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AFRICA CENTRE FOR HIV/AIDS MANAGEMENT

Developing an HIV and AIDS Policy:

Content, Process, Challenges and Implementation

JANUARY 2008



SOUTH AFRICANS AND AMERICANS
IN PARTNERSHIP TO FIGHT HIV/AIDS

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Developing an HIV and AIDS Policy: Content, Process, Challenges and Implementation

**Postgraduate Diploma in HIV/AIDS Management
(Module 12, 13 and 14)**

Joint project of:

**Africa Centre for HIV/AIDS Management
(Stellenbosch University)**

USAID | Health Policy Initiative, Task Order 4 in South Africa

**Lecturers: Prof Jan du Toit (Stellenbosch University) and
USAID | Health Policy Initiative, Task Order 4 in South Africa**

This booklet was produced, by the USAID | Health Policy Initiative, Task Order 4, for use at the Stellenbosch University Summer School. It is the printed version of three modules that form part of the Postgraduate Diploma in HIV/AIDS Management. This book is intended for the use of students registered for the Diploma course only and should not be otherwise distributed.

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About the Postgraduate Diploma

Stellenbosch University responded to the challenge by the presidency of South Africa in 2000 to develop training and capacity building programmes on HIV and AIDS which target managers and leaders of South Africa's workforce. The view was that despite what was done in the community around prevention and care, there was a need to extend the interventions to the workplace in order to make an impact on the pandemic.

The response to the presidency's challenge led to the development of the Postgraduate Diploma in HIV/AIDS Management. This part-time yearlong course has been in place since 2001. As a direct result of this diploma, the Africa Centre for HIV and AIDS Management was established in January 2003. Originally part of the Department of Industrial Psychology, the centre is now a separate unit of education, research and community service related to HIV and AIDS Management in the workplace.

Outcomes of the diploma programme

By successfully completing the diploma, candidates will have acquired the knowledge, competencies and managerial skills to:

- formulate an HIV and AIDS policy at work that is cost-effective and evidence-based, taking into account of the legal, ethical, social, economic and health issues
- influence and facilitate strategic and business planning, manage productivity and carry out performance assessment, within the HIV and AIDS context
- develop a comprehensive HIV and AIDS prevention and continuum of care programme
- implement legislation and policies affecting HIV and AIDS at work
- facilitate community support and community actions
- conduct labour planning for a future in which HIV and AIDS are prevalent
- monitor and assess HIV and AIDS prevention and care programmes
- assess the impact of HIV and AIDS in the workplace
- carry out a research project on HIV and AIDS in the workplace

In presenting the various modules/units of the programme, The Africa Centre makes use of various modes of teaching. These include the following:

- online teaching using the integrated e-learning system WebCT
- interactive satellite broadcasts
- face-to-face teaching during the summer school
- analyses of case studies
- meeting role-players in HIV and AIDS areas
- projects that enable students to apply the knowledge, skills and attitudes learned

About this book

This book is the printed version of modules 12, 13 and 14 of the diploma programme and is designed and developed by USAID | Health Policy Initiative, Task Order 4 in South Africa. The book is designed for use by students who are registered on the course. There is a CD that accompanies this book which includes reading materials from the recommended reading list of the modules.

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HOW TO USE THESE MODULES

An HIV and AIDS workplace policy can be excellent on paper, but will be rendered useless if it is not brought alive through its practical application. We therefore invite you to actively engage with the module. We encourage you to see this module more as a workbook than a document to passively read. We have provided a number of questions in the text to stimulate your thinking and apply your learning – we encourage you to reflect on the questions, apply the issues to your workplace, jot notes in the margin, post questions on the discussion board if you need further clarification.

TERMS USED IN THESE MODULES

We recognise that students come from a broad range of workplaces – hospitals, schools, government departments, NGOs, large corporates and small, medium and large companies to name a few. We therefore use certain terms interchangeably, to cater for this diversity and fit the context of the sentence. These include the terms workplace, organisation and company to describe the base from which you are developing your policy. The terms employer and management refer to the owners of the concern, or the management responsible for employment and policies.

The term PLHAs refers to People Living with HIV and AIDS. We have chosen this term out of recognition that being HIV-positive is different to, and poses different challenges to, a person who is living with AIDS-related conditions. Terms which can be found elsewhere include PWAs (People with AIDS) and PLAs (People Living with AIDS).

PARTICIPANTS FROM OUTSIDE SOUTH AFRICA

As with previous modules, participants from outside South Africa may replace South African legislation and codes of practice with those from their own countries. Where these do not exist, use the ILO standards*. References referring to government departments will be South African and you are encouraged to locate similar documents in your own country.

* International Labour office (ILO) Code of Practice on HIV/AIDS and the World of Work (2001).

<http://www.ilo.org/public/english/protection/trav/aids/code/codemain.htm>

INTRODUCTION

Module objectives

On completion of these modules, students will be able to:

- explain the importance of an HIV and AIDS workplace policy
- describe the function, content and principles of an HIV and AIDS workplace policy
- identify the rights reflected in HIV and AIDS workplace policies
- describe the process that can be used in developing an HIV and AIDS policy, and apply this to their workplace
- assist with the design of a new policy
- contribute to the monitoring and evaluation of an HIV and AIDS workplace policy
- understand and be able to apply useful tools which can assist in the development and implementation of an HIV and AIDS workplace policy
- discuss some of the key issues and challenges facing the development and implementation of an HIV and AIDS workplace policy
- identify and describe some of the key issues and challenges in integrating an antiretroviral treatment programme into a workplace policy and programme

DESIGNING AN HIV AND AIDS POLICY: FUNCTION, CONTENT AND PRINCIPLES

INTRODUCTION TO MODULE 12

Imagine a workplace where there are no policies...

Here is the scene at Moonshine Textile Designs...

Peter is angry. He has to take two days study leave, and his manager says he must take it out of his two weeks holiday leave. Thandi takes three days to look after her sick child. This is also deducted from her two weeks leave. Rose takes four days off because she would like time with her husband who works away and is at home on leave. She claims to have had terrible flu. Because this is “sick leave” it is not deducted from her leave. The staff are furious, as everyone, except the manager, knows the truth. Then Violet asks for one week off to arrange a family funeral. She is refused leave because the manager claims she “is sick and tired of all these funerals”. Everyone knows their manager had four weeks paid leave to go overseas to visit her son. They are upset and angry as they feel they have been unfairly dealt with. They approach her to discuss the matter, but she tells them if they don't like the way she runs the place they can seek employment elsewhere. The next time an employee asks for paid leave to go to the hospital, the manager refuses on the basis that the staff are taking advantage of her good nature, and all this leave leads to chaos in the factory. And the result? There is a bad atmosphere, productivity decreases, there are several resignations, and management wonders why!

It is clear from the above scenario that a workplace without policies can lead to an unhealthy, unhappy situation to say the least! In this scenario, there is inequality as different rules apply to different employees, there is favouritism, employees take advantage of the lack of procedure, and legitimate requests are declined. This results in resentment, jealousy, confusion, low morale and, ultimately, a decline in productivity. In this example, a Leave Policy would have clearly identified what paid or unpaid leave employees were entitled to (in terms of sick, holiday/annual, bereavement, family or study leave), as well as the circumstances in which the leave applies and the procedures to follow when requesting such leave. Workplace policies also go a long way to ensuring fairness and equity in addressing the rights and responsibilities of both employers and employees.

Similarly, the need for policies relating to HIV and AIDS in the workplace has arisen out of the necessity to develop a more organised, formalised response as the work sector becomes increasingly affected by the epidemic. Not only do policies provide guidelines on how to respond to HIV-positive employees, they also give expression to the importance of using the workplace as a base for prevention. Employers and employees both have a reference point, which informs them about what they are entitled to and how this should be applied in practice. Policies also attempt to strike the balance between productivity and profitability on the one hand, and a humane, fair and socially responsible response on the other.

In this module, we use as a framework the broad range of laws, guidelines and principles that have been developed internationally and nationally to guide the formulation of HIV and AIDS workplace policies. We will explore why you need an HIV and AIDS workplace policy, what the policy should contain, and how to develop a policy.

The development of a policy is only one part of a larger process, however, and the real challenge is to translate it into practice. This is addressed in several ways:

- We outline the importance and content of workplace programmes (Module 12).
- We describe some important steps which should be part of the process of developing/reviewing your HIV and AIDS workplace policy (Module 13).
- We highlight some challenges that may arise when developing and implementing a workplace policy and programme, and provide a range of questions to assist in exploring your organisation's position in relation to these issues (Module 14.1).
- We take a look at how antiretroviral treatment can be integrated into a workplace policy and programme (Module 14.2).
- (Module 14.3)
- We provide a range of tools to assist with the development and implementation of the policy (Module 14.4).
- We provide a range of questions and scenarios to enable you to interact with and apply your reading (all modules).

WHAT IS AN HIV AND AIDS WORKPLACE POLICY?

An HIV and AIDS workplace policy is a written document that sets out an organisation's position and practices as they relate to HIV and AIDS.

THE FUNCTION OF AN HIV AND AIDS WORKPLACE POLICY

An HIV and AIDS workplace policy:

- defines an organisation's position on HIV and AIDS and sets out clear guidelines on how HIV and AIDS will be managed within the workplace
- aligns the workplace response to the legal framework
- ensures fairness
- identifies and protects the rights and responsibilities of employers and employees in the context of HIV and AIDS
- sets standards of behaviour expected of all employers and employees
- establishes consistency within the organisation
- sets the standard for communication about HIV and AIDS
- provides a good foundation upon which to build an HIV and AIDS workplace programme
- informs employees about what assistance is available for HIV and AIDS
- sends a strong message that HIV and AIDS are serious issues in the workplace
- indicates commitment to dealing with HIV and AIDS
- ensures consistency with national and international practices

PRINCIPLES THAT GUIDE A WORKPLACE RESPONSE

Consensus has been developed internationally on the core principles that should underpin a workplace response to HIV and AIDS. These have formed the basis for, and have informed the development of, workplace policies around the world.

Principles are important because they provide a baseline to deal with the ever-changing and challenging environment of HIV and AIDS¹. In 2001, the ILO² issued a Code of Practice based on extensive dialogue with businesses, worker organisations and governments around the world. These provide a sound basis for shaping an organisation's policies on HIV and AIDS³. [Refer to Module 9 for further information]

Similarly, in South Africa, principles are contained in the Code of Good Practice on Key Aspects of HIV/AIDS and Employment.⁴ [In addition, refer to Module 9 for further information]

Key principles that a workplace response should include:

- The recognition of HIV and AIDS as a workplace issue. HIV and AIDS threaten productivity, profitability and the welfare of employees and their families. The workplace, as an integral part of the community, has a vital role to play in terms of prevention.
- The promotion of equality and non-discrimination between individuals with HIV infection and those without, and between individuals with HIV or AIDS and other comparable health/medical conditions.
- The creation of a supportive and enabling environment in which HIV-positive employees are able to continue working under normal conditions, in their current employment, for as long as they are medically fit to do so.
- The protection of human rights and dignity of people living with HIV and AIDS is essential to the prevention and control of HIV and AIDS.
- HIV and AIDS impact disproportionately on women and this should be taken into account in the development of workplace policies and programmes.
- Consultation, inclusivity and encouraging full participation and ownership of all stakeholders are key principles which should underpin every HIV and AIDS policy and programme.
- HIV is preventable and the workplace needs to promote effective prevention efforts.

HOW TO USE PRINCIPLES AND THE LAW TO DEVELOP AN HIV AND AIDS WORKPLACE POLICY

Below are some examples of the application of principles in an HIV and AIDS workplace policy, as outlined by the Code of Practice.⁵ This shows how principles and the law provide a framework for the formulation of policies. [It is also recommended that you refer back to Module 9 where we outlined the legal aspects of HIV and AIDS.]

Non-discrimination

Your HIV and AIDS policy should contain principles and processes to promote non-discrimination in relation to HIV and AIDS. Various measures are available, including:

- ensuring that employees with HIV or AIDS are not unfairly discriminated against within the employment relationship, and within any employment policy and practice (for example, in recruitment procedures, in the allocation of employee benefits, etc)
- taking steps to promote a non-discriminatory working environment based on the principles of equality (for example, through providing awareness, education and training on the rights of people living with HIV and AIDS or through support and accommodation for employees infected and affected by HIV and AIDS, as outlined in Module 9)

¹ Department of Public Service and Administration (2002). Managing HIV/AIDS in the Workplace: A Guide for Government Departments. Pretoria, Republic of South Africa.

² ILO (2001). Draft Code of Good Practice on HIV/AIDS and the World of Work. Geneva.

³ Rau, B (2002). Workplace HIV/AIDS Programs: An Action Guide for Managers. Family Health International.

⁴ Department of Labour (2000). Employment Equity Act: Code of Good Practice on Key Aspects of HIV/AIDS and Employment. Pretoria: Republic of South Africa.

⁵ Department of Labour (2000). Employment Equity Act: Code of Good Practice on Key Aspects of HIV/AIDS and Employment. Pretoria: Republic of South Africa.

The Code highlights the vulnerable position of women, and the disproportionate impact that HIV and AIDS has upon women in South Africa. An important element of non-discrimination and the promotion of equality in terms of HIV and AIDS are therefore to ensure that policies and programmes take into account the vulnerabilities of women employees and women job applicants. In some workplaces this particular point is included as a sentence in the HIV and AIDS policy to emphasise its importance.

HIV testing

Your HIV and AIDS policy should contain statements on HIV testing. The Code gives guidance to employers on the prohibition of testing employees for HIV, as contained in s7 (2) of the Employment Equity Act No 55 of 1998. The Act provides that employers may not require employees to test for HIV, unless they have been authorised to do so by the Labour Court. The Code outlines several instances of “permissible” testing, including:

- HIV testing as part of a healthcare service in the workplace
- HIV testing in the event of an occupational accident carrying a risk of exposure to blood or other body fluids
- HIV testing for the purposes of reporting and applying for “worker’s compensation”

However, the Code requires that even such 'permissible' testing may only take place:

- at the initiative of the employee
- within a healthcare worker and employee/patient relationship
- with informed consent and pre- and post-test counselling
- with strict procedures relating to confidentiality of an employee’s HIV status

Confidentiality

An HIV and AIDS policy should provide for strict confidentiality of all information relating to a person’s medical status, including HIV status and medical treatment. In particular:

- all employees have the right to confidentiality with regard to HIV and AIDS
- voluntary disclosures of HIV status should not be disclosed to others
- organisations should cultivate an enabling environment to ensure that employees who disclose their HIV status will be supported

Promoting a safe working environment

An HIV and AIDS policy should contain provisions relating to the promotion of a safe working environment. All employers are obliged by law, in terms of the Occupational Health and Safety Act No 85 of 1993, to provide and maintain, as far as is reasonably practicable, a workplace that is safe and without risk to the health of its employees. In the context of HIV and AIDS, this means your policy should deal with:

- an assessment of the risk, if any, of occupational transmission
- appropriate training, awareness and education on the use of universal infection-control procedures
- the provision of accessible and appropriate equipment to deal with occupational incidents
- the steps that must be taken following an occupational incident – including whether your organisation will fund post-exposure prophylaxis for affected employees
- adequate monitoring of occupational exposure to HIV

Compensation for occupationally acquired HIV

Your policy should also contain provisions relating to compensation for occupationally acquired HIV. All employees are entitled to be compensated for acquiring HIV as a result of an occupational accident, in terms of the Compensation for Occupational Injuries and Diseases Act No 130 of 1993. An HIV and AIDS policy should set out:

- the reporting of any accidents which may involve exposure to HIV
- the organisation’s procedures to be followed in applying for compensation (such as HIV testing)
- the information to be provided to employees in this regard

Employee benefits

Your HIV and AIDS policy should contain provisions regarding employee benefits, to ensure that there is no unfair discrimination in the provision of employee benefits, in relation to HIV and AIDS. Details of important principles in relation to HIV and AIDS and employee benefits have been set out in Module 9.

Reasonable accommodation

Your HIV and AIDS policy should ensure that employees living with HIV and AIDS are “reasonably accommodated” within the working environment, to maximise their performance and to ensure that they can work for as long as they are able. Increasingly, employers are recognising that employees with life-threatening illnesses or other disabilities are often physically able and want to continue to work. An HIV and AIDS policy should acknowledge this, and could also set out potential steps employers are willing to take to accommodate employees living with HIV or AIDS. [See Module 9 for more details concerning reasonable accommodation.]

Dismissals

It may be useful for your HIV and AIDS policy to set clear guidelines on dismissals for employees living with HIV and AIDS, to ensure that employees are not unfairly dismissed on the basis of HIV status. Your policy can stress the fact that:

- an employee may not be dismissed solely on the basis of his or her HIV status
- an employee who has become incapable of performing his or her duties may be lawfully dismissed for incapacity. The dismissal must, however, follow fair procedures as set out in the Labour Relations Act No 66 of 1995. [Module 9 covers this in more detail in the paragraph dealing with dismissal.]

A RIGHTS-BASED APPROACH TO HIV AND AIDS WORKPLACE POLICIES

It is important that HIV and AIDS workplace policies are seen in the context of human rights. In southern Africa, as in many other parts of the world, many employers – large or small, private or public – have responded to HIV and AIDS with acts of unfair discrimination.

Acts of unfair discrimination include: mandatory testing of job applicants and being refused the job on the basis of HIV status; mandatory testing of employees; dismissal of people suspected or known to be HIV-positive; the exclusion of HIV-positive employees from medical aids and/or other benefits; the restructuring of benefits to offset or avoid the cost of HIV and AIDS to the company; and the refusal to train, promote or invest in the development of HIV-positive employees, to name a few.

“Concern about the spread of HIV provides an opportunity to re-examine the work place environment. It provides an opportunity to create an atmosphere conducive to caring for and promoting the health of all workers. This may involve a range of issues and concerns, not only individual behaviour, but also address collective responsibility. It provides an opportunity to re-examine working relationships in a way that promotes human rights and dignity, ensures freedom from discrimination and stigmatisation, and improves working practices and procedures.”⁶

Codes of practice, policy guidelines and legal frameworks use the safeguarding of human rights as the basis for dealing with HIV and AIDS. A number of the rights identified by international law are mirrored in South African laws and policies. [Module 9 deals with this in more detail.]

⁶ WHO/ ILO (1988) Consensus Statement on AIDS in the Workplace as report in Report on the Consultation on AIDS and the Workplace. Quoted in: UNAIDS (2000) A human rights approach to AIDS prevention at work – the Southern African Development Community’s Code on HIV/AIDS and Employment.

These rights⁷ include:

- Everyone has the right to equality and non-discrimination. This includes protection on the basis of “HIV status” (ref. the Constitution, the Employment Equity Act and the Promotion of Equality and the Prevention of Unfair Discrimination Act).
- Every employee has the right to be tested only following Labour Court authorisation (ref. the Employment Equity Act).
- Everyone has the right to privacy and confidentiality (ref. the Constitution and common law).
- Every employee has the right to a safe working environment and compensation if injured at work (ref. the Occupational Health and Safety Act and the Compensation for Occupational Injuries and Diseases Act).
- Every employee has the right to equal access to employee benefits (ref. the Medical Schemes Act).
- Every employee with HIV or AIDS has the right to a minimum level of medical aid benefits from their medical aid scheme (ref. the Medical Schemes Act).
- Every employee has the right to be protected from unfair dismissal based on HIV status (ref. the Labour Relations Act).

A major challenge for employers is how to deal with an applicant who is HIV-positive. Between 1997 and 2000, an interesting legal case occurred, hailed as a landmark victory for the rights of HIV-positive people: a person (Hoffman) applied for employment at South African Airways (SAA) and was required to undertake an HIV test. On the basis of his test result he was refused employment. He took the matter to court and won the case. Read the case and think about the court’s findings (see Recommended reading: Hoffman vs SAA). What legislation (and the principles it embodies) informed the case’s outcome? What implications does this have for employers and employees in terms of workplace testing?⁸

What is your current job? How do you think being HIV positive would impact on your ability to continue in your current position? If you developed HIV related problems how do you think that would impact on you performing your job effectively? How protected are you at your workplace? Look at your policies and see what safeguards there are in terms of discrimination, benefits and being reasonably accommodated.

WORKPLACE HIV AND AIDS PROGRAMMES

What is a workplace HIV and AIDS programme?

A good HIV and AIDS workplace policy always contains an outline or a description of how the particular organisation, institution or business is going to manage HIV and AIDS on a day-to-day basis. A workplace HIV and AIDS programme outlines how all the different principles within the policy will be translated into practice at the workplace.

An HIV and AIDS workplace programme is an action-oriented plan that your organisation will implement in order to prevent new HIV infections, provide care and support for employees who are infected or affected by HIV or AIDS, and manage the impact of the epidemic on the organisation.

While your HIV and AIDS policy may not provide details on how each element of a workplace HIV and AIDS programme will be implemented, it may be useful to at least set out the key elements of the HIV and AIDS programme that your organisation is committed to providing.

⁷ Department of Public Service and Administration (2002). Managing HIV/AIDS in the Workplace: A Guide for Government Departments. Pretoria, Republic of South Africa.

⁸ Whiteside, Alan, and Sunter, Clem (2000) AIDS: The Challenge for South Africa. Human & Rousseau and Tafelberg Publishers. Appendix 2: The Legal Framework and HIV/AIDS. And: The Legal Network of South Africa (2000) Breaking the Silence – the Law, Human Rights and AIDS. AIDS Legal Quarterly (September).

Key elements of an HIV and AIDS workplace programme include:

- an impact assessment of HIV and AIDS on your organisation
- HIV and AIDS awareness programmes
- voluntary counselling and HIV-testing programmes
- HIV and AIDS education and training
- condom distribution
- encouraging health treatment for STIs and TB
- universal infection-control procedures
- creating an open and accepting environment
- wellness programmes for employees affected by HIV and AIDS
- the provision of antiretrovirals or referral to relevant service providers
- education and awareness about antiretrovirals and treatment literacy programmes
- counselling and other forms of social support for HIV-positive employees
- reasonable accommodation for HIV-positive employees
- strategies to address direct and indirect costs and other practical implications of HIV and AIDS
- monitoring, evaluation and review of the programme

What is the difference between an HIV and AIDS policy and an HIV and AIDS workplace programme? What is the link between the two?

Select one key element of a workplace programme and develop an action plan describing how you would put this into practice at your workplace. Remember to take into account issues of diversity such as gender, race, class and sexuality. You may find the following questions useful to devise an action plan:*

- Why are you doing it?
- Who would you involve?
- What resources would you need, and from where would you obtain these resources?
- What support would you need from management?
- What is your time frame? (Not in specific dates, but approximate length of time.)
- How would you recruit for and publicise your activity?
- What would you hope to have achieved by doing it?

* See Managing HIV/AIDS in the Workplace, Department of Public Service and Administration (2002), which has some interesting "leading practice" examples – see specifically Chapter 11. Also ask for examples from other neighbouring workplaces.

DEVELOPING AN HIV AND AIDS POLICY – THE PROCESS

If you were asked by your organisation, institution or department to develop an HIV and AIDS policy, what would you do? Where would you start and what information do you think you would need?

Policy development may appear to be a complicated process, but fortunately there are many resources. In particular there are a number of well-developed workplace policies, which help to make the actual drafting a relatively simple process. The process followed to develop a policy is as important as the content of the policy itself. In addition to the development of a new policy, existing policies need to be revised and updated. The process outlined below can be used in the development of a new policy, and can also be used to assist in the reviewing/updating of an existing policy.

“The process engaged to develop a policy is as important as the policy itself.”

Think about this statement. Why do you think the process we use is so vital to the successful development of an HIV and AIDS policy?

SUGGESTED PROCESS

Below are some important steps which should be part of the process of developing or reviewing your HIV and AIDS workplace policy.

- Step 1: Acknowledge that HIV and AIDS is a workplace issue
- Step 2: Secure management’s support and identify potential champions
- Step 3: Appoint a representative HIV and AIDS task team
- Step 4: Gather relevant information
- Step 5: Reach consensus on key elements of an HIV and AIDS workplace policy
- Step 6: Draft the HIV and AIDS policy
- Step 7: Establish a process of consultation
- Step 8: Popularise and implement the policy
- Step 9: Monitor and evaluate the policy

Step 1: Acknowledge that HIV and AIDS is a workplace issue

Why should an organisation respond to HIV and AIDS? Every workplace, whether in a high or low prevalence area, needs to acknowledge that HIV and AIDS is an issue that requires a response. The first step is to involve all members of the workplace in an awareness-raising process where the outcome is the acknowledgement of HIV and AIDS as an issue affecting your workplace. This process should seek to make the issues related to HIV and AIDS “real” and personal, and not just something “out there”. HIV and AIDS is already affecting many workplaces. Some of these are starting to understand, and prepare for, the impact that HIV and AIDS will have on their working environments. In the past, such a response was often the result of a crisis (for example, an HIV-positive person being discriminated against, a decline in productivity, or the loss of workers due to AIDS) that galvanised an organisation to develop an HIV and AIDS policy. Now, many managers are being more proactive – gathering information, talking with their trade and professional associations, learning more about HIV and AIDS and preparing strategies for HIV and AIDS policies and programmes suitable for their workplaces. If you have an HIV and AIDS policy, it would be interesting for you to trace what triggered its development.

Step 2: Secure management's support and identify potential champions

Why do we need to ensure the support of management? The support of management and of the organisation's leadership is vital to the process. Ultimately, it will be up to management to allocate the resources necessary for the implementation of the policy. Identifying and securing the support of leadership is important to give credibility to the process. Leaders can be both formal and informal – what is important is that they have influence over segments of the workplace and will elicit the support and buy-in necessary for the process. A useful strategy is to find 'champions' for the process – these are people who have a particular passion or vested interest in the process, and are willing to drive the process because they believe it is important.

Step 3: Appoint a representative HIV and AIDS task team

How do we ensure that the task team is representative? A good starting point for the development of an HIV and AIDS policy is to nominate and appoint a representative task team that will be responsible for driving the process. Be sure to identify a leader for the policy-development process and involve representatives of all sectors of the workplace as a team. An effective HIV and AIDS policy needs the support of all tiers of staff, including the buy-in of senior management and that of employee-interest groups such as staff associations and trade unions. There will be more interest and commitment if people are involved from the outset.

Below is a suggested checklist of possible people to include in the task team. As you can see from the list, it is important to try to include all those with a vested interest in the policy. You need to adapt this list to make it appropriate to your workplace.

Checklist of possible people to include in an HIV and AIDS policy task team

- Personnel who will be involved with the development, implementation or monitoring and evaluation of HIV and AIDS workplace policies and programmes (such as HR, personnel from employee-assistance programmes, trainers etc).
- Personnel involved with occupational health and broader wellness management programmes within your organisation.
- Key people who represent the various interests of the organisation – for example, management, staff associations or trade unions.
- Management at all levels, to ensure commitment to and leadership for the policies and programmes.
- Women, to articulate their specific perspectives, interests and concerns into the planning and the programme.
- Lower levels of staff, such as cleaners, guards and gardeners, are often excluded, but are extremely vulnerable to being affected by HIV and AIDS.
- Employees who are living with HIV or AIDS, as they, better than anyone else, can inform the committee of the capacities and concerns of employees with HIV and AIDS.
- Union representatives, to ensure participation and to maximise the potential for good communication with the workforce.
- People with relevant skills for the policy-development process (such as communication skills and training in HIV and AIDS).
- People who are respected and who are able to build support for the HIV and AIDS workplace programme.
- Employees active in HIV and AIDS activities in the community.

If you already have a policy, find out who was represented on the team when it was drafted, and compare it to this list. Was anyone omitted? Who else should have been included? If you do not have a policy, outline who you would include in your HIV and AIDS task team.

The Greater Involvement of People Living with HIV/AIDS (GIPA Principle)

It is important that any HIV-positive employees who have disclosed their HIV status be integrally involved in the policy-development process. The GIPA Workplace Model applies the GIPA Principle to the workplace and provides guidelines as to how HIV-positive employees have been successfully and effectively recruited, trained and employed to assist with development, design and implementation of HIV and AIDS policies and programmes. It is essential that the role of HIV-positive persons in the task team and the programme should not simply be one of “sharing your story of how you became infected”. HIV-positive employees have an essential role to play in giving a human face to the virus, in the breakdown of stigma and discrimination, and in assisting staff to internalise the issues at stake. Most importantly, HIV-positive persons can provide a wealth of key information in terms of providing senior management with an understanding of the implications of an HIV-positive diagnosis for employees. The information that HIV-positive persons have can also directly inform managers in terms of strategies to address and manage the wellness of infected and affected employees on a daily basis to ensure quality of health, life and ultimately productivity of all employees.

(GIPA = Greater Involvement of People Living with HIV/AIDS. The GIPA Principle was established in the 1994 Paris Declaration. It advocates that people living with HIV and AIDS have a crucial role to play in all HIV and AIDS management and prevention strategies. The GIPA Principle has been integral to many HIV and AIDS programmes throughout the world.)

Jake is HIV-positive. The occupational health nurse knows his status and has counselled him since he received the result of his HIV test. He has informed his closest work colleagues who work in his department. The occupational nurse has approached him to become part of the HIV and AIDS task team which is being formed to review and update the HIV and AIDS policy that was developed 10 years ago. She also wants him to assist with revival of the HIV and AIDS support programme which started but fizzled out two years ago. He is keen to be involved, but is very frightened about being open about his status.

- What would you do if you were Jake?
- What are the pros and cons that he needs to weigh up?
- What are Jake’s rights in this situation?
- What should Jake do to pave the way for his involvement, both in and outside the workplace?
- Why is it important to have an HIV-positive person on the task team?
- How should management and other members of staff such as the occupational health nurse pave the way for Jake’s involvement?
- How can an organisation secure the greater involvement of PLHAs?

Thabo, the human resource manager in a medium-sized company, is doing a course on HIV and AIDS in the workplace. He wants to review the current HIV and AIDS policy. His management support him. He wants to secure the involvement of PLHAs in the process. He knows of two colleagues who are HIV-positive, but they are not open about their status in the workplace. He does not even know whether they know that he knows they are HIV-positive? Do you think Thabo ought to approach his two colleagues and ask for their assistance? How can he go about securing their involvement?

Step 4: Gather relevant information

What information does the task team need? The HIV and AIDS task team needs to gather a range of information which will enable the members to design an appropriate, manageable and cost-effective response. Information gathering includes:

4.1 Information about the organisation

What are the needs and concerns of the employer, managers, supervisors and shop stewards? How can these be addressed within your HIV and AIDS policy? They may have concerns such as:

- recruiting employees who are capable of performing their assigned tasks
- retaining skilled and experienced employees
- providing training and promotional opportunities for all employees

- performance management
- providing equitable and sustainable benefits
- promoting a safe working environment
- providing an enabling environment
- keeping costs low

What are the concerns of the employees? How can these be addressed within your HIV and AIDS policy? They may have concerns such as:

- avoiding HIV infection
- being protected from stigma and discrimination on the basis of HIV status
- working in a supportive and enabling environment
- ensuring that confidentiality is maintained
- access to voluntary counselling and testing
- access to treatment, nutrition and support
- having a safe working environment
- receiving good employee benefits
- having job security
- being given opportunities for promotion and training
- being involved in and consulted on the development of relevant HIV and AIDS policies and programmes
- being able to report grievances relating to HIV and AIDS

The HIV and AIDS task team should also start to think about the nature of the particular organisation, and how this may impact on the content of their HIV and AIDS policy. They should consider questions such as:

- the size of the organisation
- the type of organisation
- the employment structure of the organisation
- the organisation's working conditions
- the terms of employment and staff benefits
- the demographics of the employees
- existing skills and resources within the organisation

4.2 Accessing technical expertise in relation to HIV and AIDS

The HIV and AIDS task team should also consider accessing technical expertise and information that is available to assist them in their information gathering. They may want to consult technical experts in order to:

- obtain information as to how HIV and AIDS is affecting the workplace, the sector or the community in which the workplace is based
- carry out an impact analysis of HIV and AIDS to determine how, and to what extent, HIV and AIDS will impact on the workplace
- determine the laws relevant to HIV and AIDS in the workplace
- find out best-practice information, for example, with regard to workplace HIV and AIDS awareness and education programmes, monitoring and evaluation tools, etc

- determine any existing minimum standards and guidelines with regard to HIV and AIDS policies and programmes (for example, minimum standards for treatment, conducting HIV testing and pre- and post-test counselling)
- learn about any existing research on HIV and AIDS policies in the workplace
- consult with and join existing regional, provincial and national task forums within their sector
- explore HIV and AIDS health management services and/or technical assistance and/or information about the provision of or referral to STI, TB, VCT and antiretroviral treatment services

While it may be helpful to contract outside expertise, the process should be as participatory as possible in order to maximise ownership of subsequent policies and programmes. The organisation should also consider how to ensure that employees living with HIV or AIDS are comfortable during the process, and don't feel blamed for causing negative impacts.

4.3 Sourcing existing HIV and AIDS policies

The process of policy development should start with a review of existing workplace policies. Essentially, this is an assessment of what protection there is for staff and for the organisation, and what responsibilities apply to staff and other members of the organisation (such as board members). A review of personnel policies will clarify existing leave allocations, performance requirements and procedures in relation to dismissal and ill-health retirement. This review will give an indication as to whether current allowances with regard to sick and compassionate leave are adequate or whether over-generous allowances leave the organisation susceptible to impact. There are many HIV and AIDS policies that have proven to be successful over time, so you don't have to create your policy from scratch. Use existing policies as a guideline as you develop your own policy. Adapt it to your particular business, fitting it to your situation so that your policy works for you.

Step 5: Reach consensus on key elements of an HIV and AIDS workplace policy

What issues does the task team need to discuss and agree upon? There are several important issues which the HIV and AIDS task team needs to discuss and reach consensus on before they can begin the process of drafting an HIV and AIDS policy. These include: what kind of policy is appropriate to the nature and size of the organisation; why you feel a policy is important; should it be formal or informal; whose support and approval you need; whether you wish to integrate the policy into existing policies or develop a separate policy document; and the goal, guiding principles and key elements of the policy. These are all challenging areas and need to be explored in an informed but open-minded way. The end of this section, "Issues to consider when developing your policy", explores these issues in more detail. [In Module 10 we outlined the joint problem-solving approach. This could be usefully applied in this part of the process.]

Step 6: Draft the HIV and AIDS policy

Once the team has been established, how does the task team begin? The next important step is for the HIV and AIDS task team to sit down and actually draft a policy. An important consideration here is to make sure your policy is located within your organisation. In other words, the kind of policy you decide to write should reflect your organisation's style – the nature of your business, the way in which decisions are made, and the underlying values and practices on which the organisation is built. Creating an HIV and AIDS policy that is appropriate for your particular business, department or organisation is an important component of a successful policy process. [Tool 4 in Section 14.3 of this module provides a checklist for drafting an HIV and AIDS workplace policy.]

Step 7: Establish a process of consultation

How does the task team ensure that all staff members feel they are part of the process and have the opportunity to give their input? Once your HIV and AIDS task team has developed a draft policy, it should be circulated widely in your organisation. It should be explained to management, supervisors, shop stewards and employees, including all employer and employee organisations, such as unions. Further opportunities must be provided to discuss the policy and its implications for the workforce, and for concerns to be raised. By discussing and resolving these concerns in advance, you maximise the ability to administer your policy with confidence. [Module 11 has useful points in effective communication.] After your consultation you need to review the policy based on all input received. Finally, the revised policy ought to be formally adopted by the organisation.

You are very inspired by this course and, because of this, you initiate either the development of a new, or the review of an existing, HIV and AIDS workplace policy. You have revitalised the task team and worked on the policy, and now wish to send it out for comment. You understand from your course reading that consultation is not simply a matter of circulating a written document, but that it is an opportunity to engage both staff and management on a range of issues related to HIV and AIDS. You are aware that there are many new members of staff and that HIV and AIDS is becoming increasingly evident at your workplace. You want to initiate a process that will allow all staff to make informed and constructive contributions to the process. With your new-found wisdom as a result of your studies, you are tasked with the development of an effective consultative strategy. What steps would you include in your consultation plans? What specific activities would be included in your consultative strategy? Who would you consult?

Step 8: Popularise and implement the policy

How does the task team ensure that the staff are aware of the existence of the policy and understand the contents of the policy? Generally, policies are boring and intimidating-looking documents. The challenge is to popularise them. This means making them appealing and easily understandable to all sectors of staff. There are various ways to do this, including:

- developing accessible media, such as pamphlets, posters and fact sheets on the HIV and AIDS policy
- displaying the policy in public places
- uploading the draft policy on the internal website and hosting an electronic list serve debate
- providing copies of the policy to all managers and employees
- holding awareness and education sessions on the HIV and AIDS policy

All too often, employers spend time writing policies that end up in a file gathering dust on a shelf. For an HIV and AIDS policy to work, it must be communicated and acted upon throughout the organisation. [See Module 11: Communication.] Your managers, supervisors, and union and staff association representatives need to understand your policy and their role in administering it. Employees need to understand the policy so that they will know what is expected of them.

It is crucial that your HIV and AIDS policy does not become another well-intentioned document which gathers dust on office shelves. Here are some strategies to ensure that it is implemented:

- The HIV and AIDS policy assigns responsibility to various stakeholders for implementation.
- The HIV and AIDS policy includes a communication strategy to communicate the policy to all stakeholders. [See Module 11: Communication.]
- The HIV and AIDS policy includes education and training, where required, for managers, supervisors and shop stewards to carry out the policy.
- The HIV and AIDS policy includes a budget to allocate resources required to fulfil the various elements of the policy.
- The HIV and AIDS policy includes potential partnerships (for example, with government departments, non-governmental organisations, AIDS service organisations, etc) to share expertise and resources in implementing the policy.

You have been asked to address a meeting with employees to explain the function and purpose of an HIV and AIDS policy, to motivate staff to be aware of the contents of the policy, and to support HIV and AIDS workplace programme activities in the future. You see it as an opportunity to couple it with awareness around HIV and AIDS at the workplace. You have only been given five minutes on the agenda to do this. How will you engage your audience? How will you explain why you think your workplace ought to have an HIV and AIDS policy? What will your key messages be to motivate staff to interact with the policy?

Step 9: Monitor and evaluate the policy

How do we ensure that our policy is relevant to the organisation, is up to date, and is being applied? When compiling an HIV and AIDS policy it is critical that you include a clause that deals with monitoring and evaluation. The issues around the HIV and AIDS pandemic are changing and dynamic, and it is important to acknowledge this in the policy. You may want to add a subsection within your policy – “Review of policy”. In this subsection, state the frequency of the review as well as reasons for the changes, for example:

- to take new submissions on the policy
- to implement changes in legislation, regulations or codes of good practice
- to plan and discuss any activity to further the intention of the policy

Monitoring and evaluation does call on all those responsible to keep abreast of new trends, and it may be important to discuss how this will be done – and who will be responsible for gathering this data. Monitoring and evaluation also extends further than just the policy – it also requires one to look at the quality of the HIV and AIDS workplace programmes being implemented.

Just as you would ensure that you built into your HIV and AIDS policy a component of review, so too, when designing an HIV and AIDS workplace policy and programme, would you build into it monitoring and evaluation tools, in order to measure its success.

Five-step process to monitor and evaluate your HIV and AIDS policy and programme:

1. Set goals and objectives

The objectives should be SMART: Specific, Measurable, Achievable, Realistic and Time bound. They should reflect the development of activities and inputs, and design results and outputs. Together, all the objectives should meet your overall goal.

2. Select indicators

By identifying indicators, we are identifying markers, which will tell us whether we are meeting our objectives. These indicators should:

- measure effectiveness – whether you are doing what you said you would do
- measure efficiency – whether you are utilising resources in the most cost-effective way
- measure the impact of the programme on the target group

3. Means of verification

This describes the tools that are necessary to measure the programme we are running, for example, questionnaires, case studies, condom distribution, registers of attendance at STI clinics, percentage of staff accessing ARVs, etc.

4. Put into action

This step requires you to think about how you are going to action the monitoring and evaluation process. You will need to consider:

- who – internal vs external staff
- developing terms of reference
- choosing the appropriate evaluation method
- implementing the evaluation

5. Use the results

The results of the evaluation are important as they will direct your future plans regarding the current programmes you are running and will also guide the revision of your HIV and AIDS policy.

ISSUES TO CONSIDER WHEN DEVELOPING YOUR POLICY

It is important that an HIV and AIDS workplace policy is appropriate and relevant to the workplace for which it is being developed. Although the law and principles guide the content, there will be differences in the HIV and AIDS workplace policies of, for example, a large corporate mining company, a school, a hospital, a large transport company, a small private business, and a non-governmental organisation. Below are some key issues which need to be discussed and agreed upon to ensure that your specific circumstances are taken into account. [Module 10: Joint problem solving, emphasises the need for consensus in decision-making.]

■ **Considering what the established business practices are:**

How will your HIV and AIDS policy relate to the established business practices within the organisation, department or institution? Building your policy around established practices leads to consistency, understanding and acceptance. Employers agree that an HIV and AIDS policy should be in a context that is understandable and acceptable to employees. If so, how will this policy relate to future policies?

■ **Taking into account a situation where there is no previous experience of written policy documents:**

Many small employers do not have formal, written policies. If this is the first formal policy of your company, it may be useful to develop your policy within the context of the following questions:

- Why have you decided to have an HIV and AIDS policy?
- Why now?
- How do you want your HIV and AIDS policy to be received?
- Should your policy have a formal or an informal tone?
- Will there be more policies in the future?
- If so, how will this policy relate to future policies?

■ **Choosing to integrate HIV and AIDS within existing policies or choosing to develop an HIV-and AIDS-specific policy:**

Some employers include their HIV and AIDS policies within general policies on life-threatening illnesses or disabilities; others have chosen to have a specific HIV and AIDS workplace policy.

■ Organisations that have chosen to integrate HIV and AIDS into existing policies argue that there is no reason to treat HIV and AIDS differently from other major illnesses – a policy covering all life-threatening illnesses is preferable. Generally, HIV and AIDS, cancer, heart disease or other life-threatening illnesses are cited in such policies. Some employers prefer this approach because it affirms their concern about all major life-threatening illnesses without singling out or favouring one over another. However, HIV and AIDS can be cited as one example of the types of illnesses addressed by the policy.

■ Many employers have implemented various policies and programmes to promote health and safety among their employees. In some cases, employers have chosen to address HIV and AIDS as a health and safety issue. This may be a good time to review all your policies to ensure that they are in line with your position on HIV and AIDS.

■ Organisations that have chosen to develop an HIV-and AIDS-specific policy argue that a separate policy acknowledges that HIV and AIDS is a major health issue and highlights the employer's commitment to addressing it in an appropriate way. A separate policy acknowledges the potential impact of HIV and AIDS in the workplace. It also addresses employee concerns that are specific to this disease by stating clearly that HIV is not casually transmitted and that employees with HIV or AIDS are not a health risk to their co-workers. As with more general life-threatening illness policies, HIV-and AIDS-specific policies protect the rights of employees who may be infected, provide guidelines for management, and encourage sensitivity and understanding among co-workers. Yet, by addressing the issues that are specific to HIV and AIDS, the policies can help to alleviate employee fears and misperceptions that may be specific to this disease. The policy itself represents the basic principles of an educational programme about HIV and AIDS.

■ **Determining the goal of the policy:**

The HIV and AIDS task team need to discuss and agree upon the overall goal of the HIV and AIDS policy. What is the goal of the policy? What does the organisation hope to achieve with the HIV and AIDS policy? What are the various objectives of the policy which will assist in meeting the agreed goal?

An example of an HIV and AIDS policy goal

The goal of the HIV and AIDS policy is to reduce the impact of HIV and AIDS upon our working environment. This will be achieved by: (i) programmes to prevent or reduce the spread of HIV and AIDS among employees; and (ii) programmes to support and care for employees infected with HIV and AIDS.

■ **Determining guiding principles:**

As previously discussed, principles are standards upon which an HIV and AIDS policy is based, and which will guide the development of the HIV and AIDS policy. An organisation should select a few principles which form the basis of the policy and which will be reflected throughout the HIV and AIDS policy. An example of a principle could be the principle of non-discrimination on the basis of HIV and AIDS.

■ **Determining elements of the policy:**

Finally, the HIV and AIDS task team needs to agree on the various elements of the HIV and AIDS policy. For example, decisions need to be made regarding what types of prevention and treatment, care and support programmes the organisation will provide for employees. However, these elements can vary in terms of their content, and organisations will need to consider their budgets and resources to agree upon the content of the various policy elements.

CHALLENGES IN THE DEVELOPMENT AND IMPLEMENTATION OF AN HIV AND AIDS WORKPLACE POLICY

In Modules 12 and 13, we focused on the design and the process involved in the development of an HIV and AIDS workplace policy. However, due to the complexity of HIV and AIDS (in terms of, for example, prevention, management and treatment), this is not always an easy, straightforward process. There are also a number of challenging questions which need to be taken into consideration when developing and implementing a policy. While the law, legal precedents, principles, guidelines and checklists are helpful, the real challenge lies in the position the organisation takes on certain issues, and how to translate these into practice.

In this section we highlight some of these challenges. You can make use of this section to prepare your workplace response to HIV and AIDS. These challenges relate to issues/dilemmas around finances, resources and logistics; the varied interpretations of rights; and the complex areas of treatment, care and support – and the responsibilities of employers in this respect. Often the key challenge for many organisations is reconciling their core business and all that comes with it (targets, profit, efficiency, cost-effectiveness, etc, in a highly competitive world) with the demands of an effective, fair, humane and socially responsible HIV and AIDS programme.

Organisations are further being challenged to weigh up complicated cost-benefit factors, for example, is it more cost-effective to provide antiretrovirals and other resources to ensure the wellbeing of HIV-positive employees than it is to replace them (and the skills and training which have been invested in them)? In addition, HIV and AIDS is a dynamic, changing field and there are many issues surfacing which would not necessarily have been dealt with in policies developed years ago. Hence, policies need to be revised periodically.

The challenges involved highlight why it is important that a representative team is involved in the development of the policy to ensure that there is, as far as possible, consensus and buy-in from all sectors of the workforce.

In the table below we identify some of these challenges and provide a range of questions to assist in exploring the issues at hand. [In exploring these issues it would also be useful for you to refer back to Modules 9 and 12 for the legal framework, organisational practices and guiding principles.]

Challenge ⁹	Some useful questions to ask
The organisation's position on voluntary counselling and testing (VCT) for HIV.	<ul style="list-style-type: none"> ■ Should VCT be provided on site? Who would do it? ■ Who would pay for the training of the VCT provider? ■ How does one ensure the confidentiality of the employees' results? ■ If VCT is not to be provided on site, should arrangements be made by the workplace for employees to have the test elsewhere? ■ Should employees be given time off to seek VCT elsewhere? ■ What is the employer able to offer once people know their status? ■ Should the organisation set targets to try to get a certain quota of employees to have VCT within a stipulated period of time?
Recruitment and selection policies in respect of persons infected with HIV and AIDS.	<ul style="list-style-type: none"> ■ Can a job applicant be required to test for HIV? ■ Can job applicants be required or requested to reveal their status? ■ What provisions should be made to protect voluntary disclosure?
The training, education and development of employees infected with HIV and AIDS.	<ul style="list-style-type: none"> ■ How do we ensure that training and education meets the specific needs of PLHAs? ■ Should an HIV and AIDS policy be more specific in its application, making distinctions between people at different stages of the disease?

⁹ HEARD (2002). AIDS Brief. HIV/AIDS in the workplace – for Human Resource Managers.

Challenge	Some useful questions to ask
<p>The interpretation of the terms reasonable accommodation and dismissal for incapacity as a result of HIV and AIDS.</p>	<ul style="list-style-type: none"> ■ Have staff been trained in the application of universal precautions? ■ Are there leaflets, posters and other information material visibly displayed to promote universal precautions? ■ Are there well-stocked first aid kits and are rubber/latex gloves immediately accessible for emergencies? ■ Have there been education and awareness programmes about transmission and prevention? ■ Are condoms (male and female) provided in discreet but accessible places at the workplace?
<p>The establishment of structures to manage the policy and its programmes.</p>	<ul style="list-style-type: none"> ■ Has a representative task team been formed? ■ Is management willing to provide resources for the task team to function effectively (for example, time off to meet, attend training, access to stationary, photocopiers, etc)? ■ Have performance targets been adjusted to accommodate the task team's efforts? ■ Is management willing to sponsor research and bring in outside experts, and to put effort into finding out what is happening within the sector and at other workplaces? ■ What is the role of the human resource and occupational health departments?
<p>Organisational involvement in promoting good health for HIV-positive employees in the workplace.</p>	<ul style="list-style-type: none"> ■ Have resources been provided for education and training, bringing in outside experts, purchasing and reproducing material, or running workshops with staff? ■ Is there an alignment with health and safety policies? Is there a system of referral?
<p>The organisation's position on the provision of antiretroviral (ARV) and other medication.</p>	<ul style="list-style-type: none"> ■ Does the workplace provide ARVs? Does it subsidise shortfalls where medical aid provision is limited? ■ Are ARVs provided to the families of employees? ■ If an employee receiving ARVs leaves the organisation, does the commitment to the provision of ARVs cease? ■ Who medically monitors the employee on ARVs? ■ The provision of ARVs usually involves voluntary disclosure. How does the workplace promote this? ■ How does the workplace safe-guard the confidentiality of the employee? ■ Who is privy to the information? ■ What happens if the employee leaves the organisation, because of retrenchment, dismissal, retirement or incapacity?
<p>The organisation's position on any special leave benefits for PLHAs and employees with HIV-positive family members, for example, additional sick leave, family leave or annual leave.</p>	<ul style="list-style-type: none"> ■ What is reasonable? ■ How does this relate to the organisation's leave policies and benefits? ■ What is cost-effective? ■ What precedents are there at other workplaces? ■ Should HIV-negative employees be invited to donate a stipulated amount of their annual leave to PLHAs?

Challenge	Some useful questions to ask
<p>The organisation's responsibility to the families and partners of infected employees.</p>	<ul style="list-style-type: none"> ■ How does the organisation deal with HIV and AIDS as it affects the families of employees? ■ Are facilities available to employees also available to their families, for example, ARVs, wellness programmes or prevention programmes? ■ How does the company deal with orphans of employees who have died of AIDS?
<p>The organisation's position on involvement with the community.</p>	<ul style="list-style-type: none"> ■ What is the organisation's social responsibility programme and how has it incorporated HIV and AIDS? ■ What commitment is there to community-based programmes? ■ Can an organisation successfully tackle HIV and AIDS without involving the surrounding community?

INTEGRATING ANTIRETROVIRAL TREATMENT INTO WORKPLACE POLICIES AND PROGRAMMES

“An antiretroviral programme is one necessary and important component of a wider social response to HIV and AIDS in South Africa. The HIV epidemic represents both a crisis and an opportunity for the country – presently in the midst of profound and dynamic transformation. In this context, a commitment to scale-up the introduction of antiretrovirals must be viewed alongside a measured and multi-dimensional approach to HIV – one founded on a renewed commitment to prevention and to a broader social response to the structural conditions that influence vulnerability to HIV.”¹⁰

This section deals specifically with antiretroviral treatment (ARV) in the workplace. This is a complicated issue and a subject of much debate. Provision of ARVs presents an opportunity to save lives and reverse/delay the devastating effects on the workplace, employees, their families and the communities in which they live. Hence, ARVs urgently need to become an integral part of a workplace response to HIV and AIDS.

This section aims to give a broad overview of the issues and challenges that are facing the implementation of an ARV strategy in the workplace:

- **Part 1** begins with an introduction to some basic but important background information. This includes a brief introduction to ARV drugs, an overview of their provision in South Africa and an outline of some of the key factors which contribute to or detract from the effective implementation of an ARV programme.
- **Part 2** takes a closer look at a range of issues involved in integrating ARVs into workplace-based policies and programmes.

PART 1: AN INTRODUCTION TO ANTIRETROVIRAL TREATMENT

ARVs have transformed the experience of HIV for those with access either through the public or private healthcare system or through workplace programmes. In developed countries, where highly active antiretroviral treatment (HAART) has been available for several years, deaths and new cases of AIDS have fallen dramatically. ARVs, although not a cure, have changed the status of HIV and AIDS from being a life-threatening illness to a manageable, chronic disease.¹¹

In support of increasing access to ARVs, the World Health Organisation (WHO) has launched an international advocacy campaign, titled “3 by 5”. The aim of the campaign is for at least three million people in need of antiretrovirals to be on treatment by the end of 2005.¹²

The South African Operational Plan and the ARV rollout

HAART is expensive, but the net costs to government are significantly lower than the direct costs of providing HAART. This is because people on HAART experience fewer opportunistic infections (OIs) – thereby saving the government the costs of treating those OIs.¹³

On 19 November 2003, the Cabinet announced the adoption of the “Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa”. The plan includes the provision of free ARVs in the public healthcare system.

Currently, less than 10% of those needing treatment have access to therapy¹⁴, but it is hoped that the government rollout will make ARVs available to many more. Through expanded availability to voluntary counselling and testing, the aim of the Operational Plan is firstly to assist as many people as possible to gain knowledge of their status and secondly to provide individuals with the opportunity to take appropriate actions such as remaining HIV-negative, living positively with HIV and/or starting treatment.

A person can test at a voluntary counselling and testing site, in the prevention of mother to child transmission (PMTCT) programme, at a clinic that is offering reproductive health and STI services, at a primary healthcare clinic, a TB clinic, at an inpatient hospital or in a prison. Following positive diagnosis and staging, individuals may be referred for antiretroviral therapy at an accredited facility for management, care and treatment of HIV and AIDS. This approach, including separate VCT and ARV facilities, is necessary because of the complexities of safe and effective ARV provision.

¹⁰ Schnedier, H ed. (2003) Seminar Proceedings: “Scaling up the use of Anti-retroviral in the Public Sector: What are the Challenges?” Seminar hosted by the School of Public Health and Perinatal HIV Research Unit, University of Witwatersrand, 1 August 2003.

¹¹ Martinson et al. (2002) South African Health Review. Health Systems Trust.

¹² WHO (2003). WHO Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach. 2003 revision..

¹³ Nattrass, Nicoli, and Geffen, Nathan (2003). Providing antiretroviral treatment for all who need it in South Africa. CSSR Working Paper No. 42.

¹⁴ Department of Health (2003). Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. 19 November 2003.

ARV medicine prices

A study conducted by the Health Economics Unit, the Infectious Diseases Epidemiology Unit and the School of Public Health and Family Medicine at the University of Cape Town¹⁵ concludes that it is relatively effective to roll out ARVs. It calculated that ARVs cost R13 754 per Quality Adjusted Life Year (QALY)¹⁶ versus R14 189 per QALY for patients who do not receive ARVs. This costing corresponds with those concluded in other recent studies.¹⁷ For patients on ARVs, the lifetime cost was calculated to be just over R93 000, and off ARV just under R24 000 (for patients with CD4 counts less than 200 cells/ μ l). The study also found an increased average life expectancy for PLHAs on ARVs. The study concludes that ARV medicines account for approximately 50% of the lifetime costs. This is particularly important for the drugs that remain relatively expensive (such as Efavirenz, ddl and Kaletra). Viral load testing and personnel costs are other major cost drivers.

The national antiretroviral drug treatment programme aims to provide antiretroviral drugs to 1.2 million people, or about 25% of the country's HIV-positive population, by 2008. The total budget required for drugs, according to the Operational Plan of November 2003, will be:

Years	Millions (R)
2003/04	42
2004/05	369
2005/06	725
2006/07	1 118
2007/08	1 650

On 3 March 2005, the government awarded a £300 million tender, divided between seven pharmaceutical companies, to supply drugs for 500 000 patients in the public healthcare system by 2007.¹⁸ The larger part of the deal is with Aspen Pharmacare, which will supply the programme with eight of the 15 required antiretroviral formulations. Only one other generic manufacturer was included in the tender – Cipla Medpro will produce a proportion of the programme's supply of d4T tablets. The remainder of the drugs will be purchased from brand-name manufacturers.

The all-generic first-line treatment regimen, d4T/3TC and Nevirapine, will cost \$200 per year. If the regimen contains Efavirenz (supplied under a de facto monopoly by innovator company, Merck) instead of Nevirapine, the cost increases to over \$550 a year. If someone must be switched to the second-line treatment regimen of AZT/ddI and Ritonavir-boosted Lopinavir (Kaletra, made under a de facto monopoly by Abbott), the cost jumps to \$500 per year.

Currently ARVs are available through:

- small-scale, funded projects based throughout the country, for example, Treatment Action Campaign, Medecins Sans Frontiers, Absolute Return for Kids
- Department of Health – designated ARV sites (see Accredited Facilities for Comprehensive Plan for Management, Care and Treatment of HIV and AIDS, on CD ROM accompanying the curriculum). Provision varies from province to province according to resources and infrastructure
- private sector – medical aids, managed care schemes or self-payment
- workplace-based programmes – the mining and motor industries have taken the lead in this respect. This will be discussed in greater detail in the next section
- South African National Defence Force - through the Phildisa Programme

The role and goal of antiretroviral treatment

Antiretrovirals assist in restoring and strengthening the immune system and in decreasing the viral load. The best treatment approach is by using HAART (highly active antiretroviral treatment), which is a mixture of three or more drugs.

¹⁵ Cleary, S et al (2004). Cost-effectiveness of antiretroviral treatment for HIV-positive adults in a South African township.

¹⁶ The research used a multidimensional outcome measure that can capture the different effects of ART and no ART in terms of both quantity and quality of life, for example, by using the Quality Adjusted Life Year (QALY).

¹⁷ Natrass, Nicoli, and Geffen, Nathan (2003). Providing antiretroviral treatment for all who need it in South Africa. CSSR Working Paper No. 42.

¹⁸ South Africa awards antiretroviral supply contracts. 14 March 2005. Aids Map News.

Goals of ARVs

The primary goal of ARVs is to decrease HIV-related morbidity and mortality:

- The patient should be experiencing fewer HIV-related illnesses.
- The patient's CD4 should rise and remain above the baseline count.
- The patient's viral load should become undetectable (<400 copies/mm³), and remain undetectable.

The secondary goal is to decrease the incidence of HIV through:

- an increase in voluntary testing and counselling with more people knowing their status and practising safer sex
- reducing transmission in couples where one person is HIV-positive and one HIV-negative
- reducing the risk of HIV transmission from mother to child

ARV resistance

The HI virus is an RNA virus and replicates itself by translating its RNA into DNA. This process allows swarms of viruses with varying mutations to be produced. ARVs suppress viral replication of the virus by inhibiting the various enzymes responsible for this replication. If there is poor adherence or the person has been infected with a resistant strain of virus, these drugs might not work and the treatment then fails the patient. New treatments are then instituted and if poor adherence continues or if the virus is still resistant, treatment will fail and the patient will deteriorate as the immune system is depleted.

Recommended ARV regimens

Two ARV regimens are recommended for adults by the Department of Health in South Africa. These are:

- Regimen 1a Stavudine (d4T), Lamivudine (3TC) and Efavirenz (EFV);
- Regimen 1b Stavudine (d4T), Lamivudine (3TC) and Nevirapine (NVP); and
- Regimen 2 Zidovudine (AZT), Didanosine (ddI) and Lopinavir/Ritonavir (LPV/r).

Other uses of ARVs

The management of occupational exposure to HIV: People who work in an environment where blood or bodily fluid is handled (for example, health workers) have a low but measurable risk of HIV infection if there is accidental exposure to infectious matter. There is generally a two-drug regimen for post-exposure prophylaxis (PEP), except in circumstances where there is an extremely high risk (for example, a deep needle stick injury) where a three-drug regimen is advised.

The prevention of transmission of HIV in men and women who have been raped or sexually assaulted:¹⁹ All women and men, aged 14 and older, who seek access to ARVs within 72 hours of being raped should be offered AZT and 3TC to prevent HIV transmission. A third drug, Lopinavir/Ritonavir, is recommended where there is an extremely high risk.

When should an HIV-positive person begin taking antiretrovirals?

According to the South African National Guidelines (based on WHO Guidelines), the following people are eligible for antiretroviral treatment through the public health care system:

- People with a CD4 count less than 200 and/or people who have certain illnesses, irrespective of AIDS stage.
- People who are at stage IV "AIDS Defining Illness", irrespective of CD4 count (ie with opportunistic infections and AIDS-related conditions).
- People who are prepared and ready to take ARVs adherently.
- HIV-positive pregnant women.

¹⁹ Department of Health (2004) National Antiretroviral Treatment Guidelines. National Department of Health, South Africa.

Some important points to note about ARVs

The administration of antiretroviral treatment is a complicated process, and is not within the scope of this module. However, in order to understand how it could be integrated into workplace policies and programmes, there are some key points to consider:

- Antiretroviral treatment is a lifelong commitment: Once a person begins the medication, they need to be on it for life, even if their CD4 cell count rises to normal levels and their viral load is no longer detectable. However, a person may need to interrupt or change treatment if the side effects are intolerable. If treatment is stopped, all drugs should be stopped at the same time and restarted together. This will reduce the risk of the virus developing resistance to the medications.
- Antiretrovirals do not cure HIV and AIDS: ARVs can reduce the viral load to such an extent that it becomes undetectable, by current laboratory methods. The person is still HIV-positive, and can still infect others.
- Adherence is vital: Adherence means taking your medications correctly. If you don't, HIV might multiply out of control. Adherence means that medication must be taken according to the instructions – the recommended dose, at the recommended time and in the recommended way.

The term “adherence” is used in preference to “compliance”. Compliance implies a power relationship where the patient must comply with certain rules and medical advice. Adherence implies more ownership on the part of the patient; and assumes a partnership between the healthcare worker and the client.²⁰

Lack of disclosure, food insecurity, meal restrictions, side-effects, toxicity and a poor psychosocial environment are the main barriers to adherence.

Factors that may increase the success of antiretroviral treatment

It is best to delay treatment until the person understands the need for treatment and has demonstrated some form of adherence. Below are some of the key factors that can strengthen the success of antiretroviral adherence. It can be helpful to include some or all of these in your workplace-based programme:

- Information, education, counselling and support before starting treatment.
- The person needs to acknowledge and understand that they are now HIV-positive and that they need to be on treatment – as opposed to being in a state of denial.
- A belief in the benefits of ARVs.
- Realistic expectations of ARVs: it is not a miracle cure.
- An understanding of lifestyle changes (where appropriate) to improve efficacy.
- A clear understanding for the need for a lifelong commitment to treatment.
- Disclosure to a close person who can support and assist with adherence.
- Understanding the possible side-effects of the medication.
- A regime that can fit the person's lifestyle needs, such as daily routine and working patterns, for example, truck drivers, shift workers, etc.
- Regular health checkups with health providers trained in HIV monitoring.
- Support groups.
- Antiretroviral literacy programmes in an appropriate and accessible language.

ARVs are only one part of a larger picture

There is no doubt that ARVs are a remarkable breakthrough in the management of HIV and AIDS. However, they are not yet universally available to all PLHAs. People with a CD4 count of over 200, or people who do not have access to ARVs, should do what they can to stay healthy – eat healthily, exercise, stop drinking and smoking, practice safer sex, and go for regular checkups, especially for infections and other ailments associated with HIV, such as diarrhoea, thrush, shingles, skin conditions, etc. In addition, programmes that include TB and STI prevention and treatment and the treatment of opportunistic infections will all contribute to the health of an HIV-positive person.

²⁰ Centre for the Study of AIDS. (2004) Four-Day Course on Counseling for Antiretroviral Treatment Adherence, Trainers Manual. University of Pretoria.

At your current workplace, what are the challenges for an HIV-positive employee seeking access to ARVs? What are the cost implications to the organisation and to the individual? What are the potential psychosocial effects on the organisation and the individual?

PART 2: ANTIRETROVIRAL TREATMENT AND THE WORKPLACE

*“Treatment is the single short-term intervention that will make a difference to the way the HIV and AIDS epidemic unfolds, both in the workplace and in the communities within which we operate. Providing treatment is a direct challenge to the ignorance, denial and stigma that has fuelled the AIDS epidemic since inception.”*²¹

Anglo Medical Senior Vice President, Dr Brian Brink

According to the Old Mutual’s 2003 Healthcare Survey²², there has been a shift in the way employers have responded to HIV and AIDS management at the workplace. In the past, hopes were largely pinned on managing HIV through education and awareness programmes, but it was soon realised that a more comprehensive approach was needed. The survey reveals an encouraging trend towards HIV and AIDS being treated similarly or even preferentially to other chronic diseases, which is a shift in the response observed five years ago.

ARVs can make a significant contribution to dealing with the effects of HIV and AIDS. At the workplace, lives are saved, experience and skills are retained, absenteeism is reduced, and performance is relatively unaffected. Not only do ARVs make the difference between life and death, but a workplace can also avoid the traumatic, costly and debilitating phase of deteriorating health when a person develops AIDS. However, in a survey of 1006 companies in 2003, only 18% had a voluntary counselling and testing programme and a mere 6% provided ARVs. Approximately 30% of the firms reported higher labour turnover rates, 27% had lost experience and skills, and 24% had incurred recruitment and training costs because of the HIV and AIDS epidemic.²³

In this section we look at ways in which ARVs can be integrated into workplace policies and programmes.

The argument that an ARV programme is too expensive is losing ground. Various studies have shown convincing evidence that it is cost-effective to invest in an ARV programme. The basic argument is simple: HIV and AIDS results in lost productivity, sick leave, a drawn-out disability process and a loss of staff morale. The impact on dependents is also critical, with several studies indicating at least a 67% decrease in family income when a family member becomes infected; spiralling the family into worsening poverty. ARVs provide a wonderful opportunity to turn this scenario around. It costs more **not** to provide ARVs.

However, poorly designed strategies can potentially double the costs. Barker and Sanne²⁴ argue that unless the HIV-positive employee gets well on treatment, there is no real value to the organisation. In order to attain maximum benefit for both the employee and the organisation, an ARV programme needs to take into account several key factors. These are discussed in a series of eight articles, written by Barker and Sanne.

The points below highlight some of the key issues:

- **The importance of timing:** The sooner an HIV-positive employee is identified, the sooner savings in productivity can be realised.
- **Impact is increased through participation:** The more employees that come forward to know their status, the greater the impact and the more the company will ultimately save.
- **Strategies for the termination of employment:** Companies need to prepare a well-designed strategy for the termination of employment where necessary – this means negotiating reduced premiums with their disability provider and speeding up the payment of benefits when the employees most need it.
- **Choice of programme:** Companies are encouraged to choose or design a programme which allows the firm to benefit from potential savings as drug prices decrease. Many firms miss out on this opportunity by using medical aids and other fixed-premium models. Medical aids are still self-funding with the load pushed onto the employee.
- **The importance of the clinical management of ARVs:** Clinical management is vital to the process – this involves correct scripting and appropriate monitoring. Ongoing support for adherence is vital. Many companies use doctors without the appropriate specialist knowledge, resulting in drug resistance, lack of adherence and loss of productivity. This points to the need for training of medical practitioners, or the use of experienced HIV and AIDS workplace health management services.

²¹ As quoted in the Mail and Guardian, 28 November 2003 (www.mg.co.za/Content/13.asp?ao=24220)

²² Old Mutual Healthcare Survey, 2003.

²³ Bureau for Economic Research (2003). The Economic Impact of HIV/AIDS on Business in South Africa. Funded by the South African Business Coalition on HIV/AIDS (SABCOHA), researched and compiled by the Bureau for Economic Research (BER).

²⁴ Barker, C (Future Foresight) and Sanne, Dr I (HIV Consulting Specialists) (2003) wrote a series of eight articles in Business Report Online.

- **Networking and providing support:** Support to primary healthcare services enables them to provide care at the community level to ensure sustainability and better adherence support.

Different ways in which workplaces provide ARV programmes

The way an organisation chooses to incorporate ARVs into its policy and workplace programme depends on a range of factors: the size of the organisation; its proximity to health services (and accredited ARV facilities); the in-house occupational health infrastructure; health insurance policies; human resource infrastructure; profitability and financial status; and HIV prevalence in the organisation/locality.

There are many different models of workplace ARV provision. The following describes four different routes to implementing an ARV programme. In practice, there are variations and combinations in their implementation:

- **In-house provision:** The provision of ARVs by the company's in-house occupational health department/medical facility.
- **In-house/outsourced:** The provision of ARVs is subcontracted to a private HIV and AIDS health management service.
- **External – supported:** The provision of ARVs is negotiated through the company's medical aid/health insurance provider as a package. Some medical aids will subcontract to a medical practitioner, whereas others leave the choice with the employee themselves.
- **External – individually negotiated and/or referrals:** The company includes the promotion of VCT and ARV education as part of its workplace programme. The employee is either reliant on the public health system, or the employee's medical aid/health insurance as a privately negotiated package.

Each model has potential advantages and challenges. These need to be critically examined, and used to weigh up the best option for the organisation.

Advantages and challenges of different modes of ARV workplace provision				
mode of ARV provision	In-house:	In-house/ outsourced:	External – supported:	External – individually negotiated and/or referrals:
		The provision of VCT and ARV by the company's in-house occupational health department. An example of a company using this system is Goldfields.	The provision of VCT and ARV by an HIV and AIDS health management company. An example of a company using this system is Anglo American.	The provision of VCT and ARV with a negotiated package with the company's medical aid/health insurance provider, or employees seek ARV treatment from their own private GP through their medical aid cover.
advantages	<ul style="list-style-type: none"> ■ Can control quality of care; an integrated holistic approach – can provide wellness management; management of opportunistic infections; monitoring of side-effects; adherence counselling and support. ■ No loss of work time for regular checkups and CD4 blood counts. ■ Specialist ARV and monitoring. ■ Accessible progression from VCT to treatment. ■ Easier to measure the cost-effectiveness of the programme on productivity. 	<ul style="list-style-type: none"> ■ The employee's HIV and AIDS management is external to the company. ■ More equity – a single policy is applicable to the entire workforce, whether on medical aid or not. ■ Can control quality of care. ■ An integrated, holistic approach. ■ Minimal loss of work time for ARV and monitoring. ■ Accessible progression from VCT to treatment. ■ Easier to measure the prevalence and cost-effectiveness of the programme on productivity. ■ Confidentiality is maintained and feedback to the company is anonymous. ■ Access to specialist care. ■ Most health management companies provide a whole package including education, VCT and ARV management. 	<ul style="list-style-type: none"> ■ Can be less costly for smaller organisations. ■ The responsibility lies with the employee to negotiate treatment. ■ Confidentiality is maintained as negotiations are mostly through the individual and the health insurance company rather than via management. ■ The rest of the family might have better access to care. 	<ul style="list-style-type: none"> ■ Less costly and may be more affordable for small businesses. ■ Support and treatment is integrated with the public health service, and not dependent on employment. ■ Referrals and links with clinic and community-based self-help groups are more likely. ■ The rest of the family might have better access to care.
	challenges	<ul style="list-style-type: none"> ■ Need a well-resourced occupational health infrastructure. ■ Expensive and out of reach for many companies. ■ Issues around anonymity and confidentiality can deter employees from utilising the service. ■ What about the rest of the family? 	<ul style="list-style-type: none"> ■ Expensive (although the benefits outweigh the costs). ■ Need to ensure that the HIV and AIDS management service is bona fide and has access to experienced ARV health personnel. ■ What about the rest of the family? 	<ul style="list-style-type: none"> ■ Private GPs do not always have specialist ARV knowledge. ■ Pre- and post-test counselling is often inadequate or non-existent. ■ ARV education and support is minimal – it is left largely to the individual. ■ Employees need to take time off work for appointments. ■ Many medical aids have a ceiling on how much they will provide. ■ There are no incentives to:²⁵ <ul style="list-style-type: none"> – find more patients – offer high-quality treatment, which can result in an expense without benefits to the company ■ The benefits of decreasing drug pricing will not be passed on to the employer.

²⁵ Barker, C (Future Foresight) and Sanne, Dr I (HIV Consulting Specialists) (2003) wrote a series of eight articles in Business Report Online.

The costs for employers to provide antiretroviral treatment

Prior to 1998, people living with HIV and AIDS could be excluded by medical funds, HIV and AIDS benefits were limited or non-existent and there was a lack of confidentiality. In addition, few doctors were familiar with HIV and AIDS treatment and medical funds were unaware of how much HIV and AIDS was costing them and could not accurately budget for the future. Since 1998, law reform has prescribed medical funds to offer prescribed minimum hospital benefits. In addition, a substantial number of medical schemes are now in a position to fund ARVs because of price reductions.

However, most medical aids have a cap on ARVs. Some pay for up to R10 000, some more and some less. This means the patient is either forced to take a cheaper regimen and often suffer side-effects, or pay for the some months of treatment out of his/her own pocket. The table below compares five medical aid schemes:

Medical aid scheme	HIV and AIDS disease management	Monthly fee	Level of ARV cover
A	Depends on sub-scheme. Most sub-schemes will only cover limited costs.	R400 – R1 000	Limited
B	Most sub-schemes will cover unlimited costs.	R700 – R1 100	Full
C	Only one sub-scheme will cover the costs. This scheme covers unlimited costs.	R1 800	Full
D	Most sub-schemes will cover. One scheme will only provide the prescribed minimum. Some schemes limit the subscriber to the use of specific service providers. No sub-scheme covers more than a maximum of R35 000.	R400 – R1 700	Full or some
E	Two of the sub-schemes will cover. Both schemes will only provide the prescribed minimum and will cover a maximum of R10 000.	R700 – R1 100	Some

The corporate workplace response to HIV and AIDS

The earliest corporate responses to HIV and AIDS in South Africa came from the mining industry. Outside the mining industry, the first major company to respond was Eskom, the state-owned electricity corporation, which adopted an HIV and AIDS policy in 1988. In the late 1990s and early 2000s, other large South African companies launched comprehensive HIV and AIDS policies, or consolidated their previous ad hoc responses. In August 2002, Anglo American announced antiretroviral drug provision for all its HIV-positive employees, on the grounds that such an initiative was cost-effective. Since then, a number of other large companies have made similar announcements. While the response of large companies to HIV and AIDS varies, a number of surveys have indicated that the response of smaller companies lags behind that of larger corporations.

According to the survey "Treatment of HIV and AIDS at SA's Largest Employers: Myth or Reality"²⁶ conducted in 2004 by the Center for International Health and Development at Boston University²⁷, financial services and mining companies are leading in providing HIV and AIDS-related benefits. Thirty-four of the (52) surveyed companies have made estimates of the prevalence of HIV among their employees. Twenty-seven of the companies (52%) disclosed the estimates to the surveyors. The average prevalence at the 27 reporting companies was 15.7% and the weighted average was 16.1%. Of the 27 companies with 600 000-plus workers that know prevalence and utilisation rates, we found²⁸:

²⁶ Only 4% of employees at South Africa's largest companies enrolled in HIV and AIDS disease-management plans, survey shows. Available at http://www.kaisernetwork.org/daily_reports/rep_hiv_recent_rep.cfm?dr_cat=1&show=yes&dr_DateTime=01-18-05#2766

²⁷ The final report by Patrick Connelly will be published later in 2005.

²⁸ Personal communication with Patrick Connelly. Research Associate Center for International Health and Development at Boston University School of Public Health.

Number and percent of companies reporting prevalence, disease management programme (DMP) and ARV rates	23 (44%)
Number of employees at companies providing prevalence, HIV DMP and ARV enrollment rates	600 600
Average prevalence rate	12.96% (weighted 14.98%)
Assumed number of employees HIV-positive	79 967
Number of HIV-positive employees enrolled on HIV DMP	26 335
Percentage of HIV-positive employees on HIV DMP	29.72%
Number of HIV-positive employees receiving ARV	3 772
Percentage of HIV-positive employees on ARV	4.2%

According to a survey by the South African Bureau for Economic Research and the South African Business Coalition on HIV/AIDS, HIV and AIDS has had a significant adverse impact on the business practices of 9% of companies in South Africa, while 43% of companies predicted they would feel an impact from the disease within five years.

De Beers' most recent impact analysis reveals a cost to the company per HIV-positive employee of between US\$1 200 and US\$3 500 per year over the next 10 to 14 years. This includes direct employment-related costs such as absenteeism, lost productivity, medical costs, training and replacement costs, medical incapacity costs and the cost of HIV and AIDS management interventions, including treatment. There are also indirect costs such as the impact on safety, low morale of employees and the risk of suppliers and business partners being unable to fulfil their obligations to De Beers because of the impact of HIV and AIDS on their businesses, but these are more difficult to measure.²⁹

DaimlerChrysler foresaw a 2006 peak in HIV and AIDS-related costs and assessed the average cost of an HIV-positive person dying while employed at \$31 000, rising to \$126 000 in higher pay bands. This cost broke down as death and disability benefits (40%) and production loss (40%). The drug was estimated to amount to only 4%.³⁰

IBM South Africa via its intervention policy, reduced absenteeism by HIV-positive employees from 25 days a year to three. The firm expects its 10-year programme, now almost halfway, to save 42% of what the non-intervention cost might have been (Ibid).

If you were a manager of a big corporation, how would you deal with the economic impact of HIV and AIDS on the company?

Some experiences from the NGO sector

The HIV and AIDS epidemic is increasingly affecting the South African NGO sector. The Community Development Resource Association (CDRA)³¹ conducted a study into the experiences of managers in the NGO sector that found the following:

- NGOs in South Africa are beginning to feel the impact of the HIV and AIDS epidemic directly through employees becoming ill with HIV or dying with AIDS.

²⁹ De Beers Group HIV and AIDS Business Case-Study. 2005. Available at www.debeersgroup.com/NR/rdonlyres/145EDC19-BE01-44ED-ABA3-CF6681687418/767/DBHIVAIDS_CaseStudy05.pdf.

³⁰ Connelly, Patrick. Firms fill antiretroviral gap in South Africa. Center for International Health and Development at Boston University School of Public Health. Report in progress.

³¹ Community Development Resource Association (2002). A Resource for NGOs. Positive Organisation: Living and Working with the Invisible Impact of HIV/AIDS.

- Directors in the NGO sector find it difficult to terminate a worker's employment as they are seldom entitled to disability benefits or a pension fund payment on resignation.
- Directors are struggling to raise funds for staff benefits such as medical aids, pension funds and funeral policies.
- NGOs are experiencing increased levels of absenteeism, not only from staff ill with HIV or AIDS, but from employees having to take time off to attend funerals and care for relatives with AIDS.
- NGOs are experiencing loss of productivity.
- NGOs are losing valuable skills, experiences and contacts when staff members die.
- Directors spend an increasing amount of time dealing with the person with AIDS and his or her family, as well as with staff emotions.
- NGOs increasingly spend funds on HIV education and counselling for staff, on HIV and AIDS policy development and on financial assistance for funerals and orphaned children.

Many directors feel that the best they can do for their staff is to make sure they belong to a good pension fund and a medical aid prior to becoming HIV-positive. However, it is challenging for NGOs to raise donor funds for staff benefits. If you were the director of an NGO, how would you deal with issues of disclosure and the personal involvement of you and other members of staff with the HIV-positive person's financial challenges and medical treatment? How would you deal with the economic impact on the organisation in terms of absenteeism and loss of productivity, your own time management and resources, recruitment and training costs, policy development and staff benefits? How would you deal with the impact of HIV and AIDS on your constituencies as the result of your organisation's staff loss? In the long run, how do you believe HIV and AIDS will impact on the future of South African NGOs?

Some important points to think about with regard to antiretroviral treatment and the workplace

The need for a multi-pronged approach

There is no doubt that ARVs are a very important and effective way of minimising the impact of HIV and AIDS on the organisation and that it dramatically changes the quality of life for an HIV-positive person. However, ARVs need to be seen as one part of a broader HIV and AIDS workplace strategy and integrated into the continuum of care within the community in which the employee lives. The success of an ARV workplace programme depends on the strength of these other key components.

Key components that need to be put in place include:

- Regular, up-to-date and appropriate education and awareness around prevention and the promotion of prevention of mother to child transmission (PMTCT) as well as treatment, care and support.
- Voluntary counselling and testing.
- A living positively programme for PLHAs which includes lifestyle education and access to services to treat HIV-and AIDS-related illnesses to maintain good health and keep the CD4 count high, as well as in-house facilities to assist staff with their medication ie adherence support counsellors.
- A clear policy and a workplace programme which deals with stigmatisation and discrimination, and provides a supportive and enabling environment for people to disclose HIV status.
- Community and workplace awareness about the benefits of VCT and ARV.³⁰
- Confidentiality is vital in encouraging take-up. Employees need to know who is going to have access to personal information about their status. A clear and transparent policy statement needs to clarify this, and written permission should be sought from the employee if there is going to be any deviation from stated practice.
- Education and awareness about TB and STIs and their links with HIV and AIDS, in-house occupational health programmes, or referral points for the treatment and management of TB and STIs.
- A list of resources for VCT and ARV services based in the community, and the Department of Health in the locality with details of contact persons, opening times, etc. Some organisations that do not provide ARVs try to identify key referral points and negotiate an undertaking that employees will be given support and treatment from this particular service point.

³⁰ Day, JH et al., Attitudes to HIV voluntary counseling and testing among mineworkers in South Africa: will availability of antiretroviral therapy encourage testing? In *AIDS Care* (October 2003), Vol.15, No.5, pp. 665-672

A willingness to deal with difficult issues

ARVs are a lifelong commitment – once a person begins the medication, it needs to be taken for as long as it benefits the individual. Policies need to explain how the company proposes to deal with employees when they leave their employment. This includes employees who retire, who are boarded, who are retrenched, who leave voluntarily and who are dismissed. While provision is often made for retired and boarded employees, retrenched and dismissed employees are left out of the loop. This raises certain financial and ethical issues.

Another difficult area is the issue of who receives ARVs. International best practice suggests that the more comprehensive an ARV programme, the greater its impact. DaimlerChrysler South Africa, for example, includes both retrenched workers and the employees' families.

The necessity for an effective VCT programme

Careful monitoring of HIV-positive employees' health and CD4 blood count is the precursor to a successful ARV programme. In order to do this effectively, people need to know their status. An effective workplace ARV programme needs an effective VCT programme.

People need to be made aware of the advantages of knowing their status.

For a person who is HIV-positive:

- Living positively – understanding the need to make lifestyle changes to sustain good health and keep the CD4 count from dropping.
- Understanding the need to protect others from the transmission of HIV and oneself from re-infection, thereby increasing one's own viral load.
- Being able to monitor one's own health and seeking help when problems arise. Regular health checks and the measurement of CD4 cell counts enable a person to begin ARV at the right moment.
- Acknowledgement of one's HIV status is critical to the person's commitment to taking ARVs – an HIV test is the only way to determine one's status.

For a person who is HIV-negative:

- Being motivated and committed to staying negative.

Some organisations set quotas in terms of take-up for VCT, for example, over a 12-month period, 60% of their workforce will have undertaken VCT. This is written into their policy and becomes part of their workplace programme.

Because VCT is such an important part of the management of HIV and AIDS, people have argued that workplace-based programmes should make it compulsory for all employees to undergo the counselling part of the VCT process, in other words, compulsory counselling and voluntary testing (CCVT). What are your thoughts on the benefits, legality and ethics of this approach?

Questions to ask when integrating antiretroviral treatment into an HIV and AIDS workplace policy

- Who will provide the VCT and ARVs – which model (or combination thereof) is appropriate?
- What will it cost in terms of initial capital outlay? Is this provided for in the current/future budget? Will an NGO donor support staff benefits?
- Who will be covered by the policy – the employee, a spouse, a life partner and children?
- What happens if the employee leaves:
 - of her or his own accord?
 - through dismissal?
 - through retrenchment?
 - through retirement?

And what happens to the rest of the family if they are on the ARV programme as well?

- Is provision made for employees living with HIV and AIDS to have time off, especially if they are receiving their treatment from the public health sector?
- Is work structured to facilitate the taking of treatment, for example, is purified or filtered water made available for staff to maintain their fluid intake and is nutritious food, time off for clinic attendances, counselling and adherence support available?
- Is the ARV programme part of a broader programme which includes VCT, wellness management, PMTCT, STI and TB education and access to treatment, and drug adherence support and education?
- What active steps is the company taking to create an enabling environment for employees to access VCT and treatment without discrimination and fear of discrimination and stigmatisation?
- In order to benefit from the provisions for ARVs outlined in the policy, to whom must the employee disclose and what guarantees are there in place to ensure confidentiality?

One of the main barriers to employees benefiting from ARVs is the fear of identifying themselves as being HIV-positive. This is because of the fear of stigmatisation and discrimination. What do you think could be done to address this issue?

Some examples of how different workplaces have provided access to treatment

Note: These examples draw out certain themes as examples of different approaches. They do not attempt to describe the full detail of each programme; they also only represent a small sample of the many organisations in South Africa that have ARV programmes.

The use of a private health service provider or “third-party” partnerships

- Anglo American has a workforce of more than 100 000 employees and an HIV prevalence rate of about 30%. A comprehensive HIV and AIDS workplace programme was developed. The provision of ARVs started in 2003 in partnership with a private health service provider, Aurum Health Research. At the end of the year, about 1 000 employees were receiving ARVs and a further 3 000 were participating in the wellness programme. Anglo’s ARV programme has 58 delivery sites with 60 doctors, 137 nurses and 40 trained counsellors.³³ Since the initiation of the programme, less than 10% of HIV-positive employees opted out of participating in the programme, 90% adhered to the treatment, 89% have shown good viral suppression and experienced an increase in CD4 count and weight gain.³⁴
- Abbott Laboratories has an ARV workplace programme for employees, in partnership with Right to Care and Alexander Forbes Health Management Solutions. This is called the Direct AIDS Intervention Programme and it supplements the existing health benefits. These “third-party” partners administer the voluntary programme to ensure full employee confidentiality. The programme is free and consists of HIV and AIDS education, counselling, testing and comprehensive health management, including ARV treatment.³⁵

A negotiated package for HIV-positive employees

- Old Mutual employees who are HIV-positive are encouraged to join the Old Mutual Healthcare HIV and AIDS Disease Management Programme. This is voluntary and is open to employees whether they do or do not have health insurance. This programme provides both education and assistance with the management and cost of HIV and AIDS treatment. Provision, with an annual limit, is made for both chronic medication and pathology tests.³⁶
- Delta Motor Corporation facilitates VCT and ARV through the Life Sense and Aid for AIDS programmes run by Sizwe and Vulamed respectively.

³³ Mail and Guardian, 28 November 2003.

³⁴ George, Gavin. April 2004. ART in the workplace. HEARD all about it, the Newsletter for the Health Economics and HIV AND AIDS Research Division of the University of KwaZulu Natal, Durban. Issue No 10

³⁵ abbott.com/citizenship/gcr_2002/7-6.htm.

³⁶ HEARD (as above)

In-house healthcare

- Gold Fields, the country's second-biggest gold producer, has begun rolling out an ARV programme. Of its 50 000 employees, 16 000 (25%) are HIV-positive. Gold Fields has developed an in-house HIV and AIDS management programme which includes ARVs. A major investment has been made in the training of healthcare personnel, with an emphasis on personalised care, confidentiality and adherence counselling.³⁷ Management support and leadership was also displayed when the Gold Fields CEO took an HIV test while visiting the company's mining sites.
- Anglo Gold has estimated that 25-30% of its 38 000 workforce is HIV-positive. In response, it has launched a massive R7.4-million workplace programme that includes awareness campaigns, training of peer educators, treatment of STIs, a wellness budget including ARVs, and home-based care.³⁸

A tertiary institution providing ARVs

- The University of KwaZulu-Natal has become the first tertiary institution in South Africa to provide ARVs to HIV-positive students. A study in 1999 estimated a 16% prevalence rate among its 40 617 staff and students. In this innovative scheme, the students pay R50 a month, which gives them access to HIV and AIDS management care, including ARV, counselling, medication, blood tests and doctor's consultations. The average monthly cost for this treatment is R800. The university also has an AIDS Treatment Fund. Part of the funding for this is generated through the deduction of R30 from each student's fees. In the first three months of the 2004 academic year, more than 250 students underwent VCT.³⁹

A public-private partnership with a strong outreach component

- The average HIV prevalence at DaimlerChrysler South Africa (DCSA) was estimated at 9% in 2001. DCSA entered into a three-year (2001-2003) public-private HIV/AIDS Workplace Project with support from GTZ, a German donor and aid organisation. In addition to providing ARVs to employees, this now includes treatment for retrenched employees and their families. The programme includes VCT, the treatment of STIs and TB, working with traditional healers, the redesign of its medical aid plan to accommodate increasing medical costs, revised funeral and disability benefits, and an employee attendance scheme which rewards employees who do not take time off.

Key outcomes include:

- A total of 75% of employees had an HIV test to determine their status, with 40% using the DCSA on-site VCT services.
- The mortality rate of DCSA employees and family members on ARV is similar to that of North America and Europe, with a four-year survival rate of 90%.
- None of the babies born to mothers on the PMTCT programme were HIV-positive.
- The TB cure rate improved from 40% to 100% using an on-site Directly Observed Treatment-Short Course (DOTS) TB programme.
- The incidence of STIs decreased by 50% among employees using the on-site occupational health services STI treatment services.
- A 56% reduction in HIV and AIDS mortality was achieved during the project period.
- Absenteeism has declined and productivity has increased.⁴⁰

³⁷ HEARD (as above)

³⁸ Sunday Times, 19 January 2003. Financial Mail, 6 December 2002

³⁹ Sunday Times, 25 April 2004 <http://www.sundaytimes.co.za/2004/04/25/news/news27.asp>

⁴⁰ <http://www.daimler-chrysler.co.za> www.daimler-chrysler.co.za.

The inclusion of spouses and life partners, and the use of a network of private doctors

- De Beers' commitment to HIV and AIDS is expressed as follows: "If a De Beers employee and a spouse or life partner tests HIV-positive, we are committed to a holistic continuum of treatment, care and support, where this is provided in a responsible and sustainable manner." VCT, confidentiality and non-discrimination are emphasised in their statement of principles.⁴¹ This is provided free of charge and includes monitoring and appropriate medication. The company has extended the network of participating medical practitioners beyond the mine medical facilities to ensure that those registered on the programme have access to trained doctors in the areas where they live or work. A specialised private healthcare management provider supports the doctors in the network to ensure that the quality of treatment complies with international best practice. The service provider renders additional support and counselling to PLHAs participating in the scheme.⁴²

The use of VCT to drive an HIV and AIDS programme

- BMW South Africa opted to establish the HIV prevalence rate through the use of its VCT programme, which includes intensive pre- and post-test counselling. This enables employees to benefit from the counselling, wellness programmes and treatment.
 - *"The success of the testing campaign rests on a spirit of caring, openness and confidence between colleagues. Individuals and teams have fully subscribed to the 'Lead by Example' campaign and have volunteered to be tested in order to encourage the rest of the workforce to come forward without fear of any form of discrimination. Departments have challenged one another to achieve maximum test numbers and this positive spirit, together with word of mouth, has proved very effective in encouraging employees to be tested."*⁴³

Some key messages to communicate to employees taking ARVs⁴⁴

- Have a treatment helper (a buddy) – before you begin treatment, make sure one person knows your status and that you are taking ARVs. This person will then be able to provide support and ensure adherence.
- Take treatment at the same time every day, all the time – by forgetting to take your treatment, you decrease the effectiveness of the treatment. If you work shift work, plan with your adherence counsellor how best to take your medicine.
- Do not share your medicines – each person is different, and your combination dosage has been worked out as the best for you. Also, the ARV medication needs to be a triple combination of medicines – check and make sure with your counsellor that you understand what you are taking.
- It is best to stop drinking alcohol before starting ARV – alcohol weakens your immune system and can make you forget your medicine. Do not stop your medication if you have the occasional drink ("safe drinking" refers to an occasional drink in moderation).
- Protect yourself and others – always use condoms when you have sex (even when you have sex with another HIV-positive person). Being on treatment does not mean that you cannot pass on the virus.
- Have regular checkups – communicate any changes and anxieties about any symptoms to your healthcare provider.
- Inform your healthcare provider if you are taking any other medication or treatment, including traditional/herbal medicine.
- Understand and look out for side-effects – some side-effects are stronger in the first few weeks of taking ARVs for the first time and will disappear over time, others may be uncomfortable but harmless, while others may be more serious and are a sign that you need careful monitoring and may need to change one or more of your medicines.
 - **Side-effects include:**
 - Nausea and vomiting – most common in the first weeks or months of anti-HIV treatment.
 - Diarrhoea – most common early in treatment. Call your doctor if diarrhoea lasts for more than three days.

⁴¹ www.debeersgroup.com/operatons/opsHIV2.as

⁴² www.debeersgroup.com/operations/content/DeBeersTreatment.pdf

⁴³ www.bmw.co.za/Info/News/Aarchives/hiv.html

⁴⁴ Soul City and Khomanani: HIV and AIDS and Treatment, 2004

- Rash – rashes are common among people who start taking anti-HIV drugs. Usually they go away by itself. It is important to note that a rash could be a sign of an allergic reaction to a drug. If you get a rash after taking these drugs, call your doctor right away.
- Problems falling asleep or staying asleep.
- Fatigue.
- Dry skin and/or ingrown toenails/renal calculi sometimes happen with Crixivan.
- Pain, numbness, tingling and/or burning in the hands and/or feet.
- Kidney stones sometimes occur in people who take Crixivan; side-effects may also include changes in the way your body deals with fat, including a range of symptoms such as developing a roll of fat between the shoulders (“buffalo hump”), enlarged breasts and losing fat in the face, arms and legs.

TUBERCULOSIS IN SOUTH AFRICA

- Basic information on TB
- Current status relating to TB in South Africa
- Management of TB in the workplace

INTRODUCTION TO SUB-MODULE ON TB

Background on Tuberculosis

Tuberculosis (TB) is a major public health problem in South Africa. In 2004, the World Health Organization (WHO) ranked South Africa fifth among the world's 22 high-burden TB countries. South Africa had nearly 265,000 TB cases in 2004, with an incidence rate of 718 cases per 100,000 population (up from 558 in 2002)¹. The number of TB cases in South Africa is likely to further increase over the next few years due to HIV and AIDS.

TB/HIV co-infection rates are high, with as many as 60 percent of adult TB patients HIV-positive. Multidrug-resistant TB (MDR-TB), largely caused by non-adherence to drug regimens or inappropriate drug regimens, is further exacerbating South Africa's TB epidemic. National studies of MDR-TB conducted by the Medical Research Council found that 1.8 percent of new TB cases in 2002, and 6.7 percent of cases in re-treatment, had MDR-TB. With such rates, approximately 6,000 new cases of MDR-TB could be expected in 2005².

History of Tuberculosis

Where and when humans first became afflicted with TB is unknown, but it appears to have existed for several thousands of years. Ancient Hindu texts (3 000 BP) refer to TB as Rogaraj, the king of disease and Rajayakshma, the disease of kings. The first of these names emphasize that this disease was, and in many countries still is, the leading cause of death in human societies. The second name stresses that TB, being an infectious disease, strikes indiscriminately and affects kings as well as ordinary people.

A German doctor, Robert Koch (1881) first identified, the organism that causes TB in humans. He named the organism *Mycobacterium tuberculosis* that means 'fungus-bacterium' because of the fungus-like membrane that the bacteria produce when grown on a liquid media. The organism that causes TB in cattle *Mycobacterium bovis* and other animals, as well as in humans, is very similar and this led to the idea that cattle were the original source of TB infection in humans. Cattle were first domesticated in the Mediterranean basin approximately 7 000 years ago and the early settlers of this area may have developed TB from drinking milk or eating infected cattle flesh. Archaeologists have identified skeletal TB of the spine in prehistoric populations from Egypt, Peru, Canada, Germany, Denmark and in Britain.

BASIC INFORMATION ON TB

What is Tuberculosis?

Tuberculosis, also known as TB, is a disease spread through the air by a person with TB of the lung. Small droplets of infected sputum are spread, through coughing, spitting or sneezing, into the air and breathed in by other people. As a result, anyone can get TB. The symptoms of TB may include; a persistent cough of more than 2 weeks, loss of weight and appetite, night sweats, feeling tired and weak, pain in the chest, short of breath, lumps or swellings, a fever that comes and goes, or coughing up blood³.

Scientists estimate that one new TB patient infects about three others before they start their treatment and that those who drop out before they are cured infect ten others before dying or presenting themselves for treatment again⁴.

¹ Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report 2006. Geneva, World Health Organisation.

Weyer K. The management of multidrug resistant Tuberculosis in South Africa. 2nd edition June 1999.

² Department of Health. Available at <http://www.doh.gov.za/tb/docs/mdrtb.html>

³ Department of Health. Stop TB...because you can. Khomanani. Pamphlet.

⁴ source: TB Annual Report 1997-1998:1

How to get help if you think you have TB

If a person thinks they have TB they should contact their nearest clinic or local doctor. At the clinic, the staff will ask for a sputum sample to determine if the patient has TB. If the results of these tests are positive for TB, the patient will be given TB medication. TB treatment is free at government hospitals and clinics. Once a patient starts TB treatment they will be asked to attend the clinic on a regular basis until they are well and the treatment is complete. TB can take between 6 – 9 months to cure.

While a patient is on TB treatment, they will be encouraged to find someone to support them throughout the process of treatment. This can be a friend, relative, colleague or member of the community. This person is called a DOT supporter – as they provide Directly Observed Treatment.

While on treatment, patients are encouraged to eat enough, eat healthy food, get fresh air and rest.

Can TB patients still go to work?

TB patients can go back to work when they have started treatment and are feeling better. They will not infect others. Many people will be ready to return to work after 2-3 weeks of treatment.

Who is at risk of getting TB?

Anyone can get TB but some people are more at risk than others. People at risk are those who:

- Share the same breathing space with someone who has TB
- People who are underweight, or have HIV infection, or are ill with another disease
- People who are exposed to silica i.e. Mineworkers

Types of TB

Nearly two-thirds of the population of South Africa are infected with TB and people are often infected with the TB bacteria without being sick. Only one out of every ten people infected with TB will get sick with the disease, since most people's immune systems can control the bacteria for a lifetime. It is not always clear what causes an infected individual to develop active TB sickness. However, immunity is sometimes weakened by poor nutrition, excessive physical stress, old age, or HIV infection. In these cases, as people's immune systems weaken, TB takes advantage. If untreated, after a long period of suffering, people with TB usually die.

TB of the lungs, or pulmonary TB, is the most common form of the disease, but people also get TB of the spine, heart, kidneys, and other parts of the body. Only those with TB of the lungs can spread the disease to others⁵.

Developing new drugs for Tuberculosis

The World Health Organization (WHO) has estimated that TB notification rates in sub-Saharan Africa are expected to surpass 200 per every 100 000 individuals by the year 2005. The reason for this is that patients do not comply in taking their medication for the full six months. Because of this only 60% of people taking TB drugs are cured. WHO have suggested that the pharmaceutical industry develop a drug regime that would last for 2 months and suggest that the cure rates would increase from 60% to 90%.

It is thought that the combination of a better drug and better detection of new cases of TB would reduce the incidence of TB by 76% in the South African population⁶.

Why it is important to take medication?

It is very important that patients take the medication until the treatment is complete. Normally people are given medicines for 6-9 months. After the first 48 hours of taking TB medicine people feel well, this is because 90% of the TB bacteria are killed by the medicine. It is important that patients continue to take the remaining medicine so that last 10% of the TB bacteria are killed. Scientists are aware that the last 10% of the TB bacteria are the most difficult to destroy and this is why the treatment program lasts for such a long time. If patients stop taking the medication after the first month they will still have a TB infection and can then develop resistance to the TB drugs.

⁵ Source: National TB Control Programme 1997-1998:3

⁶ source Dr Chris Dye. STOP TB-WHO http://www.hopkins-id.edu/tb_rpt/report_02.html

CURRENT STATUS RELATING TO TB IN SOUTH AFRICA

Tuberculosis in Africa and southern Africa

In their 2006 reports on the TB epidemic, the WHO paints a bleak picture of the global failure of health service providers to deal with the burden of TB. Data collected from 200 members of the 211 member countries of the WHO showed that in 2004 there were an estimated 9 million new cases of TB. This represents a rate of 140 cases among every 100 000 persons. There were approximately 2 million TB deaths in 2004.

In Africa the case rate is 356 per 100 000. The African region accounts for 24% of all notified new and relapsed cases and similar proportions of new smear-positive cases in 2004. SubSaharan Africa has among the highest rates of TB in the world. Among the 22 highest-burden TB countries, nine are in subSaharan Africa, including Nigeria, Ethiopia, South Africa, DR Congo, Kenya, Tanzania, Uganda, Zimbabwe and Mozambique. The HIV and AIDS pandemic in Africa, where rates of HIV and AIDS are the highest, is fueling the rapid spread of TB. Nearly 70 percent of those co-infected with TB and HIV/AIDS live in sub-Saharan Africa. HIV and AIDS is the single most important factor determining the increased incidence of TB in the last 10 years and South Africa has been identified by WHO, in its latest report on global drug resistant TB, as one of the ten MDR-TB hotspots⁷.

The 11 countries of the Southern Africa subregion contribute approximately 275 000 cases every year to the total case load in Africa. Almost half of these come from South Africa. In an analysis of TB trends and the impact of HIV infection on the situation in the subregion, it is estimated that by 2001 the smear positive case rate would have increased from 198 per 100 000 population for the region as a whole, to 681 per 100 000 if TB control efforts are not optimised. To aggravate the situation, 69% of these cases would be directly attributable to HIV infection.¹

Epidemiology of TB in South Africa

South Africa is burdened by one of the worst TB epidemics in the world, with disease rates more than double those observed in other developing countries and up to 60 times higher than those currently seen in the USA or Western Europe. The Medical Research Council (MRC) estimated that the country had an estimated 180 507 cases (55% reported) in 1997, or 419 per 100 000 of the total population. Of these, 32,8% (73 679 cases) were probably infected with HIV. Although South Africa has lagged behind other African countries in terms of HIV incidence, probably because of geographical, social and political barriers, the HIV epidemic has increased rapidly and exponentially during the last 6 years.

The TB problem in South Africa is largely a result of historical neglect and poor management systems, compounded by the legacy of fragmented health services. Prior to the introduction of the Tuberculosis Register in 1995, cure rates were unknown, and consequently control efforts could not challenge poor performance. The implication of this failure is evident from the fact that in 1997 a cure rate of only 54% could be recorded, with the consequence of continued high rates of transmission in the country⁸.

Table 1: Current status relating to TB in South Africa⁹

KEY INDICATORS	
Population (thousands) ^a	47208
TB Burdens (2004 estimates)^b	
Incidents (all cases/100 000 pop/yr)	718
Trend in incidence rate (%/yr)^c	8.5
Incidence (ss+/100 000 pop/yr)	293
Prevalence (all cases 100 000 pop)^c	160
Mortality (all cases 100 000 pop)^c	135
Prevalence of HIV in adult TB patients (15-49yrs,%)	60
New TB cases multidrug-resisitant (%) ^d	1.8
Previously treated TB cases multidrug-resisitant (%) ^d	6.7

⁷ Open Society Institute. Integrating HIV/AIDS & TB Efforts: The Challenge for the President's AIDS Initiative. Preliminary report for the U.S. Office of the Global AIDS Coordinator, February 2004

⁸ Source: Fourie, Dr B. Medical Research Council. <http://www.sahealthinfo.org/tb/tburden.htm>

⁹ Source: Fourie, Dr B. Medical Research Council. <http://www.sahealthinfo.org/tb/tburden.htm>

Demographic profile

TB is the leading infectious killer of youths and adults in South Africa and it is estimated that it kills almost 1 000 people every month. Although effective TB drugs have been available for decades in South Africa, and in nine cases out of ten TB is curable, TB in South Africa is still a major problem. The World Health Organization (WHO) declared that South Africa has one of the worst TB epidemics in the world because of the high rates of TB, increasing rates of HIV and the emergence of MDR- TB.

Estimates by the MRC National Tuberculosis Programme indicate that current trends in the epidemic will continue unless effective control is achieved, resulting in 3,5 million new cases of TB over the next decade and at least 90 000 patients dying. The financial implications are staggering: Given that more than US\$100 million are spent annually on TB in South Africa, in excess of US\$3 billion would be required over the next 10 years if current increases in TB rates are allowed to continue unabated. On the other hand, significant reductions in transmission of HIV infection together with effective TB control would mean a turn-around in the TB epidemic by the year 2003. At least 1,7 million TB cases will be prevented and more than US\$400 million would be saved.

Table 2: Statistics on TB in South Africa¹⁰

INDICATOR	NUMBER (PER 100,000 POPULATION).
1. Incidence of all TB cases / 100 000 pop/yr	718
2. Incidence (ss+/ 100 000 pop/yr)	293
3. Prevalence (all cases/100 000 pop)C	670
4. Mortality (deaths/100 000 pop/yr)C	135
5. Prevalence of HIV in adult TB patients (15-49)	60
6. New TB cases multi-drug resistant (%)d	1.8

Note: South Africa's population is 47, 208,000 in 2006.

Impact of TB/HIV co-infection

HIV and TB form a lethal combination, each increasing the other's progress. HIV weakens the immune system, creating a fertile ground for TB. TB is one of the most common AIDS-related opportunistic infections globally, and is the leading cause of death among people living with HIV and AIDS in South Africa. While HIV increases the lifetime risk of a patient getting sick with TB after being infected with TB (up to 60% in South Africa), TB also accelerates HIV's progression to full blown AIDS. HIV-positive TB patients have mortality rates that are two to four times higher than HIV-negative patients do, ranging from 6 to 39 % in sub-Saharan Africa. South Africa is facing one of the worst dual epidemics of TB and HIV in the world.

People living with HIV and AIDS can be screened for TB; if they are infected they can be given prophylactic treatment to prevent the development of TB or curative drugs if they already have the disease. TB patients can be offered an HIV test; indeed, research shows that TB patients are more likely to accept HIV testing than the general population. This means TB programs can make a major contribution to identifying eligible candidates for ARV treatment.

The threat of TB and MDR-TB to economic development to the developing world and South Africa are of great concern. WHO and its Stop TB initiative identify the following economic impacts of TB (in general) to include:

- Loss of work time, which is 3-4 months for a primary TB patient;
- 20 to 30 % of TB patients' annual household income is lost due to lost earnings.

In South Africa, lost earnings due to TB are estimated at 16 % of GDP per capita;

- About 15 years of income is lost from premature death; and
- 75 % of TB infections and death occur in the 15-54 year age group, which constitutes the most economically productive age group in the population. This has obvious negative implications for a country's work force and economic development.

¹⁰ WHO Report 2006. Global tuberculosis control: Surveillance, planning, financing

The cost of TB treatment in South Africa to the government was USD 2,570 per primary TB patient. Based on WHO's country profile of South Africa, the total costs of TB control in the country were estimated at around USD 300 million in 2003 alone. Health care costs for MDR-TB patients are estimated to be a hundred times greater than that of a primary TB case. Apart from the costs of diagnosing and treating MDR-TB to government, MDR-TB imposes additional economic costs on society, through the loss of wages and productivity, impacting on family incomes and need for children to work instead of attend school. Loss of wages and production are substantial given the long period of treatment (for primary TB is four to nine months and for MDR-TB if successful could be up to twenty four months).

The impact of TB/HIV co-infection in provinces such as KwaZulu-Natal, Mpumalanga and Gauteng, is leading to sharp increases in TB rates in these areas. Over the next 5 years the epidemiological profile of TB in South Africa is likely to change dramatically. Increasing rates are likely to continue, and will be more pronounced in provinces with fast-growing HIV infection rates. Optimal TB control efforts with high cure rates and a significant decline of more than 20% in the transmission of HIV infection will be required before stabilisation and eventually a downward turn in TB rates in the country might only become visible towards the end of this period.

On the positive side, however, TB was declared an emergency at a meeting in August 2005 by the African Health Ministers at the WHO-Afro regional committee meeting in Maputo.

The WHO Afro member states were urged to do the following:

- Implement, with immediate effect, emergency TB control strategies and plans
- Improve TB detection and treatment success rate, and reduce patient default rates to less than 10%
- Accelerate DOTS coverage
- Rapidly scale up joint TB and HIV control activities
- Expand national public and private partnerships for TB Control
- Improve the quantity and quality of the TB health workforce

In a speech by the Minister of Health, Dr Manto Tshabalala-Msimang at the World TB Day and Launch of the TB Crisis Management Plan, the Minister said that although South Africa participated actively in the development of the above resolution, she was worried that TB is still a major problem in South Africa where more than 270 000 people were suffering from the disease in 2004 and at least 12% of TB patients defaulted from treatment. The Minister indicated that the theme for 2006's World TB Day is: "Call for Action...Stop TB Now"¹¹.

The pace and extent of implementation of the programme is, however, slow in most provinces. Since 1996, a system of case registration based on strict criteria for case definition was implemented in South Africa. These registrations, based on standardised criteria, are now beginning to present a clearer picture of disease rates in the country than what was available before. Some progress is being made in certain provinces in South Africa. Mpumalanga (despite relatively high HIV rates) and the Western Cape are already showing dramatic improvements in cure rates, because of disciplined implementation of the DOTS strategy of the WHO in these provinces. Other provinces are at various stages of implementation of the process.

In comparison with the MRC estimates based on epidemiological modeling as mentioned above, actual registration reports to the National Department of Health indicated smear positive rates per province (per 100 000 of the total population) of 285 for the Western Cape, 300 for the Eastern Cape and 328 for the Northern Cape. All other provinces had rates below 200. The overall rate for South Africa was 163 for smear positive and 310 for all pulmonary TB cases. It suggests that the country might be in a slightly better situation than what had been estimated as the worst scenario. Also, it appears that the epi-centre of tuberculosis in South Africa is shifting away from the Western Cape, which had until recently been regarded as one of the regions with the highest TB rates in the world. Several factors might be responsible for this shift, including improved case-finding in the Eastern and Northern Cape, and/or more effective control procedures in the Western Cape.

Although the overall situation in South Africa still seems to be far less than optimal, these early signs of improvement could signal the beginning of better times for tuberculosis control in the country.

TB cure rate

TB cure rate is measured as the proportion of smear positive pulmonary Tuberculosis (PTB) patients who completed treatment and were proven to be cured. This means that they had two negative smears on separate occasions at least 30 days apart.

¹¹ Speech by the Minister of Health, Dr Manto Tshabalala-Msimang at the World TB Day and Launch of TB Crisis Management Plan. 24 March 2006, Durban

- All districts: No district achieved WHO target of 80%.
- 15 districts scored higher cure rates than the national target of 65%,
- 25 districts scored cure rates of lower than 50%.
- Rural Node Districts: Wide range in cure rates achieved - 72% to 30%. 5 districts scored above 50% and 3 districts scored above both the national average (56.7%) and target (65%).
- Metro View: Three of the 6 metros achieved cure rates of less than 56.7% , and only 1 over the national target.
- Provinces: One province achieved a cure rate above 65%, two were very close to the 65% target, and two achieved a cure rate of less than 50%¹².

Recommended Reading

1. WHO (2006) WHO Global Tuberculosis Control: Surveillance, Planning, Financing. Geneva, World Health Organisation.
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MANAGEMENT OF TB IN THE WORKPLACE

Managing TB in the workplace makes good business sense¹³

The workplace is a win-win setting for TB management – for both the worker and the company. For the worker, the workplace is a convenient location to gain awareness and receive treatment for TB. For companies, TB management can save costs by reducing absenteeism and staff turnover – through prompt diagnosis and effective treatment – and by reducing transmission to other workers with attendant costs.

Cost saving at the workplace is not the only reason for starting a workplace programme. As part of corporate responsibility programmes, many businesses have a broad commitment to improving the well-being of the community. Where TB prevalence is high, TB management at the workplace is an opportunity for businesses to concretely demonstrate their social commitment, as showing that they are concerned for their well-being, as part of a 'local licence to operate'.

Ten key principles guide workplace TB policy¹⁴

1. Recognize that TB is a workplace issue.

TB affects workers and enterprises by increasing labour costs and decreasing productivity. Workplace health policies and programmes should consider including TB education, diagnosis and treatment for workers and their immediate families. Case studies show treating TB in high-prevalence settings makes business sense, and the workplace is often the ideal setting to identify cases and administer treatment.

2. Practice non-discrimination.

Individuals should not be discriminated against because of their real or perceived TB status. TB is an infectious disease that can affect anyone, rich or poor. More importantly, when TB is promptly diagnosed it can be cured. Discrimination and stigmatization of people with TB causes delays in diagnosis, making it more difficult to cure patients and increasing the risks of infecting others. Only by creating positive awareness and understanding of TB among employees can stigma be reduced or prevented.

3. Respect confidentiality.

It is not necessary to disclose employees' personal information, including their TB status, to co-workers.

¹² Baron P, Day C, Loveday M and Monticelli F. The District Health Barometer Year 1. January-December 2004. Durban: Health Systems Trust; 2005.

¹³ World Economic Forum. (2002) TB management in the Workplace: An Introduction for African Business.

¹⁴ World Economic Forum. (2002) TB management in the Workplace: An Introduction for African Business.

4. Implement DOTS.

The internationally recognized strategy for the management of TB is DOTS. It requires supporting patients directly, including observing treatment. Daily contact with workers makes the workplace an ideal setting for implementation. The World Bank ranked treatment of TB with DOTS as one of the most cost-effective health interventions of all times. It can be cured with a course of therapy that can cost as little as US\$ 10 per patient and has up to an 85% success rate.

5. Work with the National TB programme (NTP).

Most African countries have an NTP, normally housed in the Ministry of Health. In South Africa, the National TB Control Programme is based at the National Department of Health. NTP managers have a mandate to work with any potential partners to implement TB management programmes. In particular, the new WHO/ILO guidelines encourage NTPs to form partnerships with employers and develop TB workplace programmes. Any business large or small can approach the NTP for technical expertise, supply of standard drug regimens and development of mutually beneficial programmes.

6. Monitor programme results.

Monitoring diagnosis and treatment outcomes is important to ensure the proper management of TB and assessment of a programme against objectives. For example, WHO estimates achieving 70% case detection and 85% cure rates of TB worldwide by 2005.

7. Report results.

Reporting results to the NTP enables comparisons of programme success rates versus the national average. This helps when reviewing workplace and national programme results. Sharing results also builds trust and stronger partnerships with the NTP.

8. Develop a sustainable network of TB programme partners.

There are many partners that can help kick-start a workplace programme as well as provide resources in the long term. These can include NGOs, professional health associations and private sector organizations that specialize in TB management.

9. Avoid pre-employment screening.

There is no justification to ask job applicants or workers to undergo compulsory pre-employment TB testing. TB is curable and normally not infectious after the first two to four weeks of treatment.

10. Link existing workplace HIV programmes to new TB programmes and vice versa.

This is of particular importance in Africa where the HIV epidemic is fuelling TB rates. Early detection of TB is particularly important for people living with HIV. WHO/ILO guidelines outline how this can be done.

Cost-effective workplace TB management at AngloGold

AngloGold South Africa estimates that each case of TB in its operations in the Vaal River and West Vilts regions costs US\$ 410 in lost shifts among unskilled employees. AngloGold runs a comprehensive TB management programme for the workplace. They have found that an effective TB detection and management programme can lead to net cost savings. AngloGold spends about US\$ 90 per employee per year and gains US\$ 105 through the prevention of active TB among HIV-positive employees.

Source: World Economic Forum. TB Management in the Workplace: A Introduction for African businesses

DOTS at the Workplace - Who Benefits?¹⁵

Employees benefit from the decisions taken by management to implement interventions that will avert the spread of TB in the workplace, through timely and supervised attention to all those suspected and suffering from TB.

TB cases benefit from easy access provided to diagnostic and treatment facilities as well as supervised chemotherapy. They also benefit from the education programmes carried out in the workplace aimed at reduction of stigma and discrimination of those infected.

¹⁵ WHO (2003) DOTS at the workplace: Guidelines for TB control activities at the workplace

Families benefit from the decreased risk of the spread of TB among family members. They also benefit from the uninterrupted household incomes, allaying their fears of deprivations associated with a long drawn out illness in an earning member.

Employers benefit from greater work productivity and profits as an outcome of a healthier workforce. There would be less labour turnover due to fewer deaths and less expenditure on replacing and training new workers. In addition to this, there are other value-added benefits. The initiative shows great potential for business and industry to demonstrate their concern for the health and welfare of their employees and to contribute meaningfully to attain the goals of one of the most important national health programmes of the country.

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Communities benefit from a healthier and therefore, a more prosperous environment, vital elements necessary for building harmony and peace.

The national TB programme benefits through enlisting the business sector to extend the reach of its DOTS programme more widely to help it achieve its target of covering the entire population of the country with DOTS by the year 2005.

The nation benefits by controlling one of its most impoverishing diseases among people who are at the peak of their earning lives and the largest contributors to the national economy.

¹⁵ WHO (2003) DOTS at the workplace: Guidelines for TB control activities at the workplace

TOOLS FOR THE DEVELOPMENT AND IMPLEMENTATION OF AN HIV AND AIDS WORKPLACE POLICY

INTRODUCTION

Even though there are challenges in trying to develop, refine and apply HIV and AIDS policies and programmes, we are fortunate to be able to reap the benefit of international and local experience over the years. From this experience, we can draw out examples of good practice and successes. We have identified a **set of six tools**. We begin with an overview of the use of advocacy as a strategy to argue for and secure support for certain HIV and AIDS issues. This is followed by guidelines to assist in the formation of the HIV and AIDS workplace task team and a quick, easy-to-use reference on the law which frames HIV and AIDS at the workplace. We have also included three checklists – the first to help with drafting the content of your policy, the second to ensure that essential steps are covered in engaging in developing the policy, and the third to guide you through the evaluation process.

- **Tool 1: Advocacy**
- **Tool 2: The formation of an HIV and AIDS coordinating committee, and the role of a leader**
- **Tool 3: Summary of laws and guidelines**
- **Tool 4: Checklist for drafting an HIV and AIDS workplace policy**
- **Tool 5: Implementation checklist**
- **Tool 6: The critical evaluation of an HIV and AIDS policy**
- **Conclusion**
- **Assignment 10**

TOOL 1: ADVOCACY

The process of developing a workplace-based response to HIV and AIDS is not always harmonious. At times, there may be a conflict of interest between management/employers and employees. There may be resistance to developing policy, changing policy or putting into action an aspect of agreed policy. You may need to argue, campaign and persuade management to convince them of the worth for both individuals and the workplace as a whole. A useful way of doing this is to use the process of advocacy. Usually this is embarked upon when we are trying to effect change for a certain group who do not have direct access to the decision-making process. These groups are often disempowered and/or discriminated against, and do not have a channel to voice what they feel is unjust and unfair. Advocacy assists in opening the channels to communicate their needs and to influence those with decision-making powers.

Advocacy can be defined as a set of targeted actions directed at decision-makers to address a specific policy issue and effect change.⁴⁵

The “3 by 5” campaign

In support of increasing access to ARVs, the World Health Organisation has launched an international advocacy campaign, “3 by 5”, with the aim, through massive international mobilisation and commitment, that at least three million people in need of ARVs will be on treatment by the end of 2005.⁴⁶

Treatment Action Campaign (TAC)

TAC is an example of a South African advocacy organisation. Formed in 1998, it focuses on issues that affect PLHAs, their families and communities. Since its formation, it has campaigned around a range of issues, for example, destigmatisation and disclosure, increased access to drugs for the prevention of mother to child transmission, reduction in the cost of ARVs, and the policy and rollout of ARV treatment in South Africa.

⁴⁵ The POLICY Project (1999) Networking for Policy Change: An Advocacy Training Manual.

⁴⁶ WHO (2003). WHO Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach. 2003 revision.

Pan-African Treatment Movement (PATAM)

PATAM is a social movement comprised of individuals and organisations dedicated to mobilising communities, political leaders and all sectors of society to ensure access to antiretroviral treatment, as a fundamental part of comprehensive care for all people with HIV and AIDS in Africa. PATAM utilises a complementary series of tactical advocacy strategies that are in character either partnership-based or less conciliatory, depending on the circumstances.

In the context of this module, advocacy would be used in the several ways:

- to support the development of a workplace policy where it does not yet exist
- to change aspects of an existing policy, for example, more time off for employees to attend HIV and AIDS education and/or training, the provision of VCT at the workplace, a negotiated subsidy for antiretrovirals for employees, or additional resources for the development of an HIV and AIDS wellness programme
- to reduce stigmatisation and discrimination at the workplace
- to support broader initiatives such as the discrimination of HIV-positive people in relation to insurance benefits

Advocacy involves a well thought-out, planned and structured process. Although the issue and circumstances will vary, it is helpful to include the following steps:

- **Define the issue:** What is the issue and why does it need action?
- **Draw together the information relevant to the issue:** Be armed with research, facts and empirical data to argue your case. Find examples of ways in which the issue has been dealt with elsewhere in similar settings. Find out about arguments relating to cost and benefits. Ultimately, businesses are concerned with the cost versus the benefits, so gather information and prepare arguments that deal with this. Be selective – information overload puts people off. Develop a realistic action plan that will assist management in the implementation of the desired action.
- **Identify the resources** required to embark on the advocacy process: funding, photocopying, printing, transport, etc, and identify where you can get these resources from.
- **Identify your goal:** This is the problem-solving step where you seek to find a solution to the problem. This must be economically and politically feasible. Define what it is you want to achieve – is it a new policy, policy/organisational change, resource allocation, etc.
- **Identify your target audience:** Think strategically – who has the power to influence change? Who can help with pressurising decision-makers?
- **Build support:** Who are your allies? Where can you get more support? Who can you collaborate with? What networks can be formed?
- **Develop the message:** Advocacy is an art. Successful advocates are able to articulate issues in ways that inspire and motivate others to take action.⁴⁷ Your message needs to be clear, short and persuasive. The way you put it across is as important as the actual content.
- **Select channels for communication:** What is the most appropriate channel for your particular target group – meetings, talks, leaflets, news bulletins, fact sheets, etc?
- **Understand the decision-making process:** As an advocate, you need to understand the decision-making procedures, the rules, who makes decisions and what is the best way to influence the decision-making process – where, when, whom and how.
- **Prepare for resistance:** Consider where and why you may encounter resistance, and how you plan to deal with this. Think about possible arguments that may be used to oppose your recommendations, and counter-arguments you will respond with.
- **Develop an implementation plan:** Adaptability, creativity and persistence are the characteristics of successful advocates. If one strategy does not work, try another, and another, until you reach your goal.⁴⁸ A plan should include monitoring, giving regular feedback to stakeholders and a plan for closure. The latter is important as many advocacy processes just fizzle out without reflecting on strategy, learning from it and consolidating gains.

⁴⁷ The POLICY Project (1999) Networking for Policy Change: An Advocacy Training Manual.

⁴⁸ Sharma, R (1997) An introduction to advocacy: training guide.

- **Develop partnerships:** Many workplaces do not have the specialist knowledge, skills or resources to drive an HIV and AIDS policy development process, or implement a workplace programme. It is therefore important to form partnerships with NGOs, governmental departments or other HIV and AIDS external agencies. Partnerships are important as they provide a vehicle through which to benefit from good practice, explore different models, understand the micro and macro trends in terms of the prevalence and impact of HIV and AIDS, and share information. They can also provide the training and capacity building necessary to implement effective workplace programmes.

Partnerships between large companies and small to medium-sized enterprises are also important. Large corporations can provide leadership, training, materials, advice and finance. Partnerships also form an effective mechanism for the dissemination of businesses' responses to HIV and AIDS.⁴⁹ The sharing of resources on this level encourages collaborative, coordinated efforts on the part of the private sector.

In the box below, we take you through the process of advocacy using the example of Chris, an employee at Moonshine Textile Designs, a medium-sized private company.

An example of the application of advocacy in practice

Four years ago, the human resource manager of Moonshine Textile Designs formed an HIV and AIDS task team with the intention of developing an HIV and AIDS workplace policy. After the HIV and AIDS policy was complete, the human resource manager's attention became diverted as she became increasingly more involved in the company's restructuring process. The team stopped meeting.

The factory is in an area where HIV and AIDS have become increasingly visible, and more employees are becoming infected/ affected. Chris is a junior member of the human resource department. He is particularly interested in HIV and AIDS and revived the HIV and AIDS task team, of which he is now the coordinator. Since he has taken on this position, there has been a burst of activity – Chris has begun the process of reviewing the policy, and he has initiated a programme to train all shop stewards as HIV and AIDS educators and develop peer educators and lay counsellors in all sections of the company.

As part of the restructuring, the company is open 24 hours a day and has a rotating shift schedule, which means the team members often need to do their outreach work out of their formal working hours in order to reach all employees.

Although on the surface it appears that the company is doing a lot for HIV and AIDS, the team is very frustrated. There is little support from management to put aspects of the policy into practice. Management and the human resource department are totally immersed in the restructuring process in an attempt to boost productivity and profit. Supervisors are refusing to allow staff to have time off or to make any finances available for outreach, education or training. The team is also concerned about the implications of night shift for HIV-positive workers who may find it too tiring, and are more vulnerable to getting colds/flu in winter. And now, to cap it all, one of the most active members of the task team has just been told in her performance appraisal that she is not achieving her outputs and that she will not be eligible for her performance-related increment if she does not "pull up her socks". She feels this is extremely unfair, as her HIV and AIDS work will ultimately benefit the company.

Chris has tried to raise the issues in his department meeting, but he feels he is not being taken seriously. He senses that his department colleagues have labelled him as the "HIV and AIDS activist" and have stopped listening to the content of what he is trying to say. He feels there is a lack of awareness and understanding of the impact of HIV and AIDS in the workplace, and that the attempts to boost productivity and profit will be negated by the impact of HIV and AIDS at the company. Chris decides to get the support of the task team to assist him in embarking on a process of advocacy to raise awareness and make changes in the issues at hand. He uses the above model to move through the process.

⁴⁹ HEARD (2002). AIDS Brief. HIV/AIDS in the workplace – for Human Resource Managers.

Define the issue

He identifies three core issues:

1. There is poor commitment from management relating to HIV and AIDS. Although the company has a good HIV and AIDS workplace policy, management is not willing to support putting the policy into practice. There are no resources, both time and financial, to put the HIV and AIDS workplace programme into practice.
2. The restructuring is not taking into account the possible needs of PLHAs.
3. Staff who are active around HIV and AIDS are being penalised in their performance appraisals.

Draw together the information relevant to the issue

Rather than being swamped with information, Chris identifies the following specific information: What does the HIV and AIDS workplace policy say specifically in relation to resources to support programmes, and reasonable accommodation? What do the legislation and guidelines say about the company's commitment to these? Are there examples of how other companies have dealt with this? What facts are available, which show HIV and AIDS prevalence in the surrounding community or the workplace itself, and the likely impact thereof?

Identify the resources required to embark on the advocacy process

Chris will need the commitment and effort of the task team and other willing employees (for example, shop stewards), access to printing and photocopying machines, speakers, examples of good practice from similar companies, relevant government departments in terms of speakers/advice (such as the Departments of Labour, Trade and Industry and Health, and the Public Service Commission). Local business sector umbrella organisations can be an important source of information on the prevalence of HIV and AIDS, projections of impact and examples of good practice.

Identify your goal/solution

As a result of the advocacy work, Chris is hoping that the task team and management will have agreed upon the following:

1. A budget is developed to support HIV and AIDS workplace programmes and this is reflected in all relevant operational budgets in the future.
2. The development of guidelines that identify HIV and AIDS responsibilities are included in the performance outputs of employees.
3. The development of guidelines that look at the process of employees doing HIV and AIDS work within their work time; access to resources will be stipulated.
4. Representation from the task team is included in discussions related to the restructuring process so that the interests of PLHAs are represented and incorporated.
5. The current HIV and AIDS policy is revised to reflect the above.

Identify your target audience

Chris identifies all levels of management, the human resource department, shop stewards and fellow employees. He also identifies several key individuals who are particularly influential within these groups and aims to engage in one-on-one discussions with them.

Build support

It is important to first get support from the human resource department, and thereafter all levels of management, the trade unions represented at the workplace, employee associations and any national umbrella organisation representing the sector. The challenge is to influence the board of directors, as only top management has direct access to them. Two tactics have been identified – to lobby⁵⁰ individual board members when they attend their quarterly meeting, and to get the head of the human resource department to formally support the requests at the board meeting.

⁵⁰ Lobbying is one of the tactics that can be used in the advocacy process. Lobbying is an activity whereby we attempt to influence an important person who has access to decision-making powers and process. When we are lobbying, we try to convince this person of the urgency and worthiness of our cause, and request them to use their power to educate and influence the decision-makers.

Develop the message

The key message is that the HIV and AIDS workplace policy needs to be translated into practice – with the concomitant resources provided. HIV and AIDS therefore need to be factored into budgets, the restructuring process needs to take into account the needs of PLHAs, and performance appraisals need to take into account the value of the HIV and AIDS work being done outside the employees' performance targets.

Select channels for communication

Here are the activities the task team decided to use for communicating their message:

- Requests will be made for the issues to be tabled at the human resource department monthly meeting.
- The task team will request an extraordinary trade union meeting.
- Each task team member has been assigned to meet certain individuals in order to convince them of the urgency and relevance of the issues.
- A fact sheet is to be prepared, identifying the local projections and likely impact of HIV and AIDS on the business sector.
- An article is to be written for the in-house company newsletter.

Understand the decision-making process

Chris and his task team have identified the board of directors, the senior management team and the human resource department head as the three important structures to influence.

Prepare for resistance

Chris conducts a brainstorming session with the task team to identify possible arguments and barriers. They develop sound, objective counter-arguments for each of these.

Develop an implementation plan

This includes a budget, time-lines and the development of proposals that represent alternative solutions. Each person on the task team is given a cluster of tasks that are followed up at each meeting.

Development of partnerships

Partnerships are developed with a local NGO which assists with training at the workplace; regular contact has been established with a national NGO dealing with the law; links are made with the trade union which provides examples of how these issues have been successfully negotiated elsewhere; and the local business sector umbrella body is extremely helpful in terms of provision of local information concerning prevalence and likely impact predictions. The local HIV and AIDS inter-sectoral structure has offered to assist with the provision of information and speakers.

Good luck, Chris and your team!

TOOL 2: THE FORMATION OF AN HIV AND AIDS TASK TEAM, AND THE ROLE OF THE LEADER

The success of an initiative of this nature depends largely on leadership and teamwork to drive the process. This involves:

- appointing an HIV and AIDS coordinator
- ensuring that the coordinator has the competencies and mandate to carry out his/her functions
- ensuring that the team has the competencies to carry out its functions
- ensuring there is representation of the different levels of employees and various interests
- establishing and maintaining lines of communication with management and workers outside the team
- convening meetings at a convenient time for all team members
- involving HIV-positive people – not in a tokenistic way, but in a way they can truly contribute to the process

The role of a leader

- facilitate the process
- foster a climate of trust
- act as a role model
- delegate tasks
- put systems in place to share and disseminate information effectively
- motivate and empower members, and give them the sense that what they are doing is of importance and benefit to both themselves and others
- deal with conflict and dissent
- network
- run meetings effectively and efficiently
- encourage participation, especially from quiet, less empowered members
- replace fear and insecurity with fact

TOOL 3: SUMMARY OF LAWS AND GUIDELINES⁵¹

Below is a summary of the key laws and guidelines that would be used to frame HIV and AIDS workplace policies. [See Module 9 for more detail and references.]

International guidelines	
The UNAIDS HIV/AIDS and Human Rights International Guidelines (1998)	International guidelines to assist countries in creating a positive, rights-based response to HIV and AIDS.
The SADC Code of Good Practice on HIV/AIDS and Employment (1997)	A regionally agreed Code to which all SADC countries are signatories.
The ILO Code of Practice on HIV/AIDS and the World of Work (2001)	Provides international standards and principles to assist with country and workplace-specific responses to HIV and AIDS.

⁵¹ Adapted from Department of Public Service and Administration (2002). Managing HIV/AIDS in the Workplace: A Guide for Government Departments. Pretoria, Republic of South Africa.

South African legal framework	
The South African Constitution Act, No. 108 of 1996	The supreme law of the country and all other laws must comply with it. The Bill of Rights within the Constitution sets out a number of specific provisions, which protect workplace rights. Section 23(1) states that “Everyone has the right to fair labour practices”. There are also more general rights, which apply to the employment relationship, such as the right to equality and non-discrimination, and privacy.
Employment Equity Act, No. 55 of 1998	Aims at ensuring equality and non-discrimination in the workplace through anti-discrimination measures and affirmative action provisions. It also has two clauses that expressly refer to HIV and AIDS: a prohibition on unfair discrimination based on “HIV status” and a prohibition on HIV testing without Labour Court authorisation.
The Labour Relations Act, No. 66 of 1995	Aims at regulating the relationships between employees, trade unions and employers; also regulates the resolution of disputes between employers and employees and sets out the rights of workers with regard to dismissal.
The Occupational Health and Safety Act, No. 29 of 1996	Places a duty on all employers to ensure that, as far as is reasonably practicable, the working environment is safe and healthy for employees.
The Compensation for Occupational Injuries Act, No. 130 of 1993	Gives every employee the right to apply for compensation if injured in the course and scope of their employment.
The Promotion of Equality and the Prevention of Unfair Discrimination Act, No. 4 of 2000	Sets out measures for dealing with various forms of unfair discrimination and inequality. It also sets out the steps that must be taken to promote equality. Provides protection against discrimination against employees living with HIV.
The Medical Schemes Act, No. 131 of 1998	Provides that a medical scheme may not unfairly discriminate, directly or indirectly, against any person on the basis of their HIV status.
The common law	Protects the personal rights of all individuals. These rights include the right to privacy and bodily integrity. This means that medical treatment (including HIV testing) must be carried out with the informed consent of the person concerned. Furthermore, a person’s HIV status may only be disclosed with his/her consent.
Codes of Practice	
The Code of Good Practice on Key Aspects of HIV/AIDS and Employment	Attached to both the Labour Relations and Employment Equity Acts, this is a standard setting out the content and scope of an appropriate response to HIV and AIDS in the workplace. The Code has two objectives: to set out guidelines for employers and trade unions to ensure that individuals infected with HIV are not unfairly discriminated against in the workplace; and to provide guidelines for employers, employees and trade unions on how to manage HIV and AIDS in the workplace.
The Code of Good Practice on Dismissal	Attached to the Labour Relations Act, it provides guidelines, for example, on when and how an employer may dismiss an employee for incapacity.
The Draft Code of Good Practice on Key Aspects of Disability and Employment	Currently being finalised by the Department of Labour, this code will give detailed guidelines on how to accommodate disabled employees, such as those with advanced HIV disease and how to adapt their working environments.

TOOL 4: CHECKLIST FOR DRAFTING AN HIV and AIDS WORKPLACE POLICY

The following checklist can be used as a guide in preparing a company, organisation or department's HIV and AIDS policy. The points in the checklist can be considered paragraphs or provisions in the policy.

Introduction

- Reason(s) why the company has an HIV and AIDS policy.
- Persons covered by the policy (some or all employees or different provisions for different categories of employees).
- Policy compliance with national and local laws and trade agreements.
- How the policy will be applied.

General considerations

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

Elements relating to employment criteria

- Statement that applicants and employees will not be screened for HIV as a condition of continued employment or promotion.
- Provision on circumstances where an employee would be asked to be tested for HIV, including:
 - Explanation of the reasons why a request would be made for an HIV test.
 - Statement of whether the employer or employee would be responsible for paying for an HIV test.
 - Statement that pre- and post-test counselling would be provided for any employee who is asked (or asks) to take an HIV test.
 - Statement of the company response if an employee refuses to be tested.
 - Statement of the company's intention to keep all medical information, including results of HIV tests, confidential.
 - Statement of company intentions towards employees who, if required to be tested, are found to be HIV-positive.
 - Statement of the appeal, arbitration and resolution options for employees who refuse to be tested or who, if tested, are found to be HIV-positive.
 - Statement of the company's position towards insurance companies that may require an HIV test for various forms of coverage.
 - Statement that the company is willing to make accommodations (such as less rigorous work or a different work environment) for employees who request such accommodations because of HIV infection.
 - Provision that the company will maintain and enforce legal, acceptable and recognised occupational safety precautions to minimise risk of workplace exposure to HIV.
 - Provision relating to the privacy of employee personnel records, including medical records.
 - Statement prohibiting stigmatisation of and discrimination against employees who are (or who are suspected of being) HIV-positive.

Elements relating to benefits and treatment for HIV-infected and HIV-affected employees

- Provision of benefits related to HIV infection is likely to be an extension of existing benefit provisions. As part of an overall prevention programme, an HIV policy can explicitly refer to assistance in the treatment of STIs. As implied in the previous section of this checklist, workers with HIV and AIDS should receive the same type, level and form of benefits as other employees with serious illnesses. Provisions include:
 - Statement about company and employee contributions to health and medical care, life and disability insurance, workers' compensation, social security and other retirement benefits, compassionate leave (for care-giving, funerals), death benefits for beneficiaries, treatment for opportunistic infections related to HIV and AIDS and treatment for HIV and AIDS.
 - Coverage for dependents.
 - Statement about company provision of or support for assistance in gaining access to life-saving treatments and drugs for HIV and AIDS and opportunistic infections.
 - Provision of or support for counselling and related social and psychological support services for HIV-infected and HIV-affected employees (and dependents).
 - Statement that the company recognises the importance of peer support groups and permits such groups to be formed and to meet on company property (during or outside of work hours).
 - Legal support services: although companies may worry about legal challenges, company support for employees (in-house or contracted out) to access legal advice can assist in safeguarding dependents through preparation of wills, transfer of property and leveraging of public services.

Elements relating to workplace prevention

- Statement that HIV prevention is the responsibility of all employees, including senior management and supervisors.
- Statement about the leadership role of managers and worker representatives, both in the company and in the wider community, in addressing HIV and AIDS.
- Statement emphasising the importance of (and company expectations of) employees avoiding risky sexual behaviour.
- Statement referring to company and union responsibilities for maintaining an environment that reinforces safe sexual behaviours.
- Statement of company and union responsibilities for providing all employees with timely, accurate, clear and adequate information about HIV prevention, community support services, treatment options and changes in company prevention activities.
- Description of the HIV prevention components that will be available to employees. Recommended components include easy and regular access to male and female condoms, access to diagnosis and treatment of STIs, training of peer educators who will be accessible to employees and information about prevention and care services that exist in the community.

TOOL 5: IMPLEMENTATION CHECKLIST

- Has an HIV and AIDS task team been formed?
- Does the HIV and AIDS task team have sufficient skills, seniority and support to implement the workplace HIV and AIDS policy and programme?
- Have responsibilities been assigned to various role-players in the organisation for implementation of the policy and programme elements?
- Does the policy provide for any necessary capacity building for those with implementation responsibilities, in order to assist them to carry out the policy and programme elements?
- Have adequate human and financial resources been allocated for the implementation of the HIV and AIDS policy and programme elements?
- Has a communication strategy been put in place to ensure adequate understanding of the policy and programme, and does information exchange take place regarding the implementation of the HIV and AIDS policy and programme?
- Has the task team formed partnerships with other organisations and institutions to assist in the sharing of expertise and resources necessary for implementing the policy and programme?

TOOL 6: THE CRITICAL EVALUATION OF AN HIV AND AIDS POLICY

Whether your HIV and AIDS policy has been in place for some time, or your workplace has just developed the first draft of its HIV and AIDS policy, the policy needs to be reviewed. It is important to do this due to the dynamic nature of the epidemic. Below is a checklist to evaluate the process of the development of an HIV and AIDS policy.

- How was the policy developed? Was the process consultative?
- Does it address the needs and concerns of the relevant role-players in your organisation?
- Have PLHAs been included in the consultative process?
- Are the key elements of an HIV and AIDS policy present?
- Does it comply with the laws relating to HIV and AIDS in the workplace?
- Is it consistent with technical expertise and best practice on HIV and AIDS in the workplace?
- Is it appropriate to your organisation?
- Have responsibilities been assigned?
- Have resources been allocated?
- Does it provide for monitoring, evaluation and review?

CONCLUSION

Having an HIV and AIDS policy prepares you to deal with HIV and AIDS in your workplace smoothly, responsibly and cost-effectively. Though some people in your organisation may not think a policy is necessary, most will respect your leadership and appreciate the direction and clarity your policy provides. Now HIV and AIDS issues in your workplace can be addressed with confidence.

Most employers find that developing an HIV and AIDS policy takes less time than expected and is an interesting, valuable experience. They also find that the employee response is surprisingly favourable. The benefit is the knowledge that they are prepared to effectively address what could have presented a serious employee relations problem, and that they are better positioned to manage the impact of HIV and AIDS and prolong their own and other employees' lives.

For many complex reasons, HIV and AIDS are difficult subjects to address. It can be controversial, can cause discomfort and can be easily dismissed. HIV and AIDS have also caused unpleasant, expensive disruption in companies that are caught unprepared. By developing your HIV and AIDS policy, you have demonstrated commitment to your employees. By taking a responsible, assertive stand on HIV and AIDS, you have joined the ranks of leaders across the country whose collaborative efforts are successfully confronting the HIV and AIDS epidemic.

Be prepared to put your HIV and AIDS policy into action at any time. Keep your managers and employees up to date on HIV and AIDS periodically through your normal communication channels. Encourage your employees to talk openly and responsibly about HIV and AIDS. Encourage employees and managers to contact appropriate resources for answers to their questions about HIV and AIDS. Allow for open discussion in the workplace between people living with HIV and AIDS and those that are HIV-negative. By maintaining open, responsible communication, over time you ensure that your workplace can address HIV and AIDS effectively, assist in the prevention of new infections and reduce the impact of HIV and AIDS on both those infected and affected.

Assignment 10

You have been appointed as the HIV and AIDS Coordinator at a new medium to large-sized factory in KwaZulu-Natal (KZN). Rainbow Factory is a motor manufacturing company which was started two years ago as a result of an empowerment deal between European and local South African entrepreneurs to create jobs in the Madadeni/ Osizweni areas of KZN. The factory has already employed 5,000 skilled and unskilled workers, who mostly live in the surrounding communities.

A health and wellness centre was developed early this year with a doctor and three nurses and they report that they were immediately swamped by employees who are sick with diseases such as pneumonia and tuberculosis. Enquiries about the prevention, treatment and care for these diseases and HIV and AIDS have increased dramatically in the past few months.

On your first day at work, you notice that Rainbow Factory does not have an HIV and AIDS policy or programmes. You have been invited to the Executive Committee meeting in the next week to present your plan for the management of HIV and AIDS.

Using the background information above, answer the following questions:

- 1 Describe the impact of HIV and AIDS on the Rainbow factory and explain to the Executive Committee why it is essential to develop a workplace policy **[20 marks]**
- 2 Outline your strategic plan for coordinating the management of HIV and AIDS at the Rainbow factory. **[25 marks]**
- 3 Describe the steps and timeframes that you would follow to develop the workplace policy at the Rainbow factory. **[35 marks]**
- 4 Describe the roles and the challenges of management in the development and implementation of the workplace HIV and policy at the Rainbow factory. **[10 marks]**
- 5 Comment on the importance of involving People Living with HIV and AIDS (PLHA) in the process of developing, monitoring and evaluating an HIV and AIDS workplace policy at the Rainbow factory. Give two examples as to how PLHAs can be involved in this process. **[10 marks]**

TOTAL = 100 marks

Your assignment (excluding the cover page) must not exceed 8 pages

Recommended reading

1. **Barrett Grant, Kitty, Strode, Ann and Smart, Rose (2002). Managing HIV/AIDS in the Workplace: A Guide for Government Departments.** Available from the Department of Public Service and Administration, Tel: (012) 314-7911/7144, Fax: (012) 323-2386, or on-line from: www.dpsa.gov.za.
2. **Centre for Health Policy (2004). Company Case Studies. Responses of two large companies to HIV/AIDS in the workplace.** Available on-line from: www.wits.ac.za/chp/docs/M82.pdf.
3. **Global Business Coalition (2003). The Role of the Business Sector in Scaling-up Access to Antiretroviral Therapy Report of the Expert Meeting Noordwijk, The Netherlands May 5–6, 2003.** Available on-line from: www.businessesfightsaids.org
4. **HEARD (2002). AIDS Briefs. A range of relevant leaflets focussing on HIV and AIDS in the Workplace – for NGOs, human resource managers, sectoral planners and managers, and trade unions.** See Course CD for Recommended Reading.
5. **HEARD (2004). Report on the Private Sector Conference on mitigating the impact of HIV/AIDS on the Private Sector, held at the International Convention Centre, Durban, South Africa, and hosted by HEARD University of KwaZulu-Natal, Durban.** Available on-line at: www.ukzn.ac.za/heard/conferencesmeetings/WorkshopReports/SIPAA%20Report%20-%20Final.pdf.
6. **ILO (2003). Tripartite Interregional Meeting on Best Practices in HIV/AIDS workplace policies and programmes – consensus statement.** See Course CD for Recommended Reading.
7. **ILO (2004). Launch of the IOE-ICFTU Joint Action Plans in Africa: follow-up to the declaration of collaboration on HIV/AIDS, 30-31 March 2004, ILO, Geneva.** Available on-line at: www.ilo.org/public/english/protection/trav/aids/publ/ieoicftumtg.pdf.
8. **Ogden, J and Nyblade, L (2005). Common at it's core: HIV-related stigma across contexts.** Available on-line at http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf
9. **POLICY Project (1999). Networking for Policy Change: An Advocacy Training Manual. October 1999.** Available on-line from <http://www.policyproject.com/pubs/AdvocacyManual.pdf> or Tel: (021) 685-4894.
10. **POLICY Project and the Centre for the Study of AIDS (2003) Siyam'kela: Tackling HIV/AIDS Stigma – Guidelines for the Workplace.** Available on-line at http://www.policyproject.com/pubs/countryreports/SA_Siyam_workplaceguide.pdf
11. **POLICY Project and the Centre for the Study of AIDS (2006) HIV/AIDS Stigma Resource Pack.** See Course CD for Recommended Reading.
12. **POLICY Project (2006). Breaking Through: Profiles of Individuals Challenging HIV-related Stigma and Promoting Human Rights Around the World. Washington, DC.** See Course CD for Recommended Reading.
13. **POLICY Project (2006). Stigma, Scale-up, and Treatment Governance: Stumbling Block or Window of Opportunity? Washington, DC.** See Course CD for Recommended Reading.
14. **Rau, B (2002). Workplace HIV/AIDS Programs: An Action Guide for Managers. Family Health International.** Available on-line from: <http://www.fhi.org/NR/rdonlyres/ehocvdvqlpgxee4suywcwepettjpyak655vqpdnmy57ictcaxa6ceovvl4pdcx63ctt4qvifkb4wk/Workplace1.pdf>
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16. **Stevens, David (2004). Out of the Shadows: Greater Involvement of People Living with HIV/AIDS (GIPA) in Policy. Policy Working Paper Series No. 14.** Available on-line at: <http://www.policyproject.com/pubs/workingpapers/WPS14.pdf>
17. **Stevens, M (2002). AIDS and the Workplace with a specific focus on employee benefits: issues and responses.** Available from the Centre for Health Policy, University of the Witwatersrand, Johannesburg, for R195.
18. **UNAIDS (2000). Enhancing the Greater Involvement of People Living with or Affected by HIV/AIDS in Sub-Saharan Africa. UNAIDS Best Practice Collection.** Available on-line from: http://data.unaids.org/Publications/IRC-pub01/JC274-GIPA-ii_en.pdf
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20. **UNAIDS (2002). The faces, voices and skills behind the GIPA workplace model in South Africa.** See Course CD for Recommended Reading.
21. **UNAIDS (2005) Access to antiretroviral therapy by three companies in South Africa.** Available on-line from: http://data.unaids.org/publications/irc-pub06/jc988-accesstotreatment_en.pdf
22. **UNAIDS (2004). Consultative meeting on HIV testing and counselling in the Africa region. UNAIDS (2004).** See Course CD for Recommended Reading.
23. **University of Witwatersrand (2004). HIV/AIDS in the Workplace. Research Symposium, University of the Witwatersrand, 29-30 June 2004.** Available on-line at: www.redribbon.co.za/documents_v2/business/00_Complete_Symposium_Proceedings1.pdf.
24. **Whiteside, Alan, and Sunter, Clem (2000). AIDS: The Challenge for South Africa. Human & Rousseau and Tafelberg Publishers. Appendix 2: The Legal Framework and HIV/AIDS, p157-167.** Book review available on-line at: www.ukzn.ac.za/heard/publications/publicationsBooks.htm

Legal frameworks and guidelines

1. **The Department of Labour Code of Good Practice on Key Aspects of HIV/AIDS and Employment.** Available from the Department of Labour, Tel: (012) 309-4313, or the Government Printers, Tel: (012) 3344538.
2. **The ILO Code of Practice on HIV/AIDS and the World of Work.** Available from the International Labour Organisation, Tel: (012) 341-2170 or at http://www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf
3. **The Southern African Development Community's Code of Good Practice on HIV/AIDS in the Workplace.**

Reading on antiretroviral treatment

1. **Brouard, Pierre (2005). The need for the integration of psychosocial support within the context of the primary healthcare system with a focus on HIV/AIDS, the ARV rollout and drug adherence.** See Course CD for Recommended Reading.
2. **Bureau for Economic Research (2003). The Economic Impact of HIV/AIDS on Business in South Africa. Funded by the South African Business Coalition on HIV/AIDS (SABCOHA), researched and compiled by the Bureau for Economic Research (BER).** Available on-line from: www.ber.sun.ac.za.
3. **Business Report articles (2003). A series of eight articles which deal with the integration of ARVs into workplace programmes.** See Course CD for Recommended Reading.
4. **Chopra, Dr Mickey (2005). ARV treatment and health systems: avoiding the pitfalls. MRC AIDS Bulletin.** See Course CD for Recommended Reading.
5. **Department of Health (2003). Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. 19 November 2003.** Available on-line at: www.gov.za/issues/hiv/careplan/19nov03.htm.
6. **Department of Health (2004) Monitoring and Evaluation Framework. Comprehensive HIV and AIDS Care, Management and Treatment Plan for South Africa. September 2004.** Available on-line at: www.doh.gov.za/docs/reports/2004/hivaids-care/monitorevaluation.pdf.
7. **Department of Health (2004) National Antiretroviral Treatment Guidelines. National Department of Health, South Africa.** Available on-line at: www.hst.org.za/publications/624
8. **Nattrass, Nicoli, and Geffen, Nathan (2003). Providing antiretroviral treatment for all who need it in South Africa. CSSR Working Paper No. 42.** Available from The Administrative Officer, Centre for Social Science Research, kforbes@cssr.uct.ac.za.
9. **Stein, J. (2005). The impact of antiretroviral (ARV) provision on HIV/AIDS prevention. MRC AIDS Bulletin.** See Course CD for Recommended Reading.
10. **WHO (2003). WHO Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach. 2003 revision.** Available on-line at: www.who.int/3by5/publications/guidelines/en/arv_guidelines.pdf.

Reading on Tuberculosis

1. **WHO (2006) WHO Global Tuberculosis Control: Surveillance, Planning, Financing.** Geneva, World Health Organisation. See Course CD for Recommended Reading.

Examples of HIV/AIDS health management services

Aid for Aids: www.aidforaids.co.za

Direct AIDS (Alexander Forbes): www.directaids.co.za

FutureForesight: www.futureforesight.com

Right to Care: www.righttocare.org

Useful resources

AIDS Law Project (2002). HIV/AIDS Current Law and Policy, “Your rights in the workplace”. Available from www.hri.ca/partners/alp/.

Community Development Resource Association (2002). A Resource for NGOs. **Positive Organisation: Living and Working with the Invisible Impact of HIV/AIDS.** Available for R100 from the Community Development Resource Association, Tel: (021) 462-3902.

DaimlerChrysler Group of Companies (2002) Workplace Policy on HIV/AIDS. Available on-line from: www.businessfightsaids.org.

Health Economics and Workplace Policy Builder (2002). The Impact of HIV/Aids on Civil Society – Assessing and Mitigating the Impact: Tools and Models for NGOs and CBOs. **Computer software for developing workplace HIV/AIDS policies. Futures Group International.** This is an interactive computer program to assist organisations in developing an HIV/AIDS workplace policy. Available on-line at: www.futuresgroup.com/policybuilder.

SACOHA (2004). SABCOHA Workplace HIV/AIDS Toolkit. SABCOHA has produced a comprehensive Toolkit as a step-by-step guide to formulating and implementing a workplace HIV/AIDS programme. The Toolkit retails for R1 200 (excluding VAT). For further information, contact Tracey King at SABCOHA, Tel: (011) 880-4821 or email tracey@sabcoha.co.za

Soul City, Khomanani and CDC (2004). HIV and AIDS and Treatment. Available from Khomanani Red Ribbon Resource Centre, Tel: (011) 880-0405.

Steps for the Future (2002). A collection of documentaries and short films from Southern Africa that intend to promote debate and discussion around HIV/AIDS-related topics such as disclosure, discrimination, treatment and living positively. The films are available from Steps for the Future at www.dayzero.co.za/steps or Tel: (021) 465-5805

Useful contacts

- **AIDS Law Project:** www.hri.ca/partners/alp/
- **AIDS Legal Network:** www.aln.org.za
- **Community Development Resource Association (CDRA):** www.cdra.org.za
- **Global Business Council on HIV/AIDS:** www.businessfightsaids.org and www.gbcaids.com
- **Health Economics and HIV/AIDS Research Division (HEARD):** www.und.ac.za/und/heard
- **Health Systems Trust:** www.hst.org.za
- **International Labour Organisation:** www.ilo.org
- **Joint United Nations Programme on HIV/Aids (UNAIDS):** www.unaids.org
- **Pan-African Treatment Access Movement:** www.patam.org
- **South African Business Coalition on HIV/AIDS (SABCOHA):** www.sabcoha4business.co.za
- **South African government gazettes** (copies of legislation) are obtainable from the Government Printers, Tel: (012) 334-4538
- **Steps for the Future:** www.dayzero.co.za/steps
- **Treatment Action Campaign:** www.tac.org.za

