PSAP) under USAID contracts HRN-5972-Q-00-4002-00 and HRN-5972-C-00-4001-00 Funding provided by the United States Agency for International Development.

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Using The *Guide*

The HIV/AIDS epidemic exists across all sectors of society and requires effective multi-sectoral responses. Workplaces are points at which HIV/AIDS prevention policies and programs can slow the spread of the epidemic. Businesses will benefit from well designed prevention policies and programs by protecting their financial, human and infrastructure resources.

The *Guide* provides a systematic way to assess the needs of companies in this era of HIV/AIDS. The needs assessment will provide information for management to make informed decisions as HIV/AIDS prevention programs and policies are developed. In some cases, management will not be committed to HIV/AIDS prevention in the workplace and will need a well-researched rationale for doing so. This *Guide* will assist in that process.

Potential users of the *Guide* include trade and employer associations, unions, consulting firms that assist businesses, and management training institutes. Any of these are likely to need information about several companies, rather than a single firm, in order to develop a profile that can be used in planning comprehensive HIV/AIDS prevention programs. Also, individual companies—whether private or joint public-private ventures—can apply the process outlined in the *Guide*. It is assumed that users will be within or working with large companies of several hundred employees. However, many of the survey questions are relevant for smaller firms, too.

The step-by-step approach outlined in the *Guide* is intended to make the design and implementation of a HIV/AIDS assessment as clear, structured, and rapid as possible. Users can adapt the materials and suggested steps to fit their particular situation.

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I. WHY CONDUCT A WORKPLACE POLICY NEEDS ASSESSMENT?

HIV/AIDS presents a major obstacle to economic growth and stability in the workforce. In many countries, it is recognized that HIV/AIDS threatens profits, productivity, and human welfare advances achieved over several decades. Both the private and public sectors have strong economic and social reasons for vigorously promoting HIV/AIDS prevention.

Workplaces are key sites for promoting HIV/AIDS prevention policies and programs. Most people spend a large part of their day at the work site. Prevention programs in the workplace expand the range of sources for information and prevention options for workers. Sensitive policies promote improved worker morale and productivity, and serve as the foundation for effective prevention programs.

Experience indicates that bringing the private sector into the public health "fold" is a challenge, as managers are primarily focused on production, efficiency, and profits. While ethical appeals may have some influence, the private sector is more likely to respond to arguments of financial soundness and productivity than to appeals to serve the public good. The benefits of workplace-based health prevention initiatives usually have to be seen to be believed. Changes in corporate policies are rarely taken lightly.

Most company HIV/AIDS policies and prevention programs are fairly limited and of an ad hoc nature. The needs assessment approach outlined in this *Guide* will provide sufficient information to work with business managers in developing and implementing HIV/AIDS prevention workplace programs.

In short, a workplace needs assessment will aid businesses and other places of formal employment by providing information for decision-making and planning of appropriate responses to HIV/AIDS that protect their profits, their employees, and themselves.

II. CONDUCTING A WORKPLACE POLICY NEEDS ASSESSMENT

There are several steps to preparing for and conducting a rapid assessment of the workplace successfully. These materials were originally designed for use in Kenya, Botswana, and Senegal; they will need to be adapted to suit local purposes.

The effectiveness of an assessment which is quickly done depends on adequate preparation. Because there is little time for major revisions in the methodology or changes in the field work, a rapid assessment relies on clear concepts, careful planning, consideration of anticipated problems, and flexibility to take advantage of unexpected opportunities for information.

The ten steps outlined below provide an overview for preparing, conducting, and analyzing the results from a rapid HIV/AIDS policy assessment for larger, formal sector businesses.

SETTING ASSESSMENT GOALS

STEP 1

The first step is to determine the goal (or goals) of the needs assessment. Clearly specifying what one wants to learn at the outset will assure that the assessment will be "rapid" and will influence the approach to gathering the information.

The goals for the assessments in Kenya and Senegal were:

- to understand what firms and workers already knew and were doing about HIV/AIDS.
- to develop a profile of the information, arguments, and methods desired and needed by managers to adopt HIV/AIDS policies and prevention programs in the workplace.
- to understand the information and training needs of managers and workers which will result in creating appropriate HIV/AIDS prevention policies and programs.

The goal(s) should be compatible with a rapid assessment approach. Too detailed or elaborate a goal may require more time and resources than will go into a rapid assessment. The rapid assessment will provide indicators of management and worker attitudes and of existing and emerging program and policy needs.

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STEP 2

DEFINING THE TYPES OF WORKPLACES

Because workplaces come in many different sizes and configurations, it is necessary to define boundaries for the survey. Some of the criteria that can be used to categorize businesses include [see also Appendix 1]:

- Company size—Firms can be categorized by their income or by the number of employees.

- Type of organization—Businesses may cover a cross-section of employers or be engaged in common activities. While there are many ways to classify firms, one suggested typology is:

    - High-technology or skilled manufacturing, industrial, or service firms (e.g., banks, pharmaceutical companies, accounting firms);

    - Low-technology or labor-intensive manufacturing, industrial, or service firms (e.g., garment manufacturing, electronic assembly, restaurants);

    - Agricultural firms (e.g., agro-industrial, plantations, large farms);

    - Government or parastatal organizations (e.g., agricultural boards, ministries);

    - Tourism-related firms (e.g., hotels, tour companies);

    - Transport-related businesses (e.g., bus and rail lines);

    - Mining companies.

- Ownership of firm—Firms can be categorized as wholly foreign- or locally-owned, joint partnerships, parastatals, or corporate or private ownership.

- Provision of benefits—Companies can be grouped by those that do or do not provide a set of benefits, such as health benefits. For example, firms with less than 100 employees are unlikely to have

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in-house health facilities, though it is possible that they may provide some health benefits. Firms with a couple of hundred or fewer workers will probably have some kind of medical facility, while companies with several hundred or more employees will likely have a fully-staffed medical clinic on-site or nearby.

- Geographic—Some assessments may focus on particular regions of a country or be interested primarily in urban or rural operations.

Other criteria can include the gender-ratio of employees, the educational level of employees, or the level of adoption and dissemination of employment policies.

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STEP 3

SELECTING A SAMPLE

Which organizations will best represent the mix of business types identified in STEP 2? For each important characteristic (e.g., manufacturing firms) or set of characteristics (e.g., locally-owned, manufacturing firms), at least two companies should be represented in the assessment.

At least eight, and probably not more than fifteen or twenty companies, represent an ideal sample size. Fewer than eight raises concerns about the representativeness of the assessment; more than twenty companies will make the survey too expensive and time-consuming to be considered a rapid assessment.

Suggestions for companies and worksites for inclusion in the sample should come from several sources. Worker and employer coalitions (such as unions or chambers of commerce), the National AIDS Control Program, and relevant government ministries all can suggest employers to include within the sample.

Once a draft list is compiled, review it to be sure that the firms meet the criteria for identified characteristics and representation. Are you familiar with all or most of the companies on the list? If so, might this reflect a bias toward certain company types rather than being truly representative? Are there worksites in the sample that have reputations for being outstanding in HIV/AIDS prevention policies or for being exploitative and harsh? If so, survey results in such firms may result in a distortion of the overall results. While some companies of both types of reputation may be included in the sample, it is best to complement them with a number of firms that are more typical or whose reputation is unknown.

A good example of the potential problems of a poorly selected sample is the initial list developed for the Kenya study undertaken by AIDSCAP/FHI. Most of the firms that were suggested to the study team were foreign-owned, manufacturing firms with extensive health benefits packages. While including a couple of these firms was appropriate and beneficial, including too many of them in the study would have offered an imbalanced view of AIDS prevention policies and practices in Kenyan workplaces.

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REFINING INTERESTS AND SCOPE

STEP 4

While this step may seem obvious, it is often overlooked: which aspects of the workplace policies and programs are of greatest interest? In some cases, a relatively comprehensive review of workplace policies and practices may be desired. In other cases, a more focused survey of employer rationales for creating existing HIV/AIDS prevention programs in the workplace may be sufficient.

In addition to assuring that these interests reflect the assessment goals, identifying the interests for the assessment is a way of making sure the task at hand is a realistic one. Are there sufficient time and resources available to conduct an assessment which will provide the level of detail desired?

The broader the scope of the study, the wider the range of information likely to be captured. The narrower the scope of interest, the greater the detail to be gained. If there is likely to be more than one study conducted, a broader study can be followed by a more specific study. For example, an initial, broad sketch assessment of workplace policies, practices and attitudes in Kenya was followed by a more specific study to collect financial and labor data from a few select companies in Senegal.

There are several possible areas of interest for an HIV/AIDS workplace assessment [see appendices 1, 3, 4 and 5]. The following list indicates some of these areas of interest:

- Health, medical, and benefits policies and practices;
- Organizational policies and policy processes;
- HIV/AIDS impacts on productivity and profitability;
- Worker knowledge and attitudes about HIV/AIDS;
- Case studies of companies' decision processes on HIV/AIDS policies;
- HIV/AIDS regulatory and legal impacts on company policies and practices;
- Workplace prevention education practices;

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- Workplace prevention services or interventions;
- Information needs or assistance organizations seek.

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DRAFTING THE ASSESSMENT QUESTIONNAIRE

STEP 5

The previous steps have provided the preparation for developing the questions to be asked. Normally, questionnaires move from general to more specific questions. Also, questions can be asked in different ways at different points in an interview in order to cross-check responses and solicit further information. Questions around a common issue or theme can be grouped together within the questionnaire.

There are several ways to assure that the draft questionnaire is as comprehensive as possible: use a group of three or four people to identify the questions; ask several people to read, add to, and change the original draft list; or test the questions with several trial interviews. In addition, by soliciting input from others, it will help assure that the questions are presented clearly. Vague questions will cause confusion and may result in vague answers.

One cautionary note: the larger the group developing a questionnaire, the more likely that questions will go beyond the scope of the assessment. One or two people should be responsible for ensuring quality and relevance on the complete list of draft questions.

The questionnaire should be clearly structured and laid out on the paper. This will make it easier to solicit information, record answers, and compile the responses. Whenever possible, typed, photocopied and/or printed questionnaires should be used rather than hand written ones.

To assist in this process, appendices 2 through 6 contain sample interview questionnaires, focus group guides, financial surveys, and other tools that may be modified to suit specific interests and objectives. The following table indicates the sample questionnaire and appendix for each category of interest identified above:

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Category	Assessment Tool	Found in Appendix
Governmental legal framework	Preliminary Interview	Appendix 2
Prevention education practices	Management Interview	Appendix 3
Prevention services or interventions	Management Interview	Appendix 3
Health, medical, and benefits practices	Management Interview	Appendix 3
Organizational policies and policy processes	Management Interview	Appendix 3
HIV/AIDS impacts on organizations	Management Interview and Financial Survey	Appendix 3 and 4
Information needs or assistance organizations seek	Management Interview	Appendix 3
Worker knowledge and attitudes	Focus Group Guide	Appendix 5
In-depth case studies of companies	All instruments and Case Study Guide	Appendix 2–6

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CONDUCTING THE PRELIMINARY INTERVIEWS

STEP 6

The purpose of the preliminary interviews is to get a "lay of the land," find out useful background information, identify potential contacts, and solicit valuable input and feedback on the assessment design while it is still in an early stage. A few meetings with persons familiar with the business community, non-governmental (NGOs) and other service organizations, and the health/AIDS situation in the country can be crucial to the study. They may identify or reframe aspects of the study that will increase its relevance or effectiveness. They may also identify other public or private sector contacts who can provide useful information or access to people to be interviewed.

Some preliminary interviews should focus on providing background information on relevant governmental labor, economic, health, and workplace practices and regulations in the country. HIV/AIDS remains a new area for employers. However, there will be a range of labor law and occupational regulations, for example, that will relate to HIV/AIDS. These meetings can often help to answer questions of methodology, inform areas of uncertainty, or raise issues of cultural or political sensitivity that may be critical to the success of the study. In some cases, printed sources—such as government economic reports and regulations issued by ministries of labor or industry—will provide information on regulations, laws, policies, and economic conditions.

If appropriate, a few preliminary interviews may provide the forum for pre-testing the management interview questionnaire to ensure that it is clear and will yield the desired information. Candidates for these preliminary workplace interviews may include:

- A representative of the chamber of commerce, employers' federation, or equivalent;
- A representative of a trade union;
- A couple of private sector leaders/managers who are sympathetic and aware of the AIDS situation;
- Staff from a couple of NGOs involved in health promotion and/or AIDS prevention.

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Though it would be ideal if any generalist could undertake all of these studies, the reality is that few people possess the background or skills to use all of these tools without special training. The preliminary and management interviews can probably be undertaken by people who have a good understanding of HIV/AIDS, have strong interpersonal communication skills, and who are comfortable in conducting interviews.

If possible, it is useful to have two people conduct the interview. This allows one person to ask most of the questions and follow-up probes while the other person records the interview in writing. It is not necessary to write everything said verbatim, but the writer should note the main points as well as quote directly any statements that capture the "essence" of an important point. A tape recorder is not recommended because most managers are highly sensitive to being "on the record."

The other assessment tools are more specialized. The financial surveys should probably be conducted by someone who has a firm grasp of micro-economics and accounting. Conducting focus groups requires both special training in leading focus groups as well as a deep cultural familiarity and rapport with the participants.[1] Finally, while simple case studies can be prepared from the management interviews, in-depth company case studies will require the data produced by the other assessment exercises as well as strong writing skills.

[1] See the AIDSCAP publication, "Conducting Effective Focus Group Discussions," Evaluation Tools, Module 2, 1994.

CONDUCTING MANAGEMENT INTERVIEWS

STEP 7

The management interview is the heart of the workplace needs assessment process, particularly if the goal of the study is to assess management views and practices with the aim of ultimately influencing managers to establish workplace prevention programs and appropriate policies.

The management questionnaire in Appendix 3 is divided into sections covering the various categories of interest identified in STEP 4, and it can be used or adapted in whole or part. The questionnaire is designed to be administered in a "semi-open interview" style. That is, the questionnaire is designed to elicit responses to particular questions, and at the same time, provide interviewees with the freedom to share thoughts and information they see as relevant or interesting. The seemingly unrelated comments a manager makes during the interview may provide far more useful information or valuable insight than the specific answer to the question.

GETTING AN INTERVIEW

The first step of a management interview is getting the interview itself. This is no small task. It may take two hours or more to initially identify the general manager or managing director of the company and to then phone or visit to arrange the interview. A referral by someone who is known to the manager will add credibility to the request for the interview.

The introductory contact will briefly explain the purpose of the study, how it may benefit the company, and how long the interview is likely to take. To capture their interest, AIDSCAP's study of businesses in Kenya explained to managers that the assessment could help companies like their own to assess the likely impact of AIDS on their operations. It is reasonable to suggest that the human resource director and clinic doctor or nurse (if applicable) attend the meeting as well.

MANAGING THE INTERVIEW

Open the interview with a brief explanation of the purpose of the survey (without giving information that might bias the manager's subsequent answers). As confidentiality may be a concern of companies, it is important to explain that the interview is confidential and that the interviewee and their company will not be identified directly in any published reports without their permission.

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If other forms of information gathering (focus groups, a financial study, or some other activities) are anticipated with the company, this introductory period is the time to suggest it. For example, the interviewer might say: "If we both find this interview interesting and useful, we might arrange to conduct an economic impact assessment that will help your company in its planning..." You can return to this theme at the end of the interview if its seems desirable.

It is important not to belabor the introduction or the purpose of the study and to turn as quickly as possible to the questions.

Many managers have their own agenda and are used to being in charge. They may deliver what amounts to a set speech for visitors and then try to end the interview without ever really answering the questions. Assertive but non-offensive interviewing will help assure that the questions asked are answered. Cross-check questions also will improve the likelihood of getting the desired information.

In many cases, it will be important to question the interviewee further about his or her response. For example, a manager may say that the reason the company began distributing condoms was because management decided it was an important issue. At this point, a follow-up question is useful to understand the experiences that contributed to the decision. It is impossible to anticipate all of the follow-up questions here; many will occur spontaneously during the interview. During the interview, it is entirely appropriate to skip questions or move around the questionnaire to accommodate the flow of the interview and time constraints.

A useful approach to wrapping-up at the end of the interview is to ask if there is anything else the interviewee would like to add or comment on that they think is important. The person is likely to offer a few very interesting or important thoughts about the subject which have not been discussed. Also, conclude the interview by asking if the person can recommend other people whose information would be useful for the study.

FOLLOW-UP

If it is decided to conduct a focus group with workers, use the company as a case study, or collect financial data, this is the time to reintroduce the theme. It should be possible to tell by the end of the meeting whether or not the manager would be receptive to any of these activities. Be clear what the activity will involve and if other peoples' assistance is required. Try to secure the manager's commitment at that time. For example, if a financial study is to be conducted, try to arrange a meeting with the accountant within a few days. Meanwhile, leave the financial survey for the accountant to begin collecting the data. If a focus group is desired, set a date for your return, explain what kinds of workers should be included, and what prior information participants should receive.

Finally, immediately after the interview is concluded, the interviewers should discuss any questions they have of each other about the interview. A typed 1–3 page narrative summary of the interview should be prepared within the day which reports the central findings and themes of the interview based on the handwritten interview notes. If possible, use a computer word-processor so that multiple interview answers can be correlated and analyzed more easily.

An Alternative to Interviews

There will be situations where neither the resources nor time is available to conduct a series of face-to-face interviews. In these situations short-cuts can be used. For example, an initial meeting with a manager can be arranged to explain the purpose of the survey and the questionnaire left behind for the manger to complete and return. Or, introductory phone calls can take the place of initial meetings, with a questionnaire subsequently mailed to the manager.

There are several disadvantages to using one of these short-cuts. Collection of the information is much more dependent on the manager's willingness to complete the written questionnaire. The interviewers cannot interact with managers to solicit additional information. If managers are confused by certain questions, there is no opportunity to provide verbal clarification.

When face-to-face interviews are not used, give extra attention to the preparation of each question and to the testing of those questions in real-life situations before circulating the questionnaire.

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STEP 8

USING FINANCIAL AND LABOR SURVEYS AND FOCUS GROUPS

Financial and labor surveys can be used to gain insight into the potential economic impact of HIV/AIDS on a company's profitability. Both surveys may generate results not readily perceived by the company, especially as the impact of HIV and AIDS is not well understood. Thus, these additional assessments can provide useful information for both the company and the needs assessment. Keep in mind that financial and labor surveys require more time than the management interviews.

Focus groups with workers are a means to quickly gather information on the particular concerns, attitudes, and ideas of workers. The results of worker focus groups can be used in helping to design workplace HIV/AIDS policies, suggest areas where workers themselves can contribute to workplace policies and programs, and indicate the degree of workers' commitment to promoting HIV/AIDS prevention in the workplace.

Each of these specialized survey methods is described in more detail in the appendices along with the respective sample questionnaire.

ANALYZING SURVEY DATA

STEP 9

One of the keys to the success of the needs assessment will be to organize and analyze effectively the potentially vast amount of data collected. Because there are many analytical techniques that can be successfully employed, it may be useful to organize the approach around typical and atypical experiences.

One of the likely purposes of the study is to find out what most organizations' and their employees' practices, knowledge, and attitudes are about HIV/AIDS. One of the goals of the assessment in Kenya and Senegal was to develop guidelines on how a business or worker association (or NGO or government agency) can approach managers to promote appropriate policies and prevention activities in the workplace. To promote prevention interventions, it is important to first know the typical situation in the private sector. Thus, the sample of companies included "typical" companies, and the survey data was organized to reveal the usual policies and practices of organizations.

At the same time, if one of the goals is to create policy change, it may be helpful to focus on the unusual as well as the average. Atypical experiences are informative because they suggest why and how unexpected and unusual outcomes occurred. **Atypical** experiences provide clues to what has worked for others and suggest recommendations for subsequent policy or program action. For example, the Kenyan study supported by AIDSCAP/FHI identified three companies (of sixteen in the assessment) which had already established comprehensive HIV/AIDS prevention programs. What was it about these organizations and/or their management that led them to develop AIDS programs and policies? The survey data should also be organized to indicate anything likely to serve as effective catalysts or approaches to influencing positive change.

The data analysis approach offered here is built around a matrix which incorporates several categories related to the survey goals and assessment questionnaire. With the matrix, it is possible to incorporate both quantitative and qualitative data and information and both typical and atypical responses.

A word processing computer program is very useful for recording the data, although the work can be done without a computer. With a computer, the data can then be moved and organized around central themes and recommendations that emerge from the multiple sources.

Below is a list of categories for one possible matrix. Appendix 8 offers an illustrative example of how to utilize this matrix to organize the data collected.

- Prevention Education Practices
- Prevention Services and Benefits Practices
- Organizational Policies
- HIV/AIDS Impact on Organizations
- Policy Processes/Influencing Change
- Policy Recommendations/Recommendations for Change
- Other

As data are collected from the interviews and focus groups, enter them into the respective categories, noting the source of data for each answer. It will be much easier to enter the findings if the interview summaries are done on computer, since they can be done by "cutting and pasting" useful sections. The management questionnaire is organized so that most findings can be disaggregated into these categories. Some of this analysis will require creative application of the findings to the categories of information desired. It may also be useful to create two subcategories for each of the first three categories: "Typical" and "Unique or Desired." If there are findings that seem important for which there is no appropriate category, enter it in the "Other" category. The Policy Recommendations/Recommendations for Change section can be made up of recommendations that managers and workers present, as well as creative ideas that you come up with as you proceed with the assessment.

The use of a matrix for collating data allows quick analysis of the findings. For example, the data may show that, "Of the 12 company managers interviewed, 8 reported having an in-depth program of HIV/AIDS education. These companies typically have formal education sessions once very 3 months in which all workers discuss AIDS and preventive practices during a special 2 hour lunch meeting..."

It is not possible within this *Guide* to describe the techniques for analyzing focus group data. However, those who are trained to conduct focus groups usually are trained to analyze the data. Suffice it to say that some of the focus group findings may also be incorporated into the analytic document. For example, if Acme Textiles' workers report that they wish management would provide condoms in the restrooms, this might be noted as something not taking place in the Prevention Services category and made part of an overall recommendation for companies in the Policy Recommendations category.

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Through the careful documentation and analysis of typical practices, existing policy processes, the atypical experiences of companies, recommendations voiced by participants, and recommendations and conclusions you form on the basis of the assessment, it should be possible to develop a Needs Assessment Report, as described in STEP 10.

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STEP 10

REPORTING ON THE ASSESSMENT

The workplace assessment can be presented in a number of different ways to serve different purposes. The examples of presentation formats discussed below assume a **policy perspective**, that is, information is being presented to draw attention to policy gaps or opportunities, or for advocacy. A needs assessment of workplace policies regarding HIV/AIDS can identify specific characteristics of and weaknesses in the policies and processes of governments and organizations. It will also provide an opportunity to develop policy options that promote successful HIV/AIDS prevention among workers.

Keep in mind that even if the focus of an assessment is on workplace conditions and/or prevention initiatives and not on workplace policies per se, the findings of the assessment can have important **policy implications**. The policy dimensions come to the fore when one shifts from describing the existing workplace practices to advocating for particular workplace prevention initiatives. For example, what is the process by which policies are made for the workplace? What arguments can be made for comprehensive workplace HIV/AIDS prevention programs? To whom should arguments be targeted, and in what form are they most likely to be persuasive? After all, it is a **policy decision** to adopt HIV/AIDS prevention programs for the workplace.

Needs Assessment Report

Appendix 9 offers an outline of one possible format for a report. The report should include an executive summary, a discussion of the main findings of the needs assessment, and recommendations for how to proceed with workplace-focused policies and activities. These recommendations should:

- Identify organizations and persons with the skills and capacities to promote workplace initiatives;
- Estimate resource inputs that may be needed;
- Suggest companies that are likely to be receptive participants to begin with;
- Identify governmental policies which promote or constrain workplace interventions;

- Identify other economic, political, or social factors which may be constraints for businesses; and

- Describe the strategies and information most likely to persuade and assist managers to initiate workplace HIV/AIDS prevention programs and appropriate workplace policies.

Case Studies

Case studies of company experiences with HIV/AIDS can be useful in describing pilot, innovative, or effective programs and policy responses. The case studies may deal with companies considering or having HIV/AIDS interventions. These examples may provide incentive and information to other organizations that are considering initiating prevention programs and supportive policies.

The case studies can be developed through analysis of the data collected on an organization for the other categories of interest (e.g., management interviews, focus groups, financial survey). They may also require follow-up interviews and additional data collection to fill in any information gaps or clarify answers. Appendix 6 provides an outline of issue areas and broad questions that may be used to structure the case studies. This outline may be helpful in developing a specific set of interview questions for managers. Appendix 7 provides an example of a case study prepared in the recommended format.

Economic/Financial Impact Analysis

The micro-economic impact analysis (Appendix 4) of companies can be used to demonstrate the importance of establishing appropriate workplace policies and prevention programs at both company and country levels. Companies may find that the projected impact of HIV/AIDS on their companies is significant and worth the investment of resources to establish prevention interventions. By making the impact analysis available to others, and perhaps integrating the data with the qualitative case studies, the impact assessments can also be used to demonstrate to other companies the likely impact of HIV/AIDS on their operations. Unless a company has agreed to make the data public, it is extremely important to protect the anonymity of companies by converting the company data into generic scenarios that do not reveal the identity of the company or its staff.

Summaries

Summary reports, articles, and the like can be drafted and disseminated. The business section of newspapers, for example, are likely to find the results of the study informative. Government departments that deal with industry, business, labor, planning, and finance will find the information important and useful. Likewise, other business and worker associations will want to see the findings.

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Workshops

The findings of the assessment can be used to inform private sector representatives in a workshop environment. Such a forum provides these leaders with the opportunity to learn what other companies are facing and how they are responding, and to discuss options for introducing policies and prevention interventions that will benefit their organization and workers.

Presentations

Presentations of the assessment findings—particularly the findings regarding the financial impact of HIV/AIDS—to company managers, their boards, community leaders, and others can be effective instruments to convince the private sector to establish or expand HIV/AIDS prevention programs and policies. For example, the AIDSCAP/FHI Kenya study found that one company's HIV/AIDS-related costs were consuming 7 percent of labor costs in 1994 and that this would likely double by the year 2000. Such findings are likely to be persuasive in convincing managers that investment in prevention may be more desirable than growing losses from absenteeism, retraining costs, and increased medical expenses.

III. CONCLUSION

From a policy perspective, there are numerous opportunities for including businesses and labor in HIV/AIDS prevention. With each passing month, more and more companies are recognizing the epidemic as a problem for them. In turn, they are seeking guidance in designing effective responses. AIDS activists can help shape those responses, assuring that well-designed policies and programs are offered to businesses. The epidemic requires more than informing individuals about the threat of HIV/AIDS; policy and prevention program responses in the workplace will reach many more people, will legitimize the changes in individual behavior required to slow the epidemic, and will add resources to prevention programs.

APPENDIX 1: TYPOLOGY OF ORGANIZATIONS

Possible categories for combining organizations in a survey:

I. Size of Company

A. Less than 100 employees

B. 100–300 employees

C. 300+ employees

II. Type of Production

A. High-technology/high-skill manufacturing, industrial, or service firms (e.g., banks, pharmaceutical companies, accounting firms, etc.).

B. Low-technology/labor-intensive manufacturing, industrial or service firms (e.g., garment manufacturing, consumer goods, restaurants, etc.).

C. Agricultural firms (e.g., agro-industrial, plantations, large farms, etc.).

D. Government or parastatal (partially government managed or owned) organizations (e.g., agricultural boards, ministries).

E. Tourism-related organizations (e.g., hotels).

F. Transport-related businesses (e.g., bus and rail lines).

G. Mining companies.

III. Ownership of Firm

A. Locally owned

B. Foreign owned

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C. Jointly owned

IV. Geographic Characteristics

A. Primarily urban-based

B. Primarily rural-based

V. Health Benefits

A. Whether or not employer pays for health services.

B. Whether or not health services are provided by company-employed staff.

C. Whether health services are provided on-site or off-site.

VI. Other Characteristics

A. Gender-ratio of employees.

B. Educational or other characteristics of employees.

C. Level of other benefits provided employees.

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APPENDIX 2: PRELIMINARY INTERVIEW FORMAT

I. Introductions

   A. Your organization

   B. Purpose of the study

   C. Brief description of the study

II. Gaining background information

   A. Relevant governmental workplace regulations, policies, and practices including:

      1. Labor

      2. Economic

      3. Health

III. Selected questions from the Management Interview Questionnaire that are appropriate for the particular interviewee.

IV. Areas of cultural or political sensitivity in conducting the research and interviews.

V. Recommendations on refining the study methodology or issues to address.

VI. Recommendations on organizations or persons to include in the study or other useful contacts/sources of information.

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APPENDIX 3: MANAGEMENT QUESTIONNAIRE

Company _____

Address _____

Phone # _____ Fax # _____

Person(s) Interviewed:	Position(s):	Date:
_____	_____	_____
_____	_____	_____

Interviewer _____

Interviewer _____

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Needs Assessment

Information needed from workplaces:

I. Basic information

I.A. What goods or services does it produce, or what is the nature of the business?

1. How long has the organization been in business (at this location, in the country, outside of the country if applicable)?

2. Where is the organization's home base?

3. What is the ownership pattern of the organization (For example, domestically-held company, foreign-owned multinational, joint foreign/domestic partnership, government-owned parastatal, family-owned, etc.)?

I.B. How many people does the organization employ? _____

1. Is production highly labor-intensive or capital-intensive?

I.C. How many are men? ____ How many are women? ____

II. Prevention Education Practices:

II.A. Does the organization presently have an HIV/AIDS Prevention Education Program for its employees?

___ NO **[If not, go to II.T]**

___ YES If so, please describe the education program.

II.B. What is the nature of the prevention education program? Does it:

____ Mainly involve distribution of literature, posters, etc.?

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____ Include a short presentation (30-60 minutes) of factual information about HIV/AIDS?

____ Or, is there a more in-depth discussion about HIV/AIDS, attitudes towards HIV/AIDS, fears and experiences, etc.?

____ Is there a formal peer education program in place? If so, please describe the program and how it was initiated.

1. **[If in-depth discussion]** Please briefly outline what topics are discussed in these education sessions.

[DO THEY HAVE COPIES OF ANY OF THE HANDOUTS OR MATERIALS THEY USE FOR THESE SESSIONS? COLLECT IF POSSIBLE.]

II.C. Why did the organization initiate a prevention education program?

II.D. Who inside or outside the organization initiated the program?

_____ _____
Person Position

II.E. When did this program begin? _____ (year)

II.F. Can employees take time away from work without penalty to participate in these prevention programs?

___ NO ___ YES **[If NO]** please explain rationale.

II.G. How long do the prevention education programs take?

___ Less than 30 minutes ___ 30–60 minutes

___ 1–2 hours ___ 2–3 hours ___ 3 or more hours

II.H. How often are the programs conducted?

___ Weekly ___ Monthly ___ Quarterly ___ Annually

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___ Other **[for example, not on a regular schedule]**

Describe _____

II.I. How many employees have participated in the prevention education program in the past 12 months?

_____

II.J. How many have participated to date? _____

II.K. Who conducts the education program?

___ Paid health workers of organization

___ Peer educators/workers of organization

___ Other types of employees paid to do this

Describe _____

___ Volunteer employees (not paid to do this)

___ Outside persons/organization paid to do this

___ Outside persons/organization not paid to do this

II.L. Please describe any technical, resource, or other assistance the organization receives in operating this program.

II.M. Who pays for, or sponsors, the education program?

_____

II.N. Is participation in the education program voluntary? Please explain rationale for either way.

II.O. Who participates in the program?

___ All employees

___ Only some types of employees

Describe _____

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___ Employees and family members. If yes, how is family defined (i.e., who can participate)?

_____

II.P. Has the organization been planning to change these programs?

___ NO ___ YES If so, why? In what ways?

II.Q. What kind of feedback, if any, has the organization gotten from employees about the program?

II.R. What has the organization done to respond to this feedback?

II.S. Have there been significant differences between male and female employees in the way the programs are conducted for them? Explain.

1. Differences between men and women in terms of their levels of interest or participation?

2. Differences between men and women in terms of the kinds of feedback men and women have given?

II.T. **[IF DO NOT HAVE A PROGRAM]** Have employees asked the organization for information on HIV/AIDS?

___ NO **[skip to III/Prevention Services and Benefits, below]**

___ YES For what kinds of information have they asked? (Are there differences between what men and women have asked for?)

1. What has the organization done to respond to their requests?

II.U. Has the organization been considering setting up a program?

___ NO **[IF NO]** Why not?

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___ YES What kind of program is the organization considering?

1. Possible follow-up probe questions:

   a. What are the main issues management is considering? The critical factors they are weighing, etc.?

   b. What information does management need to make a decision?

   c. Who are the people involved in making the decision?

   d. What options are they exploring?

   e. Is management seeking outside assistance, from whom, on what aspects, etc.?

III. Prevention Services and Benefits:

III.A. Do employees have access at the workplace to HIV/AIDS related health services, such as: **[Mark an "X" next to each service offered]**

___ Condom distribution?

___ STD diagnosis and treatment?

___ Voluntary and confidential HIV testing?

___ Counseling services?

___ Other services? Please describe.

[IF NONE OFFERED, GO TO III.F]

III.B. For the services offered above:

1. Where are the services provided?

   ___ On-site clinic

   ___ Company chosen off-site clinic

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___ Other, describe

2. Who conducts the services?

___ Paid health worker employed by the organization

___ Other types of employees paid to do this (e.g., peer educators)—Describe:

___ Volunteer employee (e.g., peer educator) **not** paid to do this—Describe:

___ Outside person/organization paid to do this

___ Outside person/organization **not** paid to do this

3. Please describe any technical, resource, or other assistance the organization receives in offering these services.

4. Who pays for, or sponsors, these services?

5. Who is eligible to receive these services?

___ All employees

___ Only some types of employees—Describe:

___ Retired employees

___ Employees and family members

III.C. Has the organization been planning to change these programs?

1. If so, why?

2. In what ways?

III.D. When did the organization start providing these services? _____

III.E. What kind of feedback, if any, has the organization gotten from employees about these health services?

III.F. **[IF DO NOT HAVE A PROGRAM]** Has the organization been considering offering HIV/AIDS-related health services?

___ NO **[If NO]** Why not?

a. Have there been requests from workers for HIV/AIDS-related health services?

___ YES If so, what kinds of services?

1. Possible follow-up probe questions:

a. What are the main issues management is considering? The critical factors they are weighing, etc.?

b. What information does management need to make a decision?

c. Who are the people involved in making the decision?

d. What options are they exploring?

e. Is management seeking outside assistance, from whom, on what aspects, etc.?

IV. Health, Medical, and Benefits Practices:

IV.A. Describe how the organization handles medical illnesses of its employees? For example, does it: **[Not mutually exclusive]:**

___ Provide treatment at an on-site clinic?

___ Pay for treatment at an employer chosen facility elsewhere?

___ Pay for health insurance for medical treatment by a health provider chosen by the employee?

___ Has no responsibility for medical illness, other than providing sick leave?

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IV.B. Describe any other health-related benefits offered to employees? For example:

___ Retirement scheme.

___ Disability payments.

___ Funeral expenses/burial fees.

___ One-time payment of death benefits/life insurance (e.g., death in-service benefit).

___ Ongoing family support.

___ Other benefits. Please describe.

IV.C. If someone were to have HIV/AIDS, would these same benefits be offered?

___ YES ___ NO **[If NO]**, please explain.

V. Organizational Policies and Policy Processes:

The following questions address health-related policies of the organization. By policies, we mean formal rules or informal practices the organization follows for dealing with employees or applicants who have, or are believed to have, various kinds of medical conditions, including HIV/AIDS.

V.A. Does the organization have any health-related criteria for hiring employees?

___ NO ___ YES

a. **[If Yes]** Do the hiring policies refer specifically to, or differ for, applicants with HIV/AIDS?

___ NO ___ YES

1. Please describe the policy.

V.B. Does the organization have any health-related criteria for terminating employees?

___ NO ___ YES

a. **[If Yes]** Do these termination policies refer specifically to, or differ for, employees with HIV/AIDS?

___ NO ___ YES

1. Please describe the policy.

V.C. Does the organization have policies about testing for HIV?

___ Do not test for HIV.

___ Test employees for HIV. ___ Is testing mandatory?

___ Test applicants for HIV. ___ Is testing mandatory?

1. **[If Yes]** Please describe the policy and its rationale.

V.D. Does the organization have policies about eligibility or maintenance of employee health insurance and/or medical benefits?

___ NO ___ YES

1. **[If Yes]** Do these policies refer specifically to, or differ for, employees with HIV/AIDS?

___ NO ___ YES

2. Please describe the policy.

V.E. Does the organization have policies about the confidentiality of medical information?

___ NO ___ YES

a. **[If Yes]** Do these policies refer specifically to, or differ for, employees with HIV/AIDS?

___ NO ___ YES

1. Please describe the policy.

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V.F. If an employee was known to have died of AIDS, would the organization record this in the employee's medical records?

___ NO ___ YES

V.G. Does the organization have policies about what to do if an employee is no longer able to work at normal capacity due to a health condition?

___ NO ___ YES

a. **[If Yes]** Do these policies refer specifically to, or differ for, employees with HIV/AIDS?

___ NO ___ YES

1. Please describe the policy (Do these policies differ for men and women?).

V.H. **[If not already answered]** What would the organization do in terms of such things as maintaining employment and benefits if it knows an employee is HIV+? And if the employee has "full blown" AIDS?

V.I. Do you know how and why these various policies were developed?

1. Possible follow-up probe questions:

a. Why were these policies adopted, what is the rationale, etc.?

b. Can you describe the process by which policies are made?

c. Who is involved in policy making?

V.J. Are any of these policies mandated by law? Which policies and by what laws?

V.K. What guidance or assistance, if any, did the organization receive in establishing these policies?

1. Possible follow-up probe questions:

a. Where did the organization learn about the external sources?

b. What made the outside sources or their recommendations credible?

V.I. What reactions, if any, have there been to these policies among employees?

1. Has there been interest or reactions to these policies outside of the organization?

V.M. Has the organization been planning to change any of these policies?

1. If so, why and in what ways?

VI. HIV/AIDS Impact on Organization:

VI.A. Has HIV/AIDS affected the operations, production, or profits and losses of the organization?

1. If so, in what ways?

2. Does the organization see HIV/AIDS as likely to be a problem in the future?

a. Why or why not?

VI.B. Do you know of any employees who are infected with HIV or who have "full blown" AIDS?

___ NO ___ YES

1. **[If Yes]** How many employees would you estimate? _____

2. Do particular types of workers appear unusually affected (e.g., Support/Maintenance, Manual Laborers, Supervisors/Middle Managers, Technical Professionals, and/or Senior Management)?

3. What percentage of the time are they out sick? _____

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VI.C. Do you know of any former employees who have died of AIDS in the past 5 years?

___ NO ___ YES

[If Yes] How many employees in 1989?_____

How many employees in 1990? _____

How many employees in 1991? _____

How many employees in 1992? _____

How many employees in 1993? _____

1. What types of workers were they (Support/ Maintenance, Manual Laborers, Supervisors/ Middle Managers, Technical Professionals, and/or Senior Management)?

VI.D. Has the organization been able to replace employees it has lost to AIDS?

VI.E. How many employees leave the organization in a typical year, for any reason whatsoever? _____

VI.F. How many weeks of training do new employees receive? _____

1. Does this depend very much on the category of workers?

   ___ NO ___ YES **[If Yes, explain]**

VI.G. How is the organization planning to respond to the effects of HIV/AIDS on productivity or operations in the future?

VI.H. Has HIV/AIDS increased the organization's health insurance or medical costs? Which costs?

1. By how much since last year? _____

2. Since 1990? _____

VI.I. Has HIV/AIDS increased significantly any other costs? Please describe.

VI.J. Has HIV/AIDS affected relations between employees or between management and employees?

VII. **Information Needs:**

VII.A. What kinds of information do you think the organization would need to make a decision about whether or not to establish an HIV/AIDS prevention program?

VII.B. If the management of the organization were convinced that an HIV/AIDS prevention program would be of benefit to it, would it be likely to contribute resources to operate these programs?

1. For example, would the organization offer:

___ Money to pay for ongoing prevention materials and services, such as condoms, STD drugs, and health employees' clinical and training services?

___ Provide transport for employees and/or trainers to conduct prevention programs?

___ Give some employees paid leave time to be trained to run prevention programs in the organization?

___ Provide work space where prevention and treatment services can be conducted?

___ Allow employees to receive prevention education and resources during working hours on the work site?

___ Other? Please describe.

VII.C. If assistance were available to plan, implement, and/or review the organization's HIV/AIDS policies and prevention activities, what kinds of specific information would be most helpful?

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1. For example:

   ___ Information about HIV/AIDS itself (i.e. what HIV is, how it is transmitted, etc.)?

   ___ Information or assistance in establishing workplace policies (e.g., benefits policies, hiring and firing policies, etc.)?

   ___ Information or assistance in how to establish prevention programs in the workplace (e.g., what kinds of information and services the organization should provide employees about HIV/AIDS)?

   ___ Information or assistance in handling employee relations, dealing with issues of management or employee attitudes about HIV/AIDS, etc.?

   ___ Other kinds of information or assistance? Please describe.

VIII. Is there anything else you would like to tell me?

APPENDIX 4: FINANCIAL QUESTIONS FOR ORGANIZATIONS

Included in the *Manager's Guide* is a micro-economic model developed by AIDSCAP for analyzing the economic impact of HIV/AIDS on an organization. A full description of this impact model, as well as a companion model to estimate the costs of a workplace HIV/AIDS prevention program, are found in Appendices 9 and 10 of the *PSAP Manager's Guide*. Computerized versions of the two models are also included on a computer disk that accompanies the *PSAP Manager's Guide*.

Some of the information required to complete the impact model is likely to be considered highly sensitive. Thus, outsiders seeking such information for analysis should ensure that strong rapport has already been establish during the interview process before pursuing the financial impact analysis. Though the model is designed to be self-administered, the information can be extremely helpful for the purposes of a needs assessment and may be more easily completed if you provide some assistance.

It may take several hours for a company to collect the information, depending on its record-keeping procedures. One effective strategy is to leave the questionnaire with the managing director or designates (probably an accountant) and to arrange to come back in a few days after they have had a chance to review the questions and collect the information. When you return, you should expect to spend an hour or two with the designate clarifying the answers and ensuring the survey is properly completed.

As an incentive to companies to participate in this part of the study, you should emphasize that the micro-economic analysis will provide management with valuable information about its own organization. The information can be used by the company to better plan for its future in terms of health and other benefits, training needs, and profitability.

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APPENDIX 5: FOCUS GROUP GUIDE

Focus group sessions with workers and/or workers' representatives can provide essential information on workers' knowledge about HIV/AIDS, their behavior, and their attitudes and perspectives about the role of their employers in promoting their health. This information can serve several purposes. One, it can be used to identify risk behavior and help determine the areas of prevention training that are most critical. Two, the level of risk behavior and level of preventive knowledge that exists among workers can be used to convince managers to adopt appropriate prevention programs. Finally, worker perspectives on company medical services and other benefits should inform what types of workplace policies and prevention activities are adopted. Policy changes or prevention interventions that are not in the interests of—or are resisted by—workers are unlikely to be beneficial.

Focus groups should be led by trained focus group facilitators who are familiar with the language and culture of the participants. The focus group guide included here was developed for use in Kenya. AIDSCAP has also produced a guide to conducting effective focus group discussions (available from the Evaluation Unit) which describes and defines the methodology.

FOCUS Group Guide

1. What do you know about HIV/AIDS?

   Probe: What are your sources of information?

2. How has this information affected the behavior or relationships among your workmates?

3. What do you think your employer should do to help workers protect themselves from getting HIV/AIDS?

4. What do you think your employer would do if he knew someone had HIV/AIDS?

   Probe: Does the employer have any policies about HIV/AIDS that you know of?

5. **[If have an on-site clinic]** How does the on-site clinic work?

6. **[If have an on-site clinic]** How comfortable do you think your workmates are in using the company health clinic?

   Probe: Are there particular illnesses you would feel uncomfortable getting treatment for at the clinic?

   Probe: How about Sexually Transmitted Diseases?

7. **[If have an HIV/AIDS education program at work]** What do you think about the HIV/AIDS program you have at the company?

8. What kind of an HIV/AIDS program would you and your workmates wish to see in the company?

9. Who would you like to have conduct an HIV/AIDS program (e.g., company doctor, trained workmates, union workers, etc.)?

10. Is there anything else you would like to ask us or tell us?

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APPENDIX 6: CASE STUDIES OF FIRMS

I. Provide a brief description of the company in terms of:

A. The nature of the organization's business, its purpose or production.

B. The number of male and female employees, categories of employees, skill level of each category, and the training process and costs required for new employees.

C. Identify the company's overall revenues and expenditures. Is the work highly labor-intensive or more capital-intensive?

D. Identify the communities where the company's facilities are located and its relationship with the communities. How long they have operated there and their major competitors.

E. Describe the company's overall policies regarding hiring practices and employee compensation (e.g., health insurance, life insurance, burial benefits, etc.).

II. Describe the organization's present understanding of how HIV/AIDS is affecting its operations.

A. Assess the overall attitude of workers and management regarding HIV/AIDS.

B. How many people in the firm do they think are HIV infected or have AIDS?

1. Are certain types of employees more highly represented in terms of HIV/AIDS?

C. How is it affecting productivity? Absenteeism? Health expenses? Insurance costs? Funeral expenses? Labor relations?

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D. How has management been responding to this problem to date?

1. What formal or informal policies do they have regarding such things as:

a. Pre-employment HIV screening?

b. Worker HIV screening?

c. Response to employees with AIDS?

d. Confidentiality?

E. What has management been thinking or planning to do in the future to deal with HIV/AIDS?

III. If applicable, describe the history of the company's realization of the need for HIV/AIDS policies and/or prevention programs.

A. Who were the key people involved?

B. What were the key factors that made them realize they had a problem?

C. What steps did they take?

D. Did they seek outside assistance or information and from where?

IV. If they have a prevention program or adopted policies to deal with HIV/AIDS, describe them in detail. Also:

A. What lessons have they learned from undertaking these programs?

B. What have been the specific financial costs of running these programs?

C. What have been the financial or other benefits of running these programs?

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APPENDIX 7: CASE STUDY OF DAVID WHITEHEAD TEXTILES[2]

Company Background

David Whitehead Textiles—a subsidiary of the Lonrho conglomerate—employs nearly 4,500 people at its three factories in the towns of Kadoma (2,544 employees), Chegutu (1,764 employees), and Gweru (175 employees) in Zimbabwe. Over 90 percent of the company's employees are male. Most of the men live in town with their wives and families, although some couples are separated for long intervals when the wife returns to the village to cultivate the fields. A health clinic at each factory provides free health care to company employees.

Impact of HIV/AIDS on the Company

The level of AIDS awareness is high among David Whitehead's workforce, largely because of management's strong commitment to AIDS prevention over the past five years and employees' active involvement in AIDS education activities.

David Whitehead Textiles has seen its share of deaths from AIDS. Since the end of 1989, the company's Kadoma factory has posted the number of AIDS deaths each month on notice boards outside the factory clinic and canteen. By the end of 1992, the company clinic had recorded 68 AIDS deaths among the workforce at Kadoma, and the death rate was increasing every year.

Company Policy

The company maintains a policy of not screening job applicants or existing employees for HIV. Procedures have been established, however, for employees to be referred to government hospitals for HIV tests on purely clinical grounds, with their informed consent.

All nursing and medical staff at the company clinics have been trained in pre- and post-test counseling techniques. The company doctor treats the results of all these tests as confidential.

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[2] This case study is based on a chapter of the book, *Work Against AIDS: Workplace-based AIDS Initiatives in Zimbabwe* by Glen Williams and Sunanda Ray, published by ACTIONAID, London, 1993. Also see the volume entitled, *African Workplace Profiles*, published by AIDSCAP along with the other materials in the *Private Sector AIDS Policy: Business Managing HIV/AIDS*.

History of HIV/AIDS Prevention Program

David Whitehead Textiles has been at the forefront of industry's response to the AIDS epidemic in Zimbabwe since 1989 when the company launched its AIDS Awareness Campaign. Company management first realized the need for an AIDS prevention program and policy in 1988 when the Blood Transfusion Service discovered that 21 percent of blood donors at the company's factories in Kadoma and Chegutu were HIV-positive. In response to this disturbing news, the company's public relations manager and the company doctor—with strong support from the Chief Executive—initiated an AIDS Awareness Campaign targeting employees, their dependents, and the surrounding communities. The following were the company's objectives:

- To establish an understanding of HIV/AIDS among the entire population of David Whitehead Textiles to ensure they were aware that AIDS is relevant to their own lives, and that they can avoid infection, either by changing their sexual behavior or by always using condoms.

- To maintain stability within the workforce so that such costs as training, medical, and funeral expenses are kept to a minimum.

- To show the workforce (and Zimbabwe as a whole) that the company cares.

- To determine the present situation within the company, and to develop strategies for awareness by all employees, for treatment of people with HIV/AIDS, and for on-going support services.

- To provide medical and counseling services to people with HIV and AIDS within the workforce.

- To publicize the campaign nationwide so that other companies will follow suit.

In designing its AIDS education program, the company sought guidance and assistance from such outside organizations as the Ministry of Health, the National AIDS Coordination Programme, the World Health Organization, and local AIDS service organizations. It was decided that the campaign would use a number of communications channels, including drama, printed information materials, and group discussions, as well as interpersonal communication to reach its target audiences effectively.

The company doctor and Ministry of Health staff provided training in HIV and other sexually transmitted diseases (STDs) to all 64 Health

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and Safety representatives from the three Whitehead factories. To this day, the trained representatives serve as AIDS Information Officers, answering questions, providing life-saving information and advice to groups and individuals at work.

A local theater group was identified to perform a play about AIDS in Shona, the local language. The company also developed a comic book entitled *AIDS: Toward a Greater Understanding,* in collaboration with the National AIDS Coordination Programme. Twenty thousand copies were published in English, Shona, and Ndebele.

The high profile campaign launch took place in November 1989 with meetings held in factory canteens, theaters, nightclubs, and school halls. The meetings, attended by David Whitehead employees, their families, and people from the local communities, featured an explanation of the campaign, a presentation by the company doctor on basic facts about AIDS, and a performance of the play "Me and My AIDS," followed by questions from the audience. Members of the audience received copies of the comic book and were advised that the company would provide free condoms to its employees.

After the campaign launch, workers could turn to the AIDS Information Officers at the work site to answer their questions about AIDS. Some AIDS Information Officers also went to bars and beer halls after working hours to talk about AIDS with sex workers and their clients and to promote condom use.

Employees at the Kadoma factory even wrote their own play about AIDS for World AIDS Day in 1991. Since that time, the group has performed the play at an Army barracks, an Air Force base, commercial farms, community halls, in the city square, and during football matches.

The company set up condom dispensing machines in all three of its factories in 1989 and has continued to incur the cost of supplying condoms free to its employees. At the Chegutu factory, an average of 1,776 condoms were distributed from the clinic, the Health and Safety Officer's Office, and the canteen each month in 1992—that's more than 21,000 condoms a year in just one of the company's factories.

Lessons Learned

The experience of David Whitehead Textiles demonstrates the importance of a strong and ongoing commitment to an HIV/AIDS prevention program on the part of management—commitment of both time and financial resources. The active involvement of employees in educational activities was also critical to the program's success. The company also found that calling attention to the number of AIDS deaths within its own workforce, while seemingly controversial, helped convince employees to take HIV/AIDS more seriously.

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Costs and Benefits

The company is very encouraged by the mounting evidence of sexual behavior change among its workforce members since initiating the AIDS Awareness Campaign. The number of STD cases treated at company clinics has dropped significantly since the start of the campaign. At the Kadoma factory clinic, for example, the number of patients treated for STDs fell by 53 percent, from 959 in 1989 to 453 in 1992. The decrease in the number of STD cases treated was even more dramatic at the Chegutu factory clinic—from 1,628 cases in 1989 to 408 in 1992, a decrease of 75 percent.

The tremendous increase in the number of condoms distributed to employees also points to sexual behavior change. Before the program began in 1989, no condoms were distributed. In 1992, 15,324 condoms were distributed at the Kadoma factory and 21,312 at the Chegutu factory. While no surveys have been conducted among the workforce, employees, particularly married men, are now choosing monogamy rather than having several sexual partners as before. The benefits of the campaign are clear. Company employees and their partners can now make an informed choice about avoiding HIV and other STDs.

The cost to the company of running an AIDS prevention program have included the costs of publishing the comic book (Z$12,400), the costs of performing the play 21 times (Z$5,250), and the cost of supplying condoms.

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APPENDIX 8: DATA ANALYSIS MATRIX

This partially completed, illustrative matrix may assist in analyzing the data. Using the matrix format, enter the qualitative data findings where appropriate, identifying the company and questionnaire number for each answer.

I. Prevention Education Practices

A. II.A. [Management Questionnaire/Question #II.A./Does the organization presently have an HIV/AIDS Prevention Education Program for its employees?]

1. Typical

CO1 [i.e. Company #1] No regular program—Conducted a one-time education session in 1991 for all employees. Have not done a program since then, but considering it.

CO2 Yes—Conduct an HIV/AIDS training session for workers every few months on voluntary basis after work hours. Estimate that 35% of workers have participated.

[Continue...]

1. Unique/Desired

CO5 Yes—10 peer educators were trained in 1992 and are encouraged to conduct formal and informal sessions regularly with workers. Formal sessions are held every 2 months during lunch hour. Estimate that 100% of workers have participated.

II. Prevention Services and Benefits Practices

A. III.A.a. [Management Questionnaire/Question #III.A.a./Do employees have access AT the workplace to HIV/AIDS related health services—Condom distribution]

1. Typical

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CO1 No
CO2 No
CO3 No

2. Unique/Desired

CO4 Yes. Note: Company purchases condoms from pharmaceutical company at wholesale price.

B. III.A.b. [STD Diagnosis]

1. Typical

2. Unique/Desired

III. Organizational Policies

1. Typical

2. Unique/Desired

IV. HIV/AIDS Impact on Organizations

A. VIII.A. [Has HIV/AIDS affected the operations, production, or profits and losses of the organization?]

CO1 No, not enough cases so far.
CO2 No.
CO3 No, but expect that it will be a problem if AIDS increases.
CO4 Yes, cost of medical insurance has increased by about 20% since last year.
CO5 No, don't think so.

V. Policy Processes/Influencing Change

[Fill in...]

VI. Policy Recommendations/Recommendations for Change

[Fill in...]

VII. Other

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APPENDIX 9: POSSIBLE OUTLINE OF REPORT

I. Executive Summary

II. Introduction

A. Purpose of needs assessment

B. Background on the country's governmental/legal framework and the private sector as relevant to HIV/AIDS workplace prevention and policies.

C. Methodology

III. Summary of management interview findings

A. What do organizations and management know, and what are they doing, about HIV/AIDS? (Use anonymous examples of companies to illustrate)

1. Prevention education practices

2. Prevention services, interventions, and benefits

3. Organizational policies and policy processes

4. HIV/AIDS impact on organizations

a. Summary of financial/labor data findings (if conducted)

IV. Summary of focus group findings (if conducted)

V. Recommendations

A. What will best persuade managers that they should establish HIV/AIDS policies and work place-based prevention programs?

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B. What kinds of information and training do managers need to establish appropriate HIV/AIDS policies and prevention programs?

C. Skills and capacities available in-country to initiate workplace prevention activities.

VI. Conclusion

VII. Appendix

A. Case study profiles of companies

B. Financial/labor data reporting

C. Focus group transcripts

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