International Labour Organization

Effective responses to HIV and AIDS at work:

A multi-country study in Africa

EFFECTIVE RESPONSES TO HIV AND AIDS AT WORK
A MULTI-COUNTRY STUDY IN AFRICA

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First published 2015

Effective responses to HIV and AIDS at work – A multi-country study in Africa / International Labour Office, HIV and AIDS and the World of Work Branch – Geneva: ILO, 2015

ISBN: 978-92-2-128769-8 (print);
ISBN: 978-92-2-128770-4 (web pdf)

International Labour Office, HIV and AIDS and the World of Work Branch

HIV/AIDS / occupational safety / occupational health / workplace communication / programme planning / health education / HIV testing / behaviour / gender mainstreaming / discrimination / medicine / absenteeism / Africa
15.04.2

ILO Cataloguing in Publication Data

This publication was produced by the Document and Publications Productions,
Printing and Distribution Branch (PRODOC) of the ILO.
Graphic and typographic design, layout and composition, printing, electronic
publishing and distribution.
PRODOC endeavours to use paper sourced from forests managed
in an environmentally sustainable and socially responsible manner.
Code: JMB – ICA

FOREWORD

The African continent is home to more than a billion women and men. It is experiencing an HIV epidemic that is evolving in accordance with different national circumstances and driven by specific factors. The diversity of responses to the epidemic, including from the world of work, provides for a wealth of information, revealing the effectiveness of HIV policies and programmes across a broad range of situations. They all offer concrete examples of what works in HIV workplace responses, demonstrating that committed, resourceful and innovative workplaces can successfully respond to one of the major challenges of our time.

This report, "Effective responses to HIV and AIDS at work. A multi-country study in Africa", is the International Labour Office's answer to requests from its tripartite constituents: governments, employers' and workers' organizations. After decades of action to address HIV and AIDS through the workplace, the ILO has taken stock of results achieved to better understand what responses worked well, how, where and why they did so.

To this end, the ILO commissioned a study to identify and analyse successful policies, programmes and measures adopted by a variety of workplaces, large and small, formal and informal, public and private, across the African continent. This study does not focus exclusively on the ILO's contribution to workplace responses. It was carried out in 10 countries, focusing on a specific period of time and examining results achieved in diverse workplaces with documented evidence of successful outcomes.

The report sets out the results of this extensive investigative study, providing an in-depth analysis of the elements identified as instrumental in workplace responses to ensure successful outcomes and maximum impact.

The ILO hopes that the findings and recommendations contained in this report can support the design and delivery of workplace HIV responses throughout Africa and in other workplaces around the world to prevent HIV transmission, increase access to HIV services and safeguard the health and fundamental labour rights of working women and men worldwide.

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ACKNOWLEDGEMENTS

This report is the product of the collective efforts of a large number of people. We wish to acknowledge the following and thank them for their expertise and effort over the two-year process that resulted in this report. Without their contributions this research project would not have been successfully completed.

At the outset, we would like to acknowledge the support provided by UNAIDS and the Norwegian Ministry of Foreign Affairs, whose funding contributed to this publication.

Our sincere appreciation also goes to the following:

- Dr Muriel Visser, who researched and wrote the global literature review that provided useful inputs into the subsequent analytical report.
- The Human Sciences Research Council (HSRC), the HIV/AIDS, STIs and TB (HAST) Research Programme and the Social Aspects of HIV/AIDS Research Alliance (SAHARA) network from South Africa contracted to conduct the research, in particular: Prof. Nancy Refilwe Phaswana-Mafuya, Principal Investigator, and her team: Mr Witness Chirinda, Ms Zamakayise Kose, Dr Batlile Maseko, Dr Dimitri Tassiopoulos, Mr Adlai Davids, Dr Clarence Yah and Mr Ryan Zahn who were instrumental in conceptualising and overseeing the implementation of the 10- country research projects, and who authored the multi-country Analytical Report; Ms Yuan Zhao, Johns Hopkins University visiting graduate student for assistance in the initial phases of data management for some countries.
- SAHARA project administrators, Ms Nomfanelo Plaatjie, Ms Thobela Burwana, and Ms Kimrochey Goliath for their administrative input in the study respectively.
- Prof Leickness Simbayi, HAST Executive Director, for providing internal approvals for the study; the HSRC legal team for reviewing and vetting the contract between the ILO and HSRC, and the respective organizations of the country researchers across the 10 countries, as well as for making

legal input throughout the study; the HSRC and HAST Finance teams for ensuring that the project remained within budget; the HSRC Supply Chain Management (SCM) team for assistance in ensuring compliance with required SCM procedures.

- All the 66 workplaces selected across sectors and business types from the 10 countries and their employees who participated in focus group discussions and in-depth interviews in spite of not receiving any direct benefits.

- The SAHARA partners accross the 10 countries who contributed to the conceptualization of the study, oversaw the implementation of the research in their own countries and secured evidence for the selection of workplaces; organized stakeholder meetings; secured in-country study approvals; reviewed study instruments; negotiated entry to the workplaces and lead data collection, translations and transcriptions in their respective countries. They also co-authored country reports which served as the basis for the analytical report. These are: Ms Prisca Dominique Dadié (Côte d'Ivoire); Dr Ben Ngoye (Kenya); Mr Atuahene Kyeremeh (Ghana); Ms Josiane Robiarivony and Dr Andry Rakotomanana (Madagascar); Dr Amal Benmoussa (Morocco); Dr Ibrahim Gaye and Ibrahima Sall (Senegal); Dr Fatima Cuembelo (Mozambique); Mr Chrispin Chomba (Zambia) and Dr Katie Hofnie (Namibia).

- The stakeholders in the 10 countries who supported the project by providing documents and evidence for workplaces that had achieved 'good outcomes', participating in stakeholder meetings and being participants in the key informant interviews. These include officials of Government ministries and departments, and National AIDS Commissions, employees of the employers organizations and Business coalitions, workers organizations, organizations of People Living with HIV (PLHIV), and other Non-Governmental Organizations (NGOs) in the 10 countries; the German Development Cooperation/Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), the Swedish Workplace HIV and AIDS Programme (SWHAP), the South African Automotive Industry Development Centre Eastern Cape (AIDC EC);

the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Development Programme (UNDP).

- The interpreters from Côte d'Ivoire, Madagascar, Morocco, Mozambique and Senegal, who assisted with interpretation during the stakeholder meetings and all the transcriptionists in all 10 countries who spent hours working on the interviews.
- The members of the Inter-Agency Task Team on HIV workplace policies/programmes and private sector engagement, particularly Dr Syed Asif Altaf, of the International Transport Workers' Federation (ITF), Mr Julian Hows, of the Global Network for and by People Living with HIV (GNP+) and Mr John Viner, SWHAP.
- Our colleagues in the ILO offices and projects in Accra, Antananarivo, Dakar, Lusaka, Maputo, Nairobi, and Pretoria: Mr Amadou Cissé, Mr Mady Diagne, Mr Simphiwe Mabhele, Ms Hellen Magutu, Ms Olive Munjanja, Ms Akua Ofori-Asumadu, Ms Nombana Razafinisoa, Mr Paulo Romao and Ms Evelyn Serima; and in ILO headquarters: Ms Adrienne Cruz, Ms Valentina Forastieri, Ms Carla Henry, Mr Mustafa Hakki Ozel and Ms Amrita Sietaram.
- A task team within ILOAIDS, coordinated by Ms Brigitte Zug-Castillo, worked on this research. It comprised Mr. Kofi Amekudzi, Mr Oluremi Doherty, Ms Julia Fäldt-Wahengo, Ms Margherita Licata and Ms Fatima N'Diaye.

"For ethical reasons, to protect the confidentiality of the 66 workplaces that participated in the study, their names have been replaced by code names, from W1 (as in "Workplace") to W66."

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ABBREVIATIONS AND ACRONYMS

TERM	DEFINITION
AFEP	Association des Femmes Espérance Positives, Madagascar (network of women living with HIV)
AIDC EC	Automotive Industry Development Centre Eastern Cape (South Africa)
AIDS	Acquired Immunodeficiency Syndrome
AMES	Association des médecins d'entreprise du Sénégal
AON	Aon Kenya Insurance Brokers Limited
ART	Antiretroviral Treatment
BCC	Behaviour Change Communication
CD4 count	Cluster of Differentiation 4: Laboratory test that measures the number of CD4 cells in a sample of blood
CEO	Chief Executive Officer
CNCS	Conselho Nacional de Combate ao HIV/SIDA, National AIDS Council
CNLS	Comité National de Lutte contre le Sida, National AIDS Council
CNP	Conseil National du Patronat
CNTS	Confédération Nationale des Travailleurs du Sénégal
CSR	Corporate Social Responsibility
DPSA	Department of Public Service & Administration, South Africa
EAP	Employee Assistance Programme
ECOSIDA	Empresários Contra HIV e SIDA, Tuberculose e Malária, Mozambique
ENDA	Environment and Development Action in the Third World
FGD	Focus Group Discussion
FHI 360	Family Health International 360

GBCEW	Ghana Business Coalition on Employee Wellbeing
GIZ	Gesellschaft für Internationale Zusammenarbeit German Development Cooperation
HCT	HIV Counselling and Testing
HIV	Human immunodeficiency virus
HR	Human Resource
HSRC	Human Sciences Research Council
IDI	In-depth Interview
IEC	Information Education Communication material
ILO	International Labour Organization
ILOAIDS	HIV and AIDS and the World of Work Branch of the ILO
KAPB	Knowledge, Attitudes, Practices and Beliefs
LVCT	LVCT Health, Kenya – NGO
M&E	Monitoring and Evaluation
MIPA	Meaningful involvement of PLHIV
MSM	Men who have sex with men
NAC	National AIDS Council
NCPI	National Composite Policy Index
NGO(s)	Non-governmental organization(s)
NNPLWA	Namibian Network of People Living with Aids
NOPE	National Organization of Peer Educators, Kenya
NUNW	National Union of Namibian Workers
PEP	Post Exposure Prophylaxis
PICT	Provider Initiated HIV Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International

RIP+	Réseau Ivoirien des Organisations de Personnes vivant avec le VIH/sida, Côte d'Ivoire
SABCOHA	South African Business Coalition on HIV/AIDS
SANAC	South African National AIDS Council
SHARe II	Leadership, Partnership & Workplace HIV/AIDS Project, Zambia
SHOPS	Strengthening Health Outcomes through the Private Sector
SME	Small and Medium Enterprises
STI	Sexually Transmitted Infection
SWHAP	Swedish Workplace HIV and AIDS Programme
TB	Tuberculosis
TUCNA	Trade Union Congress of Namibia
UN	United Nations
UNACOIS	Union Nationale des Commerçants et Industriels du Sénégal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary and Confidential Counselling and Testing
WHO	World Health Organization
ZHECT	Zambia Health Education and Communication

EXECUTIVE SUMMARY

The UNAIDS Gap Report (2014) shows that over the past decade intensified prevention, treatment care and support efforts – many in workplaces – have begun to turn the tide against HIV and AIDS worldwide. HIV incidence and AIDS-related deaths are gradually in decline; at the same time, antiretroviral treatment (ART) uptake has increased, reaching nearly 13 million people by the end of 2013 – or more than 60 per cent of all eligible individuals in low and middle income countries (UNAIDS, 2014). Today, it can safely be said that remarkable progress has been made toward achieving the Millenium Development Goal (MDG) of halting and beginning to reverse the spread of HIV and AIDS by 2015 with a view to ending the epidemic by 2030 (UNAIDS, 2014).

These developments have been especially significant in Africa, the region most affected by HIV and AIDS (UNAIDS, 2014). The decline in incidence and death among adolescents and adults and the increase in access to ART have been even more pronounced in some African countries than in the rest of the world. Furthermore, major challenges such as the persistence of HIV-related stigma and discrimination, gender inequalities, and lack of integration of HIV into broader health and development plans are being addressed by effective and robust programmes in the African workplaces, which are now leading entry points for the response to HIV and AIDS.

Since 2001, the HIV and AIDS and the World of Work Branch of the ILO (ILOAIDS) and its partners have supported the efforts of governments, employers' and workers' organizations, and networks of people living with HIV across the world to develop, implement, monitor and evaluate HIV workplace policies and programmes. These initiatives have facilitated access to HIV prevention, treatment, care and support for workers and their families, dependants and communities. Yet despite this progress, much remains to be done. Realizing the vision of zero new infections, zero discrimination and zero AIDS-related deaths in the immediate years to come will require a major expansion of efforts already underway aimed at outpacing HIV and AIDS.

This effort requires putting knowledge into action. However, knowledge about workplace policies and programmes that work in practice and achieve good outcomes and positive changes has yet to be comprehensively documented. Against this background, the ILO commissioned the Human Sciences Research Council (HSRC) of South Africa to conduct the first evidence-based study and analysis of HIV and AIDS initiatives in African workplaces to determine *what works* in achieving good outcomes in order to guide efforts to expand and accelerate this effort.

This new study is the most comprehensive assessment to date of the programmatic activities that have been undertaken in African workplaces and their associated communities. It is based on research conducted between January 2013 and October 2014 in public, private, formal and informal workplaces across 10 African countries: Côte d'Ivoire, Ghana, Kenya, Madagascar, Morocco, Mozambique, Namibia, Senegal, South Africa and Zambia. In order to ensure scientific rigour of the results, the research employed quantitative methods which involved using quantifiable evidence of good outcomes. It was also qualitative, involving in-depth interviews with individuals and focus group discussions with key informants at national and workplace levels, as well as employees in workplaces.

The demands for scientific rigour by way of a "documented evidence" criterion helped focus the research on 66 workplaces. As a result, while the findings do not purport to cover all workplaces of the African continent, they are nevertheless informative and provide valuable insights into the research area. The diversity of countries involved in the study, the different epidemic types they are facing and the variety of investigated workplaces, in terms of size, type and economic sectors, produce a wealth of information and a report rich in useful analysis and recommendations.

Each chapter provides an overview of the good outcome, an analysis of relevant workplace actions or strategies, information on other factors that facilitated the achievement of the good outcome, real-life examples of innovative and effective practices at the workplace, and summary recommendations for further action.

ACHIEVING GOOD OUTCOMES

Increasing knowledge on HIV and AIDS is not just a good outcome: it is critical to the achievement of other good outcomes. How can people increase their knowledge about HIV and AIDS? What factors contribute to increasing such knowledge? What programmatic actions can be taken to achieve it? Chapter 3 provides answers to these questions based on information from approximately 75 per cent of the workplaces surveyed about how knowledge was shared in workplace programmes, and the actions and external factors that contributed to increasing such knowledge.

The study shows that management commitment, from the inception of knowledge building activities to providing resources and facilitating implementation and evaluation, is key to increasing knowledge about HIV and AIDS. It also presents knowledge-building activities that proved to be effective for both male and female employees and highlights the value of integrating HIV and AIDS knowledge-building activities into wellness, occupational safety and health or employee assistance programmes. It further stresses the importance of engaging people living with HIV (PLHIV) in activities to raise awareness of the real conditions of PLHIV and normalize issues around HIV.

The chapter concludes that there is no "one-size-fits-all" approach to strengthening and expanding HIV and AIDS knowledge. Workplaces are encouraged to adopt flexible, context-specific and gender-tailored approaches that will help employees increase their knowledge about HIV and AIDS. In addition, it also recommends linking awareness-building on HIV and AIDS to a wider range of other health issues to help increase sustainability, reduce stigma and improve uptake of information sessions.

Voluntary Counselling and Testing (VCT) is a recognized strategy that empowers people to take the steps needed to know their HIV status and, if necessary, seek treatment. Chapter 4 examines actions and factors that contribute to increased uptake of VCT in the workplace. Again, management commitment, including allocation of human, financial and

material resources, is identified as a key driver of VCT uptake across all sectors and is crucial in running and maintaining a successful VCT programme. Management also has a major role to play in ensuring the creation of an enabling policy environment that facilitates the uptake of HIV testing.

The study found that PLHIV can contribute significantly to increasing VCT uptake by normalizing perceptions of HIV and increasing acceptability among employees. It also shows how integration of VCT into other programmes not only increases VCT uptake but also lessens stigma and discrimination. Noting that one-off VCT awareness activities may not produce a sustained increase in VCT uptake, the study recommends that workplaces consider promoting on-going VCT activities, in partnership with other stakeholders such as testing clinics, hospitals, business councils and organizations of PLHIV, among others. Management and union leaders are encouraged to lead the way by taking an HIV test, for example during HIV Testing Days. Workplaces should ensure that VCT services are accessible to all employees in a convenient location and at convenient times that will ensure privacy and confidentiality.

Changing or reducing risky behaviours is another good outcome that is critically important to slowing the advance of HIV and AIDS. Addressing risky behaviours involves reducing the number of sexual partners, having safer sex by using condoms correctly and consistently, maintaining fidelity in relationships and accessing HIV testing and counselling services. Approximately 65 per cent of the workplaces investigated provided solid evidence of actions that helped achieve this good outcome.

Chapter 5 examines the impact of management on risk-reduction strategies such as making condoms available in workplaces and corporate structures or distributed as part of special events or campaigns. In addition, it shows how effective partnerships between public and private sectors enhance the sustainability of workplace programmes on reducing risky behaviours, in particular partnerships and linkages with national AIDS bodies and ministries of health that can help ensure a sustainable supply of condoms. Another important element in risk reduction is assessing behavioural and

vulnerability factors to help employees begin to understand their own risk. Though the promotion of condom use is important, the study also shows that it should be promoted in combination with other prevention strategies, including delay of sexual initiation, abstinence, being faithful to one's partner and reducing the number of sexual partners. The chapter also underlines the importance of understanding situations that can undermine the individual's commitment to avoiding risky behaviours and recommends how to shape messages, data, information and tools that address these issues.

Chapter 6 identifies the strategies and actions used in some workplaces to ensure that **gender concerns** are integrated into their HIV policies, programmes and activities. Because the epidemic affects women and men differently, gender issues need to be addressed in the AIDS response. The epidemic poses a particular threat to women and girls, not only because of their greater physiological susceptibility to HIV, but also because of gender-related disparities in economic opportunities, legal and social disadvantages and related gender-based discrimination and violence.

In general, workplaces have put in place a number of gender-sensitive and gender-specific measures throughout the planning and implementation of workplace programmes. These include *gender-sensitive* measures aimed at designing sessions, services and other initiatives to take into account the way male and female workers perceive roles and norms in relation to HIV and AIDS, and *gender-specific* measures aimed at identifying specific risk factors and prevention needs among men and women, and designing responsive strategies to address these risks and needs accordingly. The chapter concludes with a series of recommendations for addressing the impact of gender inequality in the workplace HIV and AIDS responses, including undertaking gender analysis, developing inclusive policies and programmes for women and men workers, and putting in place monitoring and evaluation systems that take gender aspects into consideration.

Reducing stigma and discrimination is an important good outcome in that it has an impact on the successful achievement of the other good outcomes. Most obviously, respecting the rights of PLHIV improves their quality of

life, both at work and outside the workplace. Yet only 14% of workplaces investigated were able to provide conclusive evidence that their programmes had reduced HIV-related discrimination. Addressing discrimination is critical to the sustainability of workplace HIV and AIDS programmes. Moreover, ensuring the continued employment of PLHIV encourages others to go for HIV testing, and promotes treatment adherence, enhances livelihoods, improves their financial status and, in many cases, reduces their vulnerability to HIV. Chapter 7 analyses the causes and impact of stigma and discrimination, and identifies concrete actions to address them. These include initiating strong management commitment, an enabling legal and policy environment, the involvement of PLHIV in learning and dialogue about HIV and AIDS, and ensuring the use of monitoring and evaluation systems to track and guide progress.

The study shows how innovative and integrated approaches (e.g. wellness programmes) that combine HIV programming such as training and information-sharing with other health programmes, can increase their overall appeal and sustainability, while also reducing stigma. Integrated approaches also involve mainstreaming HIV education into on-going workplace activities, training or other programmes. Enterprises and organizations are urged to take advantage of national plans, strategies, policies and laws when developing and implementing their HIV workplace programmes. Situating the workplace programmes within the country context and establishing the necessary linkages also contributes to their effectiveness.

Chapter 8 examines the findings on programmatic actions undertaken by various workplaces to increase **uptake of antiretroviral treatment, or ART**. The life-saving potential of ART is well known and has significantly improved the global HIV and AIDS landscape, especially in terms of enabling PLHIV to enjoy longer and healthier lives. Employment has a reinforcing role on HIV treatment adherence; therefore PLHIV are more likely to stay on treatment if they have a job. In the world of work, accessibility to ART also has benefits for employers. For enterprises, companies and other workplaces, improving ART uptake can make business sense in terms of reducing the costs of absenteeism and hospitalization.

The study reveals, however, that in this domain much work needs to be done. It notes that only two of the 66 workplaces investigated offered strong evidence proving they had managed to achieve an increase in ART uptake. Their experiences illustrated that in order for HIV treatment to be taken up by employees, it must be accessible and affordable, and within a setting where privacy and confidentiality are guaranteed. In many low-income countries, governments play a lead role in providing HIV treatment, often at low or no cost. The study recommends that workplaces take advantage of this opportunity and establish linkages with their on-going HIV programmes to ensure the continuum of care is not broken, especially when employees leave work or lose their jobs.

Additionally, workplaces can provide help to cover the cost of treatment of opportunistic infections and reduce the financial burden on employees living with HIV. Monitoring and evaluation is also shown as adding value, in that it helps detect whether programmes are performing well and achieving expected results, and if not, provide guidance on how they should be altered to ensure adherence and the success of treatment. The chapter concludes with a number of recommendations for providing comprehensive health services (e.g. one-stop clinics) whereby ART uptake can be facilitated when combined with treatment for other illnesses.

One of the main challenges posed by the HIV epidemic in the world of work is **absenteeism and its associated costs**. Chapter 9 examines the importance of cost benefit analyses in helping management understand the costs associated with absenteeism due to illness or bereavement, and the benefits of establishing wellness and other workplace programmes to address the impact of HIV and other illnesses on the presence of their workforce. The chapter examines strategies undertaken by workplaces to reduce absenteeism and its associated costs, including a general health screening and wellness approach that focuses on overall health and well-being of employees while at the same time reducing stigma attached to a single illness. It also provides examples of management leadership in building public-private partnerships with outside stakeholders to secure affordable insurance schemes that can improve employee access to health services, promote healthy behaviours and build employee commitment and morale.

SUMMARY

Each chapter identifies factors that are external to the workplace but are conducive to successfully achieving good workplace outcomes. The existence of national HIV and AIDS plans, strategies, laws and policies, and testing and treatment programmes were deemed critically important to achieving many good outcomes. Likewise, adopting gender-specific approaches that address the needs of women and men were also regarded as vitally important. Other factors contributing to achieving good outcomes include: management commitment, monitoring and evaluation, awareness-raising, peer education and behaviour change communication (BCC) programmes, a general health and wellness approach, the involvement of PLHIV, provider-initiated counselling and testing (PICT), family and couple counselling and links to care providers, stigma level assessment, acceptance and openness towards HIV and AIDS issues, and cost-benefit analyses.

Table 1 Summary of contributing factors to achieving good outcomes, as identified in the 66 workplaces

Good Outcomes	Contributing Factors	Overarching factors conducive to making outcomes successful
Increased knowledge about HIV and AIDS	• Management commitment • Monitoring and evaluation • Awareness and education (including peer education and BCC) • General health screening and wellness approach • Involvement of people living with HIV	• Existence of HIV and AIDS national plans, strategies, laws and policies, and testing and treatment programmes • Gender-specific approaches which can address the needs of women and men
Increased uptake of (VCT)	• Management commitment • Monitoring and evaluation • Awareness and education (including peer education and BCC) • General health screening and wellness approach • Family and couple counselling and link to care providers • Provider initiated counselling and testing (PICT)	

Good Outcomes	Contributing Factors	Overarching factors conducive to making outcomes successful
Reducing stigma and discrimination	• Management commitment • Monitoring and evaluation • Awareness and education (including peer education and BCC) • Involvement of people living with HIV • Stigma level assessment • Acceptance and openness towards HIV and AIDS issues	• Existence of HIV and AIDS national plans, strategies, laws and policies, and testing and treatment programmes • Gender-specific approaches which can address the needs of women and men
Increasing uptake of (ART)	• Management commitment • Monitoring and evaluation • Awareness and education (including peer education and BCC) • General health screening and wellness approach	
Reducing absenteeism and costs	• Management commitment • Monitoring and evaluation • General health screening and wellness approach • Cost-benefit analysis	

Overall, the findings and recommendations, illustrated by concrete workplace examples, make it clear that there is enormous prescriptive value in documenting and evaluating successful workplace responses to HIV and AIDS. The findings also make a compelling argument for expanding local, regional and global activities in the world of work. The value of the workplace as a key entry point for HIV and AIDS responses is indisputable – employees living with HIV are almost 40 per cent more likely to stick to HIV treatment than those without a job[1]. Thus, the world of work becomes both a platform for a targeted response to HIV and AIDS and a vital element of global efforts to stop the AIDS epidemic and save lives. Of all the good outcomes examined here, the best good outcome of them all is just that.

[1] The Impact of Employment on HIV Treatment Adherence, ILO, 2013

CHAPTER 1: INTRODUCTION[2]

Over the past decade, intensified prevention, treatment and care activities have begun to turn the tide against HIV and AIDS worldwide. According to the UNAIDS 2014 Gap Report, the number of new HIV infections declined from 3.4 million in 2001 to 2.1 million in 2013, or by 38 per cent. At the same time, deaths from AIDS declined significantly, from 2.3 million in 2005 to 1.5 million in 2013. In the past three years alone, AIDS-related deaths have fallen by 19 per cent, which represents the largest decline in the past 10 years. In some countries, the changes were even more pronounced: HIV incidence among adolescents and adults declined annually by more than 50 per cent in 26 countries, including African countries such as Botswana, Côte d'Ivoire, Ethiopia Ghana, Namibia, Nigeria, Senegal and Zambia. These data illustrate that the world is moving steadily toward achieving the UN Millenium Development Goal Target 6.A: "Have halted by 2015 and begun to reverse the spread of HIV/AIDS" (United Nations Millenium Development Goals).

An important element of this progress has been greater access to antiretroviral treatment (ART). Between 2006 and 2013, the percentage of PLHIV who are not receiving ART has been reduced from 90 per cent to 63 per cent. UNAIDS estimates that in 2014, 13.6 million people were receiving ART globally. In sub-Saharan Africa, 86 per cent of PLHIV who know their status are receiving ART and nearly 76 per cent of them have achieved viral suppression. However, despite the increased access to ART in sub-Saharan Africa, significant gaps remain, including the fact that only 45 per cent of PLHIV know their HIV status, which underscores the need to increase HIV knowledge and expand testing.

Among PLHIV, women represent the majority in low-and middle-income countries; in Sub-Saharan Africa they represent 58 per cent of PLHIV. ART coverage among pregnant women living with HIV increased worldwide; by 2012 62% had access to ART, resulting in averting more than 900,000 new HIV infections among children since 2009.

[2] This chapter is mainly based on the UNAIDS 2014 Gap Report and UNAIDS 2013 Global report, henceforth referred to as UNAIDS 2014 report and UNAIDS 2013 report respectively.

The 2013 UNAIDS report emphasizes the centrality of gender in the response to HIV as the epidemic continues to be driven by gender inequalities. The epidemic poses a particular threat to women and girls, not only because of their greater physiological susceptibility to HIV, but also because of gender-related economic disparities, legal and social disadvantages, as well as gender-based discrimination and violence.

The 2013 UNAIDS report also states that "unequal gender norms regarding masculinity encourage men's sexual risk-taking and affect men's health-seeking behaviour negatively." Consequently, it says "men are less likely to be tested for HIV, have lower CD4 counts when they enter treatment and are less likely to adhere to treatment. Consequently, men receiving antiretroviral therapy have consistently higher AIDS-related mortality rates than women". At the same time, the 2013 UNAIDS report also found that "female sex workers are particularly vulnerable, with an estimated HIV prevalence of 12 per cent globally and 30 per cent in medium to high HIV prevalence settings", adding that "transgender women are 49 times more likely to be living with HIV than women overall, with a pooled HIV prevalence among transgender women of 19 per cent."

These factors underscore the need for transformative responses to HIV that ensure equity in the access of women and men to prevention, treatment, care and support, including in the world of work. UNAIDS reports that HIV-related stigma and discrimination persist, especially among key populations – or those most likely to be exposed to HIV or to transmit it. Globally, 60 per cent of countries report having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups.

Thus, despite encouraging progress in addressing the HIV and AIDS epidemic worldwide and especially in Africa, much remains to be done. Major obstacles to a more effective response to HIV and AIDS include reduced funding for HIV and AIDS, gender inequalities, harmful gender norms and HIV-related stigma and discrimination, and lack of integration of HIV into broader health programmes. In particular, these persistent challenges serve as barriers to efforts to scale up prevention efforts,

especially for women and key populations in sub-Saharan Africa, the region most affected by the epidemic.

The world of work has become a crucially important entry point for HIV and AIDS programme activities. Granted, HIV and AIDS still contribute to declining productivity, increased labour costs, overtime, sick leave and absenteeism in both the public and private sectors, as well as in the informal economy.

Since 2001, ILOAIDS and its partners have led the way in helping countries to address these challenges. ILOAIDS has supported governments, employers' and workers' organizations, and networks of PLHIV in more than 70 countries across the world to develop, implement and monitor HIV programmes aimed at tackling HIV and AIDS in the workplace. These initiatives have facilitated access to HIV prevention, treatment, care and support for workers and employers, as well as their families, dependants and communities. Much has been learned, yet to date the knowledge base about positive changes brought about by these innovative and effective workplace programmes has not been comprehensively and widely documented.

Against this background, the ILO commissioned the *Human Sciences Research Council* (HSRC) of South Africa to conduct an evidence-based study on what works in achieving good outcomes in HIV and AIDS workplace responses. The study examines both how and why good outcomes were achieved, as well as what conducive factors facilitated the effective implementation of the HIV response, and hence the achievement of good outcomes. It is hoped that the evidence generated from this study will strengthen global, regional and local HIV prevention, treatment, care and support strategies in the world of work, and contribute to accelerating progress toward achieving the vision of zero new infections, zero discrimination and zero AIDS-related deaths, and the goal of Ending AIDS by 2030.

CHAPTER 2: METHODOLOGY[3]

This report focuses on research conducted between January 2013 and October 2014 across 10 countries: Côte d'Ivoire, Ghana, Kenya, Madagascar, Morocco, Mozambique, Namibia, Senegal, South Africa and Zambia. The study included countries with different epidemic types and geographic diversity. In order to ensure scientific rigour of the results, the research employed methods which involved using quantifiable evidence of good outcomes. It was also qualitative, involving analysis, in-depth interviews and focus group discussions. All study tools were pre-tested prior to finalization.

Examples of good outcomes that the study was to research are included below and were derived from the ILO's HIV and AIDS Recommendation, 2010 (No. 200) concerning HIV and AIDS and the World of Work. This list was not exhaustive but was rather meant as guidance:

- Reduced absenteeism and staff turnover of women and men workers
- Reduced employment-related discrimination based on real or perceived HIV status
- Reduced stigma towards PLHIV,
- Reduced stigma and discrimination experienced by PLHIV,
- Reduced risky behaviour of women and men,
- Increased uptake of Voluntary Counselling and Testing (VCT)
- Increased employee knowledge on HIV and AIDS, including its gender dimension
- Increased uptake of ART and other treatment services (STIs, opportunistic infections, TB etc.)

  Increased uptake of Prevention of Mother To Child Transmission (PMTCT)
- Reduced occupational risk (through PEP, TB treatment, Universal precautions etc.)
- Reduced costs (recruitment, supervision, training and lost productive time) and
- Increased productivity.

[3] Tables in Annex 1 (p. 131).

However, in the 66 researched workplaces, no solid evidence on the achievement of the last four good outcomes was found.

Several preparatory steps were undertaken. Country researchers received training to familiarize themselves with research objectives and research tools and techniques in a culturally sensitive manner, and to ensure adherence to the criteria for selection of eligible workplaces, research ethics and the uniformity and standardization of the data collection procedures.

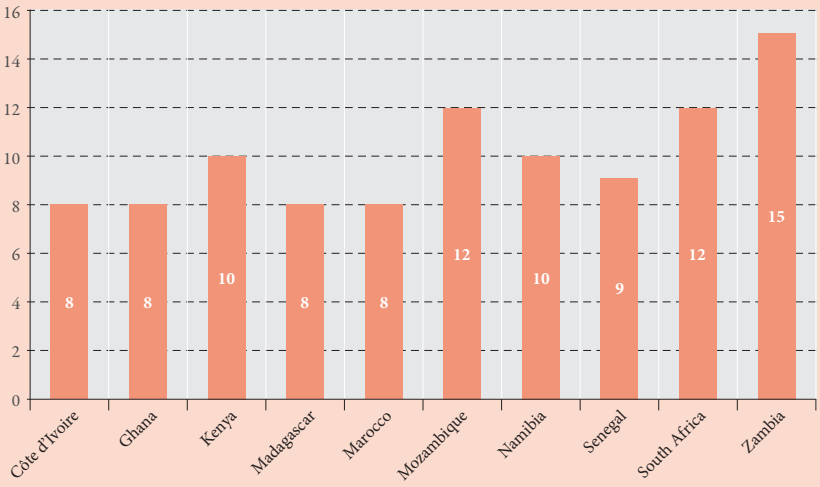
Following their training, country researchers secured study approvals from their respective recognized authorities and identified key stakeholders from the public and private sectors, the informal economy, employers' and workers' organizations, United Nations agencies and organizations representing beneficiary groups. They also organized and conducted "project inception" meetings together with the HSRC research team. These meetings were held in the respective countries from May to July 2013 to explain the purpose of the research to the identified stakeholders, secure their buy-in and identify eligible workplaces in their countries.

Eligible workplaces were identified on the basis of the availability of documented evidence of any of the good outcomes, regardless of the type of workplace, its size or other characteristics.

A situational analysis was conducted by reviewing the "*Global Literature Review on What Works to Achieve Good Outcomes in HIV and AIDS Workplace Initiatives – Final Report* (Visser, 2012), henceforth referred to as "Visser;" and project evaluation reports, monitoring and evaluation records, surveys, assessments and journal articles providing evidence that the reported good outcomes were actually achieved. The situational analysis included consultations with national stakeholders.

Once evidence of a good outcome or outcomes was confirmed, the workplace was included in the study. Overall, 66 workplaces were identified. The distribution of workplaces per country was as follows (number of workplaces and per cent of the total in the study): Côte d'Ivoire (n=5; 8 per cent), Ghana (n=5; 8 per cent), Kenya (n=7; 10 per cent), Madagascar (n=5; 8 per cent), Morocco (n=5; 8 per cent), Mozambique (n=8; 12 per cent),

Figure 1 **The distribution of workplaces that participated in the study, per country (per cent)**



Namibia (n=7; 10 per cent), Senegal (n=6; 9 per cent), South Africa (n=8; 12 per cent) and Zambia (n=10; 15 per cent), as depicted in Figure 1.

In-depth interviews (IDIs) were conducted with key informants at both the national and workplace levels, while focus group discussions (FGDs) were held exclusively at the workplace level. The interviews lasted about 50 minutes, while group discussions took about two hours. For the purposes of extracting data, the interviews and discussions were recorded electronically where possible, or interview notes were taken where it was not possible to record.

Of the 75 national stakeholders interviewed 41 (55 per cent) were men and 34 (45 per cent) were women (Figure 2). The interviews were aimed at eliciting information about national "conducive" factors that contributed to achievement of good outcomes. (A distribution by sex per country is provided in Figure 3.)

Figure 2 **Distribution of national stakeholder IDIs by sex across 10 countries (per cent)**

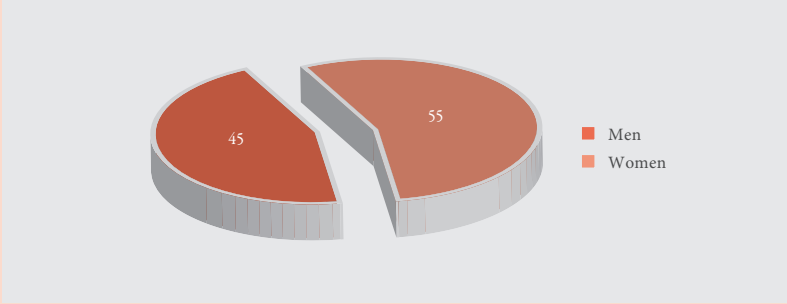
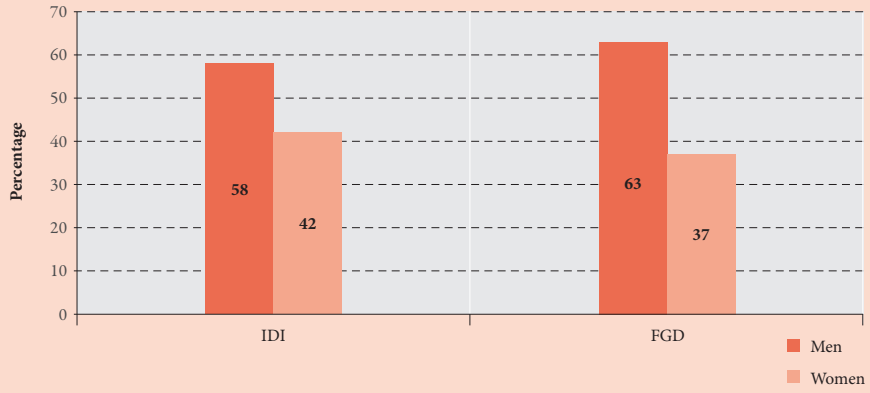


Figure 3 **National stakeholder interviews (IDIs) by sex per country (per cent)**

In half of the countries – Madagascar, Mozambique, Namibia, Senegal and South Africa – the majority of national stakeholders interviewed were men, while in the other half – Côte d'Ivoire, Ghana, Kenya, Morocco and Zambia – the majority were women (Figure 3, also see Annex 1, Table 2). The interviewees were drawn from representatives of governments (ministries of labour) and employers' and workers' organizations, other government

Figure 4 **Distribution of workplace informants by type of interview and by sex (per cent)**



ministries (health, transport, construction and others), national AIDS council representatives, civil society organizations including networks or support groups for PLHIV and networks of sex workers, and UN agencies.

In-depth interviews and focus group discussions were conducted in workplaces in all 10 countries. Pilot-tested in-depth interviews were administered at the workplace level by trained and experienced country researchers (as described above) to 158 key informants – 92 men (58 per cent) and 66 women (42 per cent) (Figure 4). Key informants were knowledgeable individuals involved in the leadership of HIV workplace programmes in one way or another. They included HIV coordinators, human resource managers, and other management and HIV committee members.

In addition, 44 focus group discussions involving 378 employees (237 men or 63 per cent and 141 women or 37 per cent) were conducted in workplaces where it was feasible to do so (Figure 4, also see Annex 1, Table 3). Focus group participants included both junior and senior employees who were knowledgeable, but not responsible for the management, of HIV programmes. They included programme beneficiaries and facilitators (e.g. peers). All participants were over the age of 18 and gave their consent to participate.

DATA PROCESSING, CAPTURING AND ANALYSIS

Data collected from these sources and existing records and documentation were transcribed, cleaned, processed, captured, triangulated and analysed using thematic content analysis at workplace and country levels. The purpose

of this process was to find out "what works", and what conducive factors contributed to achieving each "good outcome" at the workplace. Code lists were developed based on research questions, hypotheses, literature, key concepts and important themes in order to organize, assemble and reduce data into analysable units, i.e. code lists for workplace and stakeholder interviews, and workplace focus group discussions (Miles and Huberman, 1994). The researchers identified, grouped, and named themes and sub-themes and came up with possible interpretations of the data to ensure accuracy (ibid.). Country reports were then generated. Thereafter, data from the country reports were meta-analysed to determine what works within each good outcome across the 10 countries as well as identify common and unique approaches within each good outcome and lessons learnt.

LIMITATIONS OF THE STUDY

The study had some limitations, which were addressed to ensure that the results were reliable and accurate. These limitations included:

- Construct validity: There could have been a misunderstanding of some of the questions. Besides providing intensive training to country researchers and pre-testing of tools, follow-up interviews were conducted to clarify the information provided and correction measures were put into place in order to improve consistency and accuracy.
- External validity: Purposive sampling was used to select eligible workplaces that had evidence of good outcomes. Therefore, workplaces that did not have evidence of good outcomes were excluded from the study. While the findings from this study cannot be assumed to be representative of all workplaces across the 10 countries, they will assist in gaining insight into the research area given the diversity of workplaces in terms of size, type and economic sector as well as epidemic type.
- Internal validity: Although the categories of employees and employers who were interviewed were knowledgeable about the research area, there could have been information bias. The responses given were compared with the evidence provided to ensure internal validity.

- Conclusion validity: While the results of a qualitative study are indicative rather than statistically significant, the use of multiple sources of data (triangulation) facilitated validation of data through cross verification and thus allowed for a more rigorous analysis of data.

PROFILE OF WORKPLACES INVESTIGATED

This research provides a rich diversity of evidence-based, rigorous findings of what works, to help inform and guide future HIV and AIDS workplace policies and programmes. The study involved 66 workplaces, of which, 6 per cent were small (<50 employees), 18 per cent were medium-sized (50 to 499 employees) and 76 per cent were large (>500 employees) (Figure 5, and Annex 1, Table 4). Overall, the number of small and medium-sized workplaces with documented evidence of good outcomes was smaller (24 per cent) compared to large organizations (76 per cent), hence the overrepresentation of large workplaces in this study. Many small- and medium-sized workplaces did not meet the eligibility criteria of availability of documented evidence of good outcomes. Small- and medium-sized workplaces had many constraints including human resource capacity and the unavailability of financial resources. The distribution of workplaces by size and country is presented in Figure 6.

Figure 5 **Distribution of workplaces by size across the 10 countries (per cent)**

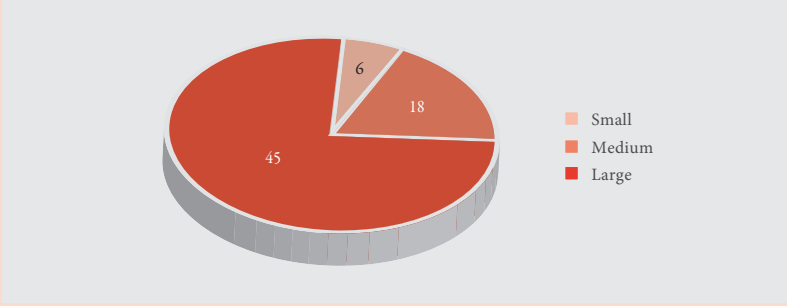


Figure 6 Distribution of workplaces by size and by country

TYPES OF WORKPLACES

Most of the workplaces were in the private sector (74 per cent), with public sector workplaces accounting for 14 per cent and the informal economy 12 per cent (Figure 7, and Annex 1, Table 5). See Figure 8 for the distribution of workplaces per country and per type.

Figure 7 Types of workplaces across 10 countries (per cent)

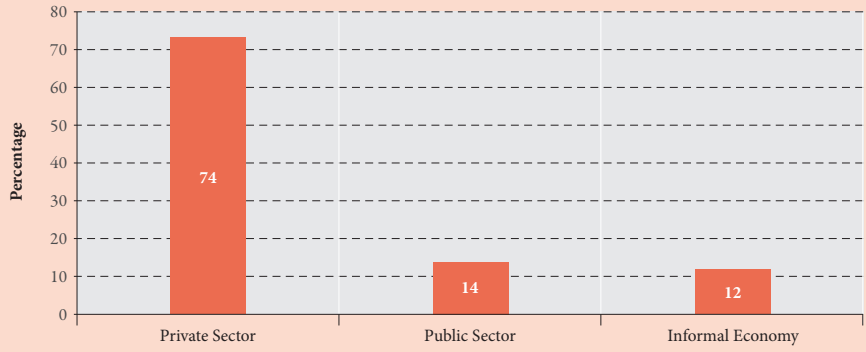


Figure 8 **Number of workplaces by type per country**

TYPES OF ECONOMIC SECTORS

The study covered the following economic sectors: private services (21 per cent); manufacturing (20 per cent); maritime and transport (20 per cent); public service, utilities and health (14 per cent); agriculture, food and forestry (9 per cent); energy and mining (8 per cent); infrastructure,

Figure 9 **Distribution of workplaces by economic sector (per cent)**

construction and related sectors (6 per cent) and education and research (3 per cent) (Figure 9 and Annex 1, Table 6).

TYPE OF EPIDEMIC

Seven countries had generalized epidemics and three concentrated epidemics as presented in Table 1 below. Concentrated epidemic countries are countries where the HIV prevalence is under 1 per cent in the general population but higher than 5 per cent in the most affected subpopulations. Key populations at higher risk include commercial sex workers, men who have sex with men and people who inject drugs. Generalized epidemic countries are those where more than 1 per cent of the general population are HIV positive (ibid.).

Table 1 Epidemic type, by country

Country	Generalized epidemic	Concentrated epidemic
Côte d'Ivoire	X	
Ghana	X	
Kenya	X	
Madagascar		X
Morocco		X
Mozambique	X	
Namibia	X	
Senegal		X
South Africa	X	
Zambia	X	
Total	7	3

CHAPTER 3: INCREASED KNOWLEDGE ABOUT HIV AND AIDS[4]

How can people increase their knowledge about HIV and AIDS? What factors contribute to increasing such knowledge? What programmatic actions can be taken in workplaces to achieve such an increase? This chapter presents the results of surveys in which approximately 76 per cent of workplaces provided clear evidence on how they had increased knowledge about HIV and AIDS among their employees (Annex 2, Table 8). This included effective actions and strategies such as management commitment, monitoring and evaluation, peer education and training, a "wellness approach" and importantly, the meaningful involvement of people living with HIV (MIPA) (Annex 3, Table 14).

Figure 10 Actions used by workplaces to increase knowledge (per cent)

MANAGEMENT COMMITMENT TO INCREASED KNOWLEDGE

Management support and commitment was a key element in increasing knowledge about HIV and AIDS in 96 per cent of the workplaces surveyed. The study identified types of management support in four key areas. First, management was involved at the very outset and actively contributed to

[4] Tables in Annex 3 (page 144)

discussions about education activities and setting up structures to execute them. Second, management invested resources such as key personnel, time and budgets for knowledge building activities, especially in large private sector workplaces. Third, management created an enabling environment by putting in place policies, procedures and practices to guide the implementation of knowledge building activities and, by doing so, institutionalized the workplace programme. Fourth, management ensured that that all stakeholders and beneficiaries were actively involved, creating a participatory environment. Similar results were reported by Visser (2012: viii).

MANAGEMENT INVOLVEMENT AT EARLY STAGES OF PLANNING FOR KNOWLEDGE BUILDING PROGRAMMES

Buy-in and commitment of managers and leaders in the workplace are essential to motivating workers to acquire knowledge on HIV, how it is transmitted and how it can be prevented, without fear of being discriminated against. Management was involved at the earliest stages, during the conceptualization and planning of the activities, as well as during implementation and monitoring and evaluation.

Managers at the companies of W1, W2 and W3 in South Africa were at the forefront of awareness and education sessions about workplace policies. Their commitment resulted in workers being informed of the existence and content of policy principles. Through the managers' leadership, a workplace committee was established to coordinate awareness and knowledge building sessions at the enterprise level.

At W4 in Madagascar, a direct line of communication was established between senior management and the health and safety department responsible for informing leadership about any planned HIV-related event and its outcome.

INVESTMENT OF RESOURCES

Management support for workplace programmes was demonstrated by the investment of resources encompassing key personnel, budget and

well-resourced structures (e.g. coordination committees). This investment ensured the smooth running of education and awareness activities aimed at increasing the knowledge of employees about HIV and AIDS.

In Ghana, management at W5 allocated an annual budget of US$100,000 for the programme. They demonstrated their commitment by appointing a full-time programme manager, providing logistics and equipment including vehicles and office space. At W6, management demonstrated commitment to HIV and TB knowledge building programmes by providing an annual budget and employing a full time Employee Wellness Programme coordinator with three focal points included in the human resources system.

"INSTITUTIONALIZATION" OF HIV AND AIDS PROGRAMMES WITHIN THE COMPANY

Management facilitated the "institutionalization" of HIV and AIDS programmes by integrating them into their company's mechanisms and frameworks, such as policies, procedures and practices. While this approach helped increase awareness and knowledge, it also had positive implications for sustainability and reducing stigma.

PARTICIPATORY APPROACH

Programmes where management provided the leadership and also facilitated a participatory approach with the active engagement of personnel from all levels of the workplace were successful in fostering knowledge building, buy-in, ownership and sustainability. Moving from an "exclusive" approach to a "participatory" approach is more appropriate for all key stakeholders and beneficiaries. The findings showed that support from the highest levels of corporate leadership was more effective when combined with the participation of other workplace stakeholders (workers' representatives, women and men on an equal footing, PLHIV etc.) at all levels in the planning, execution, monitoring and evaluation of awareness and knowledge building activities. This improved ownership of, and commitment to, increasing HIV and AIDS knowledge.

At W7 in Ghana, senior management is part of a task team that oversees the planning, implementation, monitoring and evaluation of awareness and education programmes. The task team also consists of different stakeholders, including PLHIV, workers' representatives and HR managers. This ensures representation from all levels and increases participation.

In Namibia, W8 established an HIV and AIDS operating committee which was chaired by a director of the board, and charged with facilitating the coordination and communication of best practices. This committee worked with various stakeholders such as the chief medical officer, the pharmacist, HR personnel, top management and non-governmental organizations (NGOs).

MONITORING AND EVALUATION SYSTEM

In 96 per cent of the workplaces surveyed, the establishment of a sound monitoring and evaluation system proved essential in assessing and tracking changes in levels of knowledge, identifying gaps and redefining education strategies, if needed. Visser (2012: viii) found that "putting in place instruments for monitoring" was essential. It should be noted that large public and private workplaces conducted more frequent, structured and formal assessments than did smaller workplaces and informal economy enterprises. Further, the frequency of evaluations tended to vary. Bigger enterprises tended to evaluate programmes more often than smaller ones.

ASSESSMENT OF KNOWLEDGE LEVELS

A first step in planning knowledge programmes is the assessment of knowledge levels (reported in 84 per cent of the workplaces that achieved this outcome). It involves conducting Knowledge, Attitudes, Practices and Behaviour (KAPB) surveys and in-depth reviews of existing scientific data and literature prior to planning the appropriate education activity.

The surveys showed that these assessments generated evidence-based information on which knowledge building activities were designed,

monitored and evaluated. Assessment of knowledge levels helped in identifying employee knowledge gaps and health literacy levels (i.e. what is known, what is not known); the prevailing social, economic and cultural issues with regard to HIV and AIDS; and the profile of the employees as well as HIV related gender issues. Consequently, knowledge building activities were acceptable, relevant and responsive to the knowledge gaps. The assessments also ensured that HIV and AIDS knowledge building activities were optimally responsive to the needs of employees.

The findings in this regard are supported by those of Visser (2012: vii; viii) that revealed that "prior assessments are needed because interventions should be tailored to the needs and characteristics of specific audiences."

HIV AND AIDS KNOWLEDGE ASSESSMENT TOOLS

The study identified assessment tools used for tracking knowledge levels, including baseline data collected from male and female employees through KAPB surveys, monthly evaluations, pre-training assessments and in-depth reviews of existing data and literature. It is essential that workplaces have tools to continuously assess knowledge levels.

MONITORING OF CHANGES IN KNOWLEDGE

The study findings show that during and after the implementation of activities, knowledge changes were monitored to understand whether any improvement had taken place and to help identify areas for further improvement. Approaches used to track progress included: conducting follow-up surveys; preparing periodic evaluations; keeping and reviewing M&E records; and consulting beneficiaries, clients, partners and providers on the education sessions' quality and need for change.

Knowledge, Attitudes, Practices and Behaviours (KAPB) surveys were conducted prior to programme implementation at W9 in South Africa in 2009 (assessment survey) with 363 employees, and in 2011 (follow-up survey) with

481 employees. In Morocco, five workplaces conducted KAPB surveys in 2007 to assess knowledge levels and needs, and in 2012 to evaluate the change in knowledge. These included: W10, W11, W12, W13 and W14. In Ghana, a trade union and W15 conducted a KAPB survey in 2004 to assess knowledge, and in 2006 to track progress in levels of knowledge. In South Africa, W16 and W17 conducted assessments in order to develop appropriate programmes in response to knowledge gaps.

AWARENESS ON HIV AND AIDS THROUGH PEER EDUCATION AND TRAINING

Findings show that *on-going* HIV and AIDS education sessions provided in an efficient, targeted and acceptable manner to workers helped increase knowledge about HIV and AIDS among the workforce on how HIV is transmitted, how it can be prevented and what to do to access care and support. The following elements were considered during the planning and implementation of education and awareness sessions: targeting and acceptability; organization of sessions during working hours; organization of sessions in "hotspots" (where workers seek entertainment or sex); extension of HIV programmes to sub-contractors and smaller businesses; and a peer education approach.

TARGETING AND ACCEPTABILITY

Targeting was ensured by adapting the knowledge methodology to the needs and conditions of specific workers (i.e. truck drivers or other mobile workers). For example, education was made available at truck stops, cross border sites, docks and depots in order to reach high numbers of mobile workers. In some cases education sessions were conducted during the lunch hour in workplaces where the production chain could not be disrupted. Extension of education sessions to other workplaces was also a strategy used to share learning with smaller workplaces (e.g. sub-contractors) that did not have resources to initiate their own HIV and AIDS education activities.

Acceptability was, among others, ensured through the training of peer educators to educate and inform their co-workers. The assumption is that lay people (in this case workers) are in the best position to encourage healthy behaviour among their peers, rather than health professionals educating members of the workforce. Male and female peer educators, being part of the same workplace community, understand their fears and behaviours, and share their social norms and working conditions. Peer educators who had an excellent understanding of the industry culture were assigned on the basis of age and sex, their strong interpersonal skills and the trust, respect and the accessibility they had with their peers. The concept of coaches was also used, especially in large workplaces, whereby some of the peers acted as trainers of trainers (coaches) in order to expand education sessions.

The study provided evidence that this worked because:

- It empowered employees with correct, relevant and up to date information on HIV transmission, myths, prevention, risks, treatment, counselling, support and care using context specific approaches.
- It strengthened individual capacities in dealing with HIV and AIDS, promoted a learning environment, and boosted employee confidence.

ORGANIZATION OF SESSIONS DURING WORKING HOURS

Sessions were in many cases organized during working hours to create ownership and show corporate commitment.

In W9 in South Africa, awareness sessions were mainstreamed into day-to-day workplace activities. Sessions were kept to 15 minutes to ensure efficiency. Convenient and relaxed locations (e.g. canteen) were used to maximize learning. In Kenya, W18 and W19 conducted awareness sessions during paid working hours as attendance was considered part of workers' obligations. The sessions were conducted on an on-going basis to keep employees well informed at convenient times across workplaces such as during tea break, lunch or allocated business time.

ORGANIZATION OF SESSIONS IN SPACES WHERE WORKERS CAN BE REACHED

In some cases, HIV sessions were organized in locations and spaces where vulnerable workers could be reached with awareness and knowledge building information. A flexible approach was adopted to ensure that meeting places were comfortable for participants.

W22 in Namibia used context specific approaches to conduct education sessions for high risk groups or key populations in order to reach them. It used the corridor-based approach by conducting awareness sessions in transport corridors in order to reach their truckers. Corridors included truck stops, cross border sites, docks and depots where there were high numbers of truck drivers. Efforts were also made to reach sex workers.

EXTENSION OF HIV PROGRAMMES TO SUB-CONTRACTORS AND SMALLER BUSINESSES

Another useful approach to organizing HIV sessions was to reach out to sub-contractors and small businesses that had little capacity to organize education sessions for their own workers. This enabled larger workplaces to increase the reach of their HIV programmes beyond their employees.

A Government Agency in South Africa facilitated knowledge sharing among groups of companies through joint training and shared learning and resources – approaches that contributed to their replicability. Basically, it acted as a "Big Brother" to a cluster of supplier companies. The cluster approach targeted 1,000 employees per project year, thereby allowing economies of scale.

Companies in Kenya helped vendors and clients initiate awareness-raising sessions in their workplaces. The Supply Chain concept was useful in supporting and mentoring small, medium and micro-sized enterprises with large numbers of mainly casual workers, but did not have enough capital to initiate awareness activities on their own. The support involved the establishment and training of the steering committee, peer education training,

technical support for policy development and internal awareness and onsite HIV education activities.

PEER EDUCATION APPROACH

The peer education approach works because it made on-going HIV and AIDS awareness activities feasible, accessible and sustainable. Visser (2012: ix) also found that peer education "impacts on the degree of comfort and willingness to discuss HIV and AIDS issues." Visser (2012: vii) states that using a "train and engage" strategy induces employees to continue to be actively involved after training, which eventually leads to increased knowledge and promotes behaviour change. Working with male and female peer educators to increase knowledge proved to be one of the most impactful approaches identified in this study.

W17 in South Africa collaborated with sex workers as active agents in conducting HIV and AIDS awareness sessions enabling them to be at the forefront of service provision and outreach activities. Serving as peer educators, they understood the "industry culture" and had access to informal networks that were highly stratified and compartmentalized in different spaces such as brothels, roads, clubs and certain hotels. Female and male sex worker peer educators each conducted awareness sessions with male and female sex workers in separate groups, using familiar and safe settings. The sessions focussed on rights and empowerment, including knowing your rights, being able to make informed choices and protect yourself, and speaking out to end violence.

W20 in South Africa introduced the concept of coaches – a training of trainers approach - where peers coach, train or mentor other peers. Coaches trained peer educators and conducted two hourly coaching sessions on a monthly basis.

WELLNESS APPROACH/MAINSTREAMING

Another effective strategy for increasing knowledge about HIV and AIDS was integrating it into broader health education programmes. Education

sessions were integrated or mainstreamed into programmes on wellness, occupational safety and health and employee assistance.

INTEGRATION OF EDUCATION SESSIONS IN WELLNESS PROGRAMMES

The integration of awareness activities into wellness and health programmes contributed towards stronger receptiveness of programmes and the active involvement of employees, while increasing sustainability, reducing HIV and AIDS related stigma and increasing workers' access to information.

W21 in Kenya established a medical department and integrated the HIV and AIDS programme into its health services. It also made the programme part of the wellness sessions, which helped in attracting more staff and facilitated broader discussions about health issues.

W6 in Ghana integrated their HIV and AIDS education programme into their Employee Wellness Programme, resulting in an increase in programme uptake. Their programme used information, education and communication (IEC) materials and videos, sensitization and advocacy sessions.

Education sessions were integrated into health education programmes covering diabetes, blood pressure and other diseases. The sessions covered all health topics, and HIV was part of the overall education module.

INTEGRATION OF EDUCATION SESSIONS IN OCCUPATIONAL SAFETY AND HEALTH PROGRAMMES (OSH)

Workplace OSH programmes are often part of the overall company strategy for a healthy workplace. Hence there may already be structures in place that can be used to mainstream HIV. The purpose of such mainstreaming is to offer a comprehensive health service for all employees and make HIV programmes more sustainable and acceptable to the workers.

W22 in Namibia integrated the HIV and AIDS education programme into their occupational health programme, resulting in a one-stop approach for employees. The workplace reported that this integration resulted in reducing stigma (which is prevalent in many HIV "stand-alone" programmes).

INTEGRATION OF EDUCATION SESSIONS IN EMPLOYEE ASSISTANCE PROGRAMMES (EAPs)

Employees and their family members often use EAPs, where they are available, to manage issues in their personal lives. Some workplaces have EAP counsellors who provide assessment, support and referrals. EAPs provide support for issues such as substance abuse, distress, life events, health care, and work relationships. These elements can be directly or indirectly linked to higher HIV vulnerability; hence the need to address HIV as an integral part of these programmes.

In South Africa, W20's EAP has assisted employees who are having adherence problems with their ART and TB treatment in order to help them develop coping strategies and to follow up on their treatment. Further, a Health & Safety Co-ordinator was appointed to implement the peer educator program in the directorates.

An integrated approach helps to de-stigmatize programmes and improve their acceptability. Furthermore, integrated approaches helped increase sustainability and uptake of education sessions because people became less stigmatized and less likely to stigmatize others. Visser (2012: x) also found that "integrating HIV and AIDS interventions within a broader health promotion context can potentially produce increased knowledge acquisition."

MEANINGFUL ENGAGEMENT OF PEOPLE LIVING WITH HIV (MIPA)

The engagement of PLHIV in planning and implementing education sessions allowed for key technical expertise in shaping the interventions,

its content and to share personal testimonies with employees. It fostered visibility, openness, disclosure, and improved acceptability around HIV issues. Visser (2012: vii) also found that "enhancing the visibility of HIV and AIDS through a strong and active engagement of PLHIV at all stages of the workplace process" was effective in bringing about knowledge and attitudinal change.

At W23 in Madagascar PLHIV shared their experiences with employees during awareness sessions, trainings and campaigns. W21 in Kenya invited PLHIV to share their experiences with employees who were diagnosed with HIV and living positively. W24 in Kenya enrolled staff members living with HIV as peer educators to provide HIV prevention messages.

In Zambia, W25 involved their employees living with HIV to facilitate education sessions. PLHIV acted as champions and peer educators who provided other employees with needed information. W26 involved their HIV champions in face-to-face educational sessions.

It must be noted that the concept of MIPA goes well beyond engaging PLHIV as peer educators. It involves engaging PLHIV at all stages in the design and implementation of HIV workplace programmes.

EXTERNAL FACTORS CONDUCIVE TO INCREASING KNOWLEDGE

Several factors contributed to the proven successes of workplaces in increasing knowledge on HIV and AIDS. In Ghana, Workplace HIV Policy Guidelines (2004) were published through the collaboration of the Ghana AIDS Commission, the National Tripartite Committee and the ILO. A National Workplace HIV and AIDS Policy was developed and endorsed by the national authorities. This provided a solid institutional basis for developing comprehensive workplace programmes. As a result, a growing number of ministries, departments and agencies, private sector organizations and metropolitan, municipal and district assemblies have adapted the generic policy to develop their own workplace policies (Ghana Country AIDS Progress Report, 2012:74).

In Kenya, national campaigns have been conducted to empower the general population with HIV and AIDS knowledge (NACC & NASCOP, 2012). The country has undertaken eight mass media campaigns per year (ibid.). "Behaviour change interventions are primarily delivered by more than 16,000 organisations that sponsor HIV-related programmes in Kenya" (Gelmon et al., 2009 in NACC & NASCOP, 2012:57).

In Namibia, the mass media was used to increase HIV awareness, discourage engagement in multiple and concurrent sexual partnerships and encourage HIV testing (Republic of Namibia, 2012) in the context of the "Break the Chain" campaign.

In Morocco, the Ministry of Employment and Vocational training endorsed the National Strategic Plan to implement the ILO HIV and AIDS Recommendation nº 200 and respond to HIV and AIDS at the workplace. The initiative of developing a strategic plan for the world of work by the ministry makes Morocco a pioneer country among other low prevalence countries.

RECOMMENDATIONS

The following recommendations can be drawn from the findings and analysis above:

Management commitment

- Management commitment, from the inception of knowledge building activities to implementation and evaluation, is central to sustaining efforts to increase knowledge about HIV and AIDS.
- Proactive, participatory and resource-based management is essential for sustaining programmes and achieving the desired goal of increased knowledge.
- Management should be encouraged to invest resources (human, financial and material) in knowledge building HIV and AIDS workplace programmes.
- The task teams or steering committees established by management to provide oversight and stewardship to the workplace programme should

have representation from workers at all levels in the workplace and be sensitive to gender issues.

- Management should work towards the institutionalization of HIV workplace programmes as this enhances sustainability and takes HIV out of isolation.

Monitoring and evaluation

- Assessment of knowledge levels provides contextual information for designing knowledge building activities, and serves to inform the design of such activities so they are relevant, responsive, targeted, specific, focused, feasible, applicable and acceptable to male and female employees.
- The implementation of M&E systems across workplaces is instrumental in ensuring that HIV awareness sessions remain relevant, responsive and reliable. Workplaces should conduct M&E on an on-going basis, and not as ad-hoc measures, to ensure that their activities remain relevant.
- Partnerships with the national AIDS coordinating bodies should be sought at the level of the ministries of labour and business and union associations to develop a M&E system across sectors (formal or informal) to consolidate world of work data at the country level, linked with the national M&E system.

Awareness raising and education

- Increasing HIV knowledge among the workforce is the first step towards the achievement of other good outcomes (voluntary counselling and testing [VCT] uptake, behaviour change, reduced absenteeism, ART uptake and reduction of stigma). Hence the need for comprehensive workplace AIDS education programmes that can reinforce workers' knowledge about HIV transmission and its prevention.
- There is no one-size-fits-all approach in strengthening and expanding HIV and AIDS knowledge. Workplaces should adopt flexible context-specific, gender-tailored approaches that accommodate their needs and programme objectives while also learning from each other.
- Peer educators (both male and female) remain active agents in delivering HIV and AIDS messages in an accessible and acceptable manner. As

with other approaches, it is essential to assess needs, knowledge gaps, working conditions and the corporate culture of the targeted audience in order to design peer education programmes that effectively address the needs of the workers. The first important step of any peer education programme is to empower and equip peer educators to build knowledge, provide support on VCT and guide peer workers towards what behaviour change is.

- Integration of the peer education approach into the corporate structure of companies is essential for ensuring high and sustainable impact of HIV and AIDS awareness building activities and can be easily replicated, especially in resource constrained environments.
- Education programmes must aim to reach vulnerable workers in the hotspots where they seek entertainment or sex. Identifying all hotspots is thus integral to effective targeting.

Mainstreaming HIV into broader wellness programmes

- Integration of HIV and AIDS knowledge building activities into wellness, occupational health or employee assistance programmes also helps increase knowledge about HIV and AIDS. Expanding awareness sessions beyond HIV and AIDS should become part of the corporate approach in addressing HIV and AIDS. This needs to be replicated as it increases sustainability, reduces stigma and improves uptake of information sessions.

Engaging PLHIV

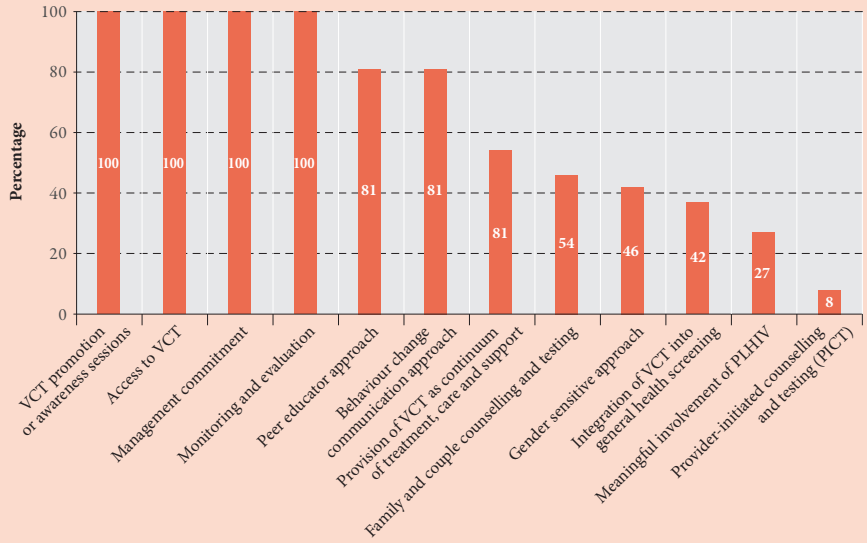
- The engagement of women and men living with HIV in knowledge building activities is crucial in ensuring improved visibility around the real situation of PLHIV and normalizing issues around HIV.
- Using the acquired knowledge around the needs of PLHIV is important to formulating principles and standards for the workplace.
- Concerted efforts to move beyond stigma and put PLHIV at the centre of HIV and AIDS knowledge building activities are needed, since doing so adds credibility to HIV awareness activities and improves their impact.

CHAPTER 4: INCREASED UPTAKE OF VOLUNTARY COUNSELLING AND TESTING (VCT)[5]

UNAIDS estimates that around half of all PLHIV do not know they are HIV positive and thus do not seek treatment. Voluntary counselling and testing (VCT), conducted in accordance with the provisions of the ILO's Recommendation on HIV and AIDS and the World of Work (No. 200), goes a long way toward enabling workers to know their HIV status and seek treatment, if necessary. What factors contribute to increased uptake of VCT in the workplace? Do external factors facilitate this increase? This section presents findings and programmatic actions undertaken in various workplaces to ensure increased uptake of voluntary counselling and testing and recommendations for further action.

Approximately 79 per cent of the workplaces studied provided evidence indicating that they had increased VCT uptake (Annex 2, Table 8).

Figure 11 Actions used by workplaces to achieve increased VCT uptake (per cent)



[5] Tables in Annex 4 (page 148)

The research identified actions (Figure 11 and Annex 4, table 20) that contributed to this, including:

- Management and leadership commitment
- Behaviour change communication, awareness sessions and education
- Increasing access to VCT services
- Integration/mainstreaming of VCT into general health screening
- Promotion of provider initiated counselling and testing (PICT)
- A monitoring and evaluation system

MANAGEMENT AND LEADERSHIP COMMITMENT

Management commitment is crucial in initiating, implementing, maintaining and sustaining VCT activities. Visser (2012: viii) also found that "involving management from the earliest stages in key activities, including initial discussions around VCT services, baseline studies and training, works in improving VCT uptake." The role of management involves showing leadership, providing resources and creating an enabling environment for HIV testing, and ensuring respect for quality provision of VCT services.

LEADERSHIP IN HIV TESTING

When managers and leaders publicly undergo VCT themselves, it encourages workers to access VCT services. In case studies, testing of the company CEO was an effective strategy in promoting behaviour change that resulted in increased uptake of HIV testing among male and female employees.

During the Wellness Week of 2011, the Executive Mayor of the W20 in South Africa publicly underwent testing for HIV, while other municipal counsellors volunteered for testing. Photos were circulated on the internal network (RiseOnline) and helped de-stigmatize HIV testing and increase VCT uptake in the community from 125 in 2011 to 541 in 2012.

In Zambia, W27 opened an HIV Counselling and Testing (HCT) centre and started a "know your status" campaign in 2004. Management underwent HIV testing as a way of demonstrating leadership. Privacy and confidentiality were emphasized from the outset. Two years later, 80 per cent of the company's employees were aware of their HIV status.

In Ghana, the involvement of managers and labour union leaders in VCT campaigns at W5 contributed to an increase in VCT uptake from 6,599 in 2007 to 6,845 in 2008. At W7, senior management, departmental heads and their spouses underwent HIV testing and had their photographs displayed on notice boards, encouraging all to undergo HIV testing.

INVESTMENT OF RESOURCES IN HIV TESTING

The study also showed that VCT was successful when adequate resources were invested by management. The financial investments covered test kits, infrastructure ensuring privacy and confidentiality and even basic medication. A principal aim was to ensure a continuum of care for male and female employees who test positive.

In Madagascar, W4, W23, W28, W29 and W30 allocated budgets towards HIV and AIDS programmes. In Senegal, W31 set aside an annual budget for HIV and AIDS activities.

ENSURING QUALITY SERVICES IN THE PROVISION OF VCT

The study further showed that VCT uptake improved when management supported the provision of total quality management of VCT services in the form of quality counselling services, availability of well-trained male and female counsellors as resource persons and close supervision and support of HIV and AIDS programme staff.

W32 in Côte d'Ivoire reported that availability of rapid HIV test kits at their facilities made it possible for employees to be tested during their medical con-

sultations. Since these tests were rapid, employees could know their status immediately. Further, the availability of professional staff to effectively perform VCT helped achieve increased VCT uptake.

The availability of dedicated and trusted staff was reported to have contributed to the quality of services and, as a result, increased uptake of VCT. Management was instrumental in ensuring that employees have access to quality services.

In the words of the manager of the employee wellbeing HIV programme at W5 in Ghana, VCT was provided by a team of dedicated staff, including an HIV coordinator, laboratory personnel, a pharmacist and a doctor who are "…open, friendly, show empathy and provide confidential services."

CREATING AN ENVIRONMENT CONDUCIVE TO HIV TESTING

Workplaces used a variety of approaches to create an enabling environment for HIV testing. These include developing and implementing workplace policies and strong messages from senior management on zero discrimination. An enabling environment is characterized by management encouraging zero discrimination and stigmatization, maintenance of confidentiality and non-disclosure of HIV status.

The workplaces studied ensured that persons who were open about their HIV status were protected against discrimination and stigmatization. They developed policies on HIV testing, including confidentiality and disclosure to ensure that all those who underwent VCT enjoyed the same level of protection. Visser (2012, p.54) reported that "employee perceptions of company support, of levels of confidentiality and of non-stigma and discrimination were critical in ensuring increased VCT uptake."

In Madagascar, W30 displayed a policy on non-discrimination in company waiting rooms and dispensaries. W4, also in Madagascar, has a component of stigma and discrimination in its HIV and AIDS policy. As a result of clear policy principles and a strong position supported by management on non-discrimination and stigma, W4 increased their VCT uptake from 163 in 2010 to 297 in 2012.

BEHAVIOUR CHANGE COMMUNICATION, AWARENESS SESSIONS AND EDUCATION PROGRAMMES

The study found that a strong focus on educating employees on the benefits of VCT increased both awareness on the need for testing and the overall demand for testing. Throughout the workplaces studied, communication through electronic messages, events, plays, drama and other media was carried out across business units and other workplace networks in order to create demand for HIV testing. In some workplaces, VCT services were contracted out to sub-contractors and distributors.

The use of peer educators in 81 per cent of the workplaces as a means to promote VCT was a cost-effective way to educate employees. Trained peer educators could reach out to employees during work hours, leisure time and on employee commuter buses. They also encouraged employees by using drama, role plays, poems, dance and demonstrations to promote VCT.

Such behaviour change communication was found to be particularly important in increasing VCT uptake because it helped workers move from knowledge of the issue, awareness of the risks and the need for HIV testing to actually being tested. In some workplaces, PLHIV were involved in programme implementation by giving testimonies and acting as peer educators. The meaningful involvement of PLHIV (MIPA) helped to alleviate fears about HIV testing and improved acceptability of testing.

According to the study findings, education sessions also worked well by empowering employees about the importance of knowing their HIV status. Such sessions covered issues ranging from the basics of HIV transmission, prevention and status disclosure to more complex issues supporting behaviour change. Visser (2012) also found that building the capacity of workers and managers contributed to individual behaviour change in terms of uptake of HIV testing. Behaviour change is an iterative process, in which an individual progresses from increased knowledge about HIV and AIDS and increased self-risk assessment to eventual uptake of HIV services.

Hence the need to follow systematic steps, including:

- Developing a clear profile of the workforce through a KABP survey and a formative assessment before the start of a project to help staff identify target population profiles to be used in developing messages;
- Identifying the desired change in behaviour;
- Shaping messages, data, information and tools that address the needs of the workforce;
- Understanding and addressing situations that can undermine the expected change (alcohol abuse, sexual harassment at the workplace, interactions with key populations at higher risk, etc.);
- Monitoring and evaluating progress.

At the W24 in Kenya – IEC materials on VCT were developed and made available in English and Kiswahili and distributed to employees. This resulted in 120 people seeking VCT during the family day, with 275 seeking VCT during the two weeks of the campaign in 2008.

TRAINING OF EMPLOYEES

Most workplaces conducted training sessions for employees that actively promoted the uptake of VCT services. In most cases, training focussed on the benefits of VCT to the individual, their partners, families and the larger community.

W31 in Senegal trained their service providers, community members and peer educators on VCT. This resulted in the uptake of workplace testing for 247 employees and their dependents in Ndioum, Dagana and Richard Toll in 2013. Training of trainers from various workplaces was organized.

At a Ghana trade union, workers were selected and trained on VCT, then they trained their peers. As a result 15,583 workers were tested for HIV between May 2010 and May 2012.

PEER EDUCATION

VCT promotion through peer educators contributes to improved uptake of VCT because employees are more comfortable discussing such issues with their peers. Visser (2012: ix) found that the use of peers "impacted on the degree of comfort and willingness to discuss HIV and AIDS issues." Peer educators can serve as role models, using various means and channels such as safety talks, awareness sessions, wellness road shows and cultural shows to motivate employees to undertake HIV testing. In order to have employees take up VCT, peer educators can be used to educate employees about the importance of reducing stigma and discrimination and to promote confidentiality during counselling so as to eliminate fear of testing and stigma.

In Zambia, W33 used one-on-one "safety talks" during leisure time to reach employees regarding VCT uptake, while at W34 and the W27 peer educators encouraged employees to undergo VCT using drama, role playing, poems, dance and demonstrations.

In South Africa, W20 used peer educators to organize wellness road shows and cultural shows to promote VCT uptake.

All five workplaces in Ghana worked with peer educators who conducted VCT promotion through talks and drama, both to employees and also to the surrounding communities. In these instances, the work of peer educators was not limited to the workplaces.

In Kenya, in W18, W21, W24 and W35, workers reported increased VCT uptake due to peer educator efforts. At W24, a team of dedicated and passionate peer educators referred to as "champions" conducted awareness to promote VCT to all employees.

In Mozambique, W36, used peer educators to popularize VCT, whilst peer educators at W37 had been trained on referral processes and were able to promptly refer employees who tested HIV positive to the nearest or most appropriate health facility.

In Morocco, peer educators worked with interveners to promote HIV testing among taxi and truck drivers at W10, W11, W12, W13 and W14. The peer educators provided individual and group awareness sessions all day at the

workplace. The interveners communicated with peer educators and drivers in the workplace to encourage drivers to undergo testing. They were instrumental in reaching drivers.

INVOLVING PLHIV IN EACH STEP OF THE PROCESS

The involvement of PLHIV during the implementation of HIV workplace programmes gives the programmes a human face, allows the needs of PLHIV to be ably addressed and creates more awareness not only among the workforce but also among the management. Visser (2012: viii) found that "involving PLHIV in workplace programmes from design to implementation, monitoring and evaluation brought about increased uptake of VCT" and that PLHIV involvement and having champions in place was found to be critical in encouraging VCT uptake (Visser, 2012, p. 54). From the studies, a variety of approaches were used by workplaces to engage with PLHIV, including testimonies by women and men living with HIV, PLHIV acting as peer educators and involvement of PLHIV as experts at all levels of the HIV and AIDS programme.

At W38 in South Africa, VCT uptake increased from 72 per cent in 2009 to 82 per cent in 2010 as a result of inviting PLHIV to provide testimonies and support. This also motivated PLHIV in the workplace to disclose their HIV status and become champions for the programme.

After W27 held workshops with the participation of PLHIV who encouraged employees to take up VCT, HIV testing increased from 2.3 per cent in 2000 (and earlier) to 70.5 per cent in 2008. In 2012, 75 per cent of staff re-tested for HIV.

Similarly, after W7 in Ghana invited PLHIV to promote VCT uptake among employees, the number of people tested increased from 250 in 2008 to 1,414 in 2011.

INCREASING ACCESS TO VCT SERVICES

The study findings suggest that VCT uptake was higher in workplaces that made services available free of charge at onsite or mobile clinics. Referrals

to nearby clinics were made when there were no onsite VCT services or employees preferred to undergo VCT outside the workplace. Quality services were guaranteed through certified service providers to ensure that employees testing positive could be counselled and receive psychosocial support. The link to care was critical to motivating workers to undergo VCT.

Employees were encouraged to test because they knew that if they tested positive, they would receive a continuum of treatment, care and psychosocial support. This allayed fears of knowing their HIV status and contributed to improved VCT uptake. Access to VCT was also facilitated by including family members and spouses in counselling and testing. This created mutual accountability leading to increased uptake of VCT. Approaches used to involve family members in VCT included conducting VCT campaigns, family VCT days, home counselling and testing, couples' testing (e.g. organized during Valentine's week) and making VCT available to family members onsite (and not just during special events). Medium and large private workplaces extended VCT to spouses and family members.

Visser (2012, p. 54) found that "VCT at the workplace offers the potential for high uptake when offered onsite; convenience and accessibility were viewed as critical."

Several strategies were used to improve access to VCT. It is worth noting that strategies for providing VCT often depend on the working conditions and the size of a workplace. Onsite VCT is mainly offered to employees physically stationed most of the time in one workplace. Mobile VCT is more suitable for those who are typically on the move, such as truck drivers. Small businesses and those in the informal economy generally access VCT services through linkages to communities.

W17 in South Africa established 20 VCT clinics and mobile vans in sex worker hotspots throughout the country with peer educators to offer VCT, education and other services, resulting in 88 per cent (511) of sex workers having an HIV test in 2011.

W20 in South Africa provided on-going HCT throughout the year for employees at two municipal occupational health clinics, increasing VCT uptake

from 125 employees in 2011 to 541 employees in 2012. According to the W20 M&E records, 8,568 employees visited the wellness clinics in 2012 and 2013.

W9 and W38 of South Africa had monthly family planning mobile clinic visits offering HIV testing, increasing testing from 74 per cent in 2009 to 94 per cent in 2011, and VCT uptake from 72 per cent in 2009 to 82 per cent in 2010.

In Zambia, W27 offered VCT onsite, contributing to an increase in uptake from 2.3 per cent in 2000 to 70.5 per cent in 2008.

W35 in Kenya organized VCT onsite for employees, increasing VCT uptake from 74.3 per cent in 2010 to 96.8 per cent in 2011, and staying high in 2012 (86.7 per cent).

In Senegal, the W39 offered employees VCT onsite, contributing to an increase in VCT uptake from 180 in 2011 to 659 in 2012.

REFERRAL TO OFFSITE VCT SERVICES THROUGH PARTNERSHIPS

Workplaces without onsite clinics established linkages with VCT testing facilities and used a referral approach to ensure that employees who wish to test have access to testing services. This was done through forging strategic partnerships like those derscribed below.

W40 and W41 in Zambia referred their employees to a network of facilities they worked with.

W42 in Côte d'Ivoire offered their employees the option to test at facilities that they had an agreement with. VCT uptake records show that 294 people tested from 2007 to 2010 and 777 tested from 2012 to July 2013.

In Kenya, W21 partnered with the Gold Star Network and Psychological Health Services, that trained their onsite medical team to provide free testing, treatment and counselling services for HIV and AIDS, TB and malaria at company clinics, as well as referrals to government hospitals as needed. W18 developed partnerships with a local hospital and a business council to support in-house VCT drives or community outreach.

EXTENSION OF HIV TESTING BEYOND EMPLOYEES

The extension of HIV testing beyond employees to spouses and family members was an important approach aimed at ensuring a significant uptake of HIV testing. This approach also creates mutual accountability among family members and contributed to increasing uptake of VCT.

In Kenya, W35 promoted the "know the status of your partner" campaign. The campaign informed employees about the advantages of partner testing and employees have as a result taken up couples testing. W35 reported that to date 1,850 family members were reached and of those, 959 underwent VCT.

At W24 in Kenya, a family day event was organized in which VCT was extended to employees and their families. A total of 120 people sought VCT services. Of these, 39 were W24 staff, 68 were dependents and 13 fell into other categories.

At W31 in Senegal, 120 out of 150 employees and their dependents received HIV counselling and testing in 2013 (68 per cent). W43 in Senegal, provided VCT to employees together with their families. In 2011, 80 out of 100 employees and their families were tested, making it an 80 per cent uptake.

In South Africa, W16 offered free HIV Counselling and Testing (HCT) for members and their dependents, which contributed to about 37,778 workers and their dependents being tested in 2013.

EXTENSION OF HIV TESTING TO SUB-CONTRACTORS

Some workplaces extended VCT services to smaller sub-contractors and businesses they worked with as part of their corporate social responsibility and co-investment initiatives. This approach allowed employees of smaller workplaces to have increased access to HIV testing based on their association with larger workplaces.

W8 in Namibia extended the scope of its VCT programme to include all its subcontractors. Also in Namibia, the Chamber of Mines expanded its Occupational Health Education and Awareness Programme (OHEAP) to all interested non-mining companies, the Namibian Port Authority and

several fishing companies. OHEAP often does combined training with small businesses in small towns or accommodates businesses that are unable to pay for such programmes.

W35 in Kenya extended VCT services to neighbours, customers and distributors. "Through this approach, a medical camp was established at Mukuru promotion centre, and 410 people from the surrounding areas turned up to access services and treatment of general illnesses". This contributed to an increase in VCT uptake at W35 from 74 per cent in 2011 to more than 85 per cent in 2012, with some 960 of 1,850 family members reached participating in VCT.

ESTABLISHING LINKAGES TO CARE

In all cases, ensuring linkage to care for follow-up is essential. The study found that implementation of a total package of care promoted an increase in VCT uptake. This included linking VCT services to treatment, care and psychosocial support. Thus, VCT became a foundation for increased care, rather than an end in itself. Visser (2012, p. 54) also reported that VCT uptake increased when "linked to basic HIV care."

W17 in South Africa established support groups to ensure positive living with HIV and treatment adherence. The support groups offered a six-module programme on integrated access to care and treatment.

W44 in Mozambique provided AZT, an antiretroviral drug, to those who tested positive through referral to public sector facilities or at private health facilities with which the workplace had links.

W35 in Kenya introduced medical insurance covering employees on an 80/20 percentage basis for all other conditions except HIV, which has 100 per cent coverage for ART.

W42 in Côte d'Ivoire has a clinic onsite, with medical personnel who administer and manage ART to all employees who are eligible as per national guidelines.

INTEGRATED WELLNESS APPROACH TO VCT

A wellness approach that entails integration of VCT into various health related programmes also contributes to improved VCT uptake by minimizing stigma and discrimination that could be experienced when a separate distinct VCT programme is in place.

W45 in Mozambique linked VCT to occupational medical surveillance programmes and general wellness programmes to encourage VCT uptake by employees.

At W23 in Madagascar, VCT was integrated into other health services such as maternal and child health, and other illnesses. VCT uptake at W23 increased from 95 employees tested in 2011 to 167 in 2012.

PROVIDER INITIATED COUNSELLING AND TESTING (PICT)

With provider initiated counselling and testing (PICT), the provider proactively tests all employees for HIV unless they decide to opt out. PICT also contributes to an increase in VCT uptake. When employers take proactive steps showing the importance of VCT, employees become responsive and receptive to the idea of undergoing VCT. This approach significantly scaled up HIV testing.

In Côte d'Ivoire, an opt-out counselling and testing strategy was adopted by W46 and W32, which increased VCT uptake at both companies. All employees who visited the W46 health facilities were offered VCT and could choose to accept or decline. Through this, W46 was able to better monitor testing rates and repeat testing. Testing at W46 increased from 341 in 2005, to 789 in 2011 and 932 in 2012. W32 indicated that the number of employees tested increased from 314 in 2008 to 1,534 in 2012.

When W33 in Zambia adopted PICT at one of their mine clinics and gave every employee who visited the clinic for HIV counselling the choice to be tested, VCT uptake rates increased from 5 per cent to 20 per cent.

ASSESSMENT, MONITORING AND EVALUATION OF VCT SERVICES

In order to achieve an increased uptake of VCT services, the workplaces investigated set up a sound M&E system that ensured quality control and allowed programmes to track the change in uptake. This step is particularly important in ensuring quality control of VCT services and utilizing lessons from what works. It also enables management and programme implementers to communicate, both internally and externally, the difference the programme is making. The study identified some key aspects of M&E systems including periodic KABP surveys, M&E records and VCT registers.

In South Africa, W9 kept M&E records which allowed the company to show progress in the VCT uptake, which increased from 74 per cent in 2009 to 94 per cent in 2011. W16 kept monitoring and evaluation records showing that in 2012, at least 37,778 members and their dependents received HCT, while 38,966 workers and their dependents were counselled in 2011. W17 kept VCT registers to monitor their programme performance and conducted a survey in 2010 that found 88 per cent of the sex workers underwent an HIV test.

In Zambia, W27 conducted a KAPB survey in 2000 (baseline) and a follow up survey in 2008 revealing that VCT uptake increased from 2.3 per cent at baseline to 70.5 per cent at follow up. By 2012, 75 per cent of employees re-tested for HIV.

W39 in Senegal – kept VCT M&E records which showed that 180 employees were tested for HIV in 2011 and 659 in 2012.

W29 in Madagascar had monitoring systems in place showing that the number of employees tested increased from 40 in 2008 to 900 in 2013.

W47 in Mozambique also kept M&E records showing that 3,000 members received VCT in 2011. Extension of VCT services to 45 markets from 2008 to 2011 resulted in reaching 22,000 informal traders in the three main cities of Mozambique, according to the records.

Tracking the number of employees and their families and dependents who undertake VCT is useful for many purposes including: demonstrating the

success and effectiveness of the programmes, using the information for advocacy purposes and creating linkages with national M&E systems to demonstrate the contribution of workplaces to the national response.

EXTERNAL FACTORS CONDUCIVE TO FACILITATING WORKPLACE UPTAKE OF VCT

Many of the countries made HIV testing a priority, contributing to the creation of an enabling HIV testing climate that facilitates HIV testing at the workplace level.

In Ghana, "Know Your Status (KYS)" campaigns were conducted to ensure an increase in VCT uptake, reaching 1 million people within a year. The country has a policy ensuring women access to services outside the context of pregnancy and child birth through educational programmes and KYS campaigns. This provides services for both women and men, although there is still a need to address further involvement of men in this context. (Ghana Country AIDS Progress Report, 2012, p.46). In addition, 251 HCT centres were established in 2010 (Ghana Country AIDS Progress Report, 2012, p.37).

Kenya also invested in intensive VCT campaigns that were very successful. In 2008, 700,000 people were tested during a one week campaign and 1.2 million during a three week campaign. In 2012, 2.6 million people were reached by two campaigns, one lasting one month and the other three weeks. (NAC, 2012:40). Annual testing of corporate leaders in Kenya has helped support workplace testing initiatives: 19 CEOs and 603 workers were tested in one day (NACC and NASCOP, 2012).

The President of South Africa launched a national HCT campaign, in partnership with civil society and the private sector, to reach out to citizens to test for HIV and undergo screening for TB and other chronic diseases. This campaign resulted in "three times the number that the public sector is able to screen annually." Available data indicates that "by June 2011, over 13 million South Africans had been tested for HIV" (Republic of South Africa, 2012: 15). During this period, a survey conducted among

30 members of the South African Business Coalition on HIV and AIDS showed that 65 per cent had VCT campaigns. Nearly 160 clinics and 1,200 nurses reported being involved in HIV workplace programmes.

In Namibia, there was collaboration between NawaLife Trust, the Ministry of Health and Social Services, and Intrahealth to create a demand for HCT, and in 2010 a campaign known as "be strong, get tested" was initiated, specifically targeting men to utilize HCT as the "strong" thing to do. This "be strong" campaign contributed to Namibian National HIV testing day 2010 (Republic of Namibia, 2012:22).

Madagascar developed a National Policy on VCT and related HIV testing standards and protocol. The number of health facilities offering VCT went from 365 in 2006 to 1,613 in 2012, or 47 per cent of the more than 3,400 health facilities in the country (CBS, CHD, CHRR, CHU). In 2008, the commitment of the then President of the Republic, who took an HIV test, greatly influenced the uptake of VCT, including workers in the public and private sector.

RECOMMENDATIONS

Management commitment

- Management commitment is a driver of Voluntary and Confidential Counselling and Testing (VCT) activities across all sectors and is crucial in running and maintaining a successful VCT programme.
- Management and union leaders are encouraged to lead the way by publicly taking the HIV test (e.g. CEO HIV Testing days). Male and female leaders at all levels should show the way.
- Management commitment includes allocating resources – human, financial and material – to support the uptake of HIV testing. This is a clear demonstration of management's commitment.
- The most significant barrier to the uptake of VCT remains stigma and discrimination. Management has a major role to play in ensuring the

creation of an enabling legal and policy environment that facilitates the uptake of HIV testing.

- Making policies visible on the walls and in walkways is one sure way of demonstrating management commitment.

VCT services

- One-off VCT awareness activities do not produce sustained increased VCT uptake. Workplaces need to promote on-going VCT activities in partnership with stakeholders in order to sustain increases in VCT uptake.
- Bringing VCT to employees, while making them aware of the need to test, increases the demand for testing and thereby improves VCT uptake.
- Workplaces should ensure that VCT services are accessible to all employees in a convenient location and time that ensures privacy and confidentiality.
- Uptake of VCT services can be sustained only if linkages to health and support services are ensured in order to guarantee follow up for workers and dependants testing positive.
- Proactively offering of VCT to employees with an emphasis on the choice to opt in or out contributes to improved uptake of VCT.
- The involvement of PLHIV in VCT is central to increased VCT uptake by normalizing HIV and increasing acceptability among workers.
- Extension of VCT to couples and family members creates mutual accountability that increases uptake of VCT.
- Integration of VCT to other programmes not only increases VCT uptake but also lessens stigma and discrimination.

CHAPTER 5: REDUCED RISKY BEHAVIOURS[6]

Changing risky behaviours is vitally important in slowing the advance of HIV and AIDS and includes: reducing the number of sex partners; having safe sex by using condoms correctly and consistently; maintaining fidelity in relationships; and accessing HIV testing and counselling services. What actions can workplaces take to reduce those risky behaviours that occur mainly outside the workplace, promote knowledge and awareness on such behaviours and on how to reduce them? And how can the success and impact of risk reduction programmes be monitored and evaluated? This section reviews the programmatic actions undertaken by the workplaces surveyed that contributed to a reduction in risky behaviours and offers a series of recommendations for further action.

Approximately 65 per cent of the workplaces investigated provided strong evidence of actions that helped achieve this good outcome (Annex 2, Table 8). These actions included: the commitment of management to promoting strategies for risky behaviour reduction; sexual risk assessment; education and awareness; providing access to condoms; and monitoring and evaluation.

Figure 12 **Actions used by workplaces to reduce risky behaviours (per cent)**

[6] Tables in Annex 5 (page 154)

MANAGEMENT COMMITMENT TO PROMOTING STRATEGIES TO REDUCE RISKY BEHAVIOURS

The support and commitment from management was critical to ensuring a reduction in risky behaviours. Several approaches were used to demonstrate management's commitment, including: "normalization" of condom use; establishment of coordinators and task teams; and leveraging of resources and linkages with service providers.

Management also played a key role in promoting an environment where condoms were part of prevention strategies, and employees could access them without feeling stigmatized. Management commitment to male and female condom promotion included ensuring that consistent and regular supplies of condoms were made available to and accessed by workers.

The leaders at a Ghana trade union "normalized" condom use by developing a policy directing their employees to use them if they could not abstain from sex.

W43 and W48 workplaces in Senegal made condoms conveniently accessible and available during working hours. For example, W43 had condoms placed in the living quarters of its employees.

ESTABLISHMENT OF COORDINATORS AND TASK TEAMS

Management supported concrete actions that included investing in coordinators and task teams that planned, implemented and monitored condom awareness, distribution and outreach activities in the workplace.

W5 in Ghana had dedicated coordinators and task teams who worked with peer educators to promote awareness, condom distribution and outreach activities in the workplace and at high road traffic sites, stressing the importance of using condoms.

LEVERAGING RESOURCES AND LINKAGES WITH SERVICE PROVIDERS

It is only through management support that companies can leverage resources to ensure a continuous supply of condoms. Furthermore, company leaders can use their networks to establish links with outside providers or health facilities to ensure a sustainable risk reduction strategy.

The W50 in Mozambique leveraged resources to ensure an uninterrupted supply of high quality condoms that were free or affordable. They established several condom supply links which included purchasing flavoured condoms from PSI and accessing free condoms from ECOSIDA.

W24 in Kenya formed alliances with Crystal Hill, which provided the condoms and held sensitization campaigns.

W22 signed an agreement with the National Social Marketing Association in Namibia for the purchase of condoms and dispensers.

SEXUAL RISK ASSESSMENT

The risk assessment is a multi-layered process designed to help workers change their behaviours. This may include:

- Assessment of the workers' knowledge about HIV, its transmission and how it is prevented (basically to assess how much information the individual has on HIV).
- Analysis of the workers' behaviours and identification of those that put them at risk.
- Review of knowledge and behaviours, and of misconceptions, myths and other factors that put workers (female and male) at risk so as to plan interventions accordingly.
- Assessment of workers' willingness and motivation to take steps to change their behaviours.

- Prioritization of the behaviours that workers want to work on first, helping them to "own" their decision and the plan that will be developed.

By helping to identify risky sexual behaviours, risk assessment provides vital information needed for the development of risk reduction strategies. Risk assessment also identifies gaps, needs and targets to inform programme development at the workplace. The evidence base for risk reduction was generated through KAPB surveys, internet-based surveys and meetings. Generally, risk assessments were conducted more often in public and private sector workplaces than in informal economy workplaces, across all eight sectors (Annex 5, Table 27). This may be attributed to a lack of adequate resources and organized structures in the informal economy to accurately evaluate vulnerability.

Visser (2012, p.10) also provided an example of a study (Chimbetete & Gwandure, 2011) where "employee HIV and AIDS risks were measured for factors such as attitudes to condom use, sexual risk recognition, HIV and risk taking behaviour, stigma and disclosure."

W24 in Kenya conducted an initial KAPB survey to establish gaps in knowledge and associated risk so they could be addressed. Results from the survey showed that 90 per cent of employees were aware of the existence of female condoms, but only about 55 per cent had seen one and only 11 per cent had used one. The results also showed a gap in the provision of female condoms. Based on these results, W24 launched a programme to educate employees about use of female condoms and make them available, resulting in 6,000 condoms being distributed each month to employees and their spouses in 2008.

W7 in Ghana conducted a risk assessment which led management to provide resources for the workplace programme. In this case, risk assessment was used for advocacy purposes.

W17 in South Africa indicated that risk assessment forms were completed by peers to assess risks. Findings of this survey led to the distribution of half a million male and 19,000 female condoms in 2012; 95 per cent of sex workers reported an increase of condom use during their last sexual encounter with a client, and 81 per cent with a sexual partner who is not a client.

EDUCATION AND AWARENESS ABOUT CONDOMS

On-going education sessions regarding the importance of male and female condom use in preventing transmission of HIV, as well as understanding how to store and dispose of them, empowered employees with knowledge, increased their acceptance and utilization and created demand. Education involved various strategies such as designing targeted messages and using communication channels, a peer education approach and outreach to communities and families.

These approaches were used in trainings, social events, seminars, and group discussions. Educational tools included theatre, videos, posters, comic books, pamphlets and IEC materials to increase awareness of risky sexual behaviours and promote safer sexual behaviours. This study and Visser (2012, p.55) found that "encouraging safer sex practices and attempting to normalize the use of the male and female condoms, (and) raising workers' consciousness has worked."

W5 in Ghana used billboards, information sessions, posters, brochures and group discussions to explain condom use, increasing condom uptake from 32,000 to 76,000 in 2005. The company distributed 60,600 condoms in 2010 and by 2012, 97.3 per cent of W5 employees indicated they use condoms (KAP Survey 2012).

W15 in Ghana conducted information sessions on the prevention and control of STIs, the reduction of multiple partners and alcohol intake, the promotion of VCT, addressing the factors that contribute to women's vulnerability. These activities led to the workplace distributing 109,609 condoms to informal sector workers between May 2010 and May 2012 (ILO, 2012).

W18 in Kenya conducted employee sensitization forums, community outreach initiatives and distributed educational materials such as condom promotion leaflets. The company used condom "kings" and "queens" to demonstrate correct and appropriate use of condoms. Condoms were distributed to staff and the surrounding community to encourage ownership of the condom strategy and uptake within the organization.

At W49 in Zambia, weekly talks on the importance of condom use were given by HIV and AIDS experts. These talks were effective in promoting condom use as evidenced by the increase in monthly condom distribution from 500 in 2012 to 2,000 in 2013. Education activities took into consideration cultural issues and allowed space for discussions on concerns and misunderstandings about condom use.

W39 in Senegal used information kits as well as condom promotion through IEC materials such as posters, videos, pamphlets, campaigns and leaflets. As a result of behaviour change messaging, condom uptake increased over the years, from 571 in 2010 to 823 in 2011, 1,886 in 2012 and 3,579 in 2013.

At W46 in Côte d'Ivoire, demonstrations and education and communication (IEC) materials about condom use were provided to encourage reduction in risky behaviours, increasing the number of condoms distributed from 60,000 in 2011 to 80,000 in 2012.

PEER EDUCATION APPROACH

Peer educators were instrumental in ensuring condom acceptability and uptake because workers can relate to them. Condom awareness sessions conducted by male and female peer educators contributed to a significant increase in knowledge about the importance of correctly using them to prevent HIV transmission. Peer education was the most common way to disseminate information about condom use across workplaces of various sizes and economic sectors, as well as types of epidemic. Peer educators at W7 in Ghana, for example, led most of the discussions providing up-to-date information about HIV and promoting risk reduction behaviours such as reducing the number of partners, having safe sex, using condoms correctly and consistently, maintaining fidelity in relationships and accessing testing and counselling. The workplaces ensured that the peer educators were properly trained in order to be able to execute their duties.

At W30 in Madagascar, peer educators were trained to conduct awareness sessions with employees. At W50 in Mozambique, focal points were trained

as peer educators in each department and they were responsible for collecting condoms from the HIV office to distribute them in their departments.

At W9 in South Africa, peer educators kept condoms in their possession so that when they walked past employees they could also distribute them. According to the results from the 2011 follow-up survey, the use of condoms with partners increased from 34 per cent (2009) to 40 per cent (2011).

In Morocco, peer educators provided truck drivers with information on safe sex and condom use. The number of peer educators ranged between two at W14 to 10 at W12. Among employees of the W10, who were part of the Truck Driver Programme, condom use increased in both the last commercial sex act (from 35.5 per cent to 60.2 per cent) and the last casual sex act (from 36 per cent to 47.6 per cent). Consistent condom use also increased with commercial sex partners, from 23.5 per cent to 33.7 per cent.

W37 in Mozambique also reported the use of peer educators to promote condoms. This approach resulted in an increase of condom use at the most recent sex act, from 49 per cent in 2004 to 50.9 per cent in 2005.

OUTREACH TO COMMUNITY AND FAMILY

This strategy extended beyond the workplace to address community norms that could put employees at risk of HIV infection, and it contributed to reduced stigma around the use of male and female condoms, as well as increased condom uptake. It involved conducting community-wide promotion of condoms, education on their safe and consistent use and facilitating their distribution to the surrounding communities. In cases where condoms were sold, they were grouped in vending machines along with other products such as sweets, drinks and snacks. This made them accessible because vending machines are generally placed in busy places and are relatively anonymous and offer many other different products.

At W30 in Madagascar, condom distribution in the workplace increased from 2,500 in 2010 to 2,650 in 2011, and 3,200 in 2012, and in the community from 26,972 in 2010 to 31,337 in 2012.

PROVIDING ACCESS TO CONDOMS

Ensuring access to male and female condoms is an essential element in increasing their use. Several workplaces showed evidence that access to condoms was facilitated through the establishment of condom distribution points, placing them in various public areas in workplaces, in condom dispensers in the wash rooms, and in some cases condoms were placed in employee pay slips.

In Ghana, W5 ensured condom distribution at the workplace and high road traffic sites, and a trade union distributed condoms at bars and road stops in order to make them more accessible to truck drivers and sex workers. At W7, condoms were made accessible in the dispensaries located in the washrooms.

W9 in South Africa used condo-cans or a simple box for distributing condoms.

The informal sector association W47 in Mozambique also targeted the main transport corridors where sex workers, truckers and traders congregated, informing them about HIV risks and prevention and resulting in the distribution of 45,000 condoms.

Innovative marketing of male and female condoms was employed to ensure that condoms were affordable, accessible, attractive and easy to obtain in order to increase their uptake.

- The use of expensive condoms was generally avoided so as to dispel the myth that less expensive condoms distributed by the government were inferior.
- In some cases, *"flavoured"* and coloured condoms were used in order to add a fun factor while in other cases condoms were branded with striking names to attract employees' attention.
- *A mainstreaming approach* using vending machines and similar to that involved in community outreach, was deployed (see above).

MONITORING AND EVALUATION (M&E)

M&E was used to ensure timely, correct and complete recording of male and female condom availability and uptake. It should be noted, however, that fewer workplaces had established comprehensive M&E mechanisms

that went beyond the distribution of condoms to track the success and impact of their risk reduction programmes.

A sound M&E system should include:

- Baseline information gained through a simple questionnaire.
- Indicators to track outputs and measure changes.
- Knowledge assessment forms to be administrered before and after training workshops.
- Monitoring plans and monthly or periodic assessments.
- Annual evaluation reports to assess change.
- Capacity of staff (especially focal points and peer educators) to manage and sustain the M&E framework.
- Partnerships with the national AIDS bodies to link workplace M&E systems to the national system and seek support in building M&E capacity in the workplace.

W9 and W38 in South Africa conducted KAPB baseline and follow up surveys in 2009 and 2011 to compare indicators on risky behaviour, among others factors. W42 in Côte d'Ivoire conducted monthly assessments and reports to show trends of sexually transmitted diseases.

The Morocco workplaces W10, W11, W12, W13 & W14 conducted baseline and follow-up surveys in 2007 and 2012.

In Ghana, W15 conducted KAPB surveys in 2004 and 2006 respectively.

At W21 in Kenya, monthly meetings were held between the representatives of peer educators and the training coordinator. They reviewed the activities, updated the condom distribution and completed uptake records.

EXTERNAL FACTORS CONDUCIVE TO REDUCING RISKY BEHAVIOURS

As a response to the HIV epidemic, countries developed various strategies to combat the spread of the disease that have influenced workplaces to develop strategies for reducing risky behaviour among their employees.

Access to prevention services are provided for free in Ghana, although condoms are still supplied at a subsidized cost to the marginalized and at-risk populations (MARPs) such as commercial sex workers (CSW) and men who have sex with men (MSM).

Kenya adopted a strategy to promote safer sexual behaviours by focussing mainly on behaviour change communications strategies aimed at the general public as well as targeting key populations at higher risk of acquiring HIV, such as young adults. In 2010, Kenya launched prevention networks among youth in all provinces. The number of condoms distributed from 2007 to 2009 increased by one third, and 15 million condoms were distributed each month (National AIDS Council, 2012: xi - xii).

In South Africa, the National Strategic Plan on HIV, TB and STIs 2012-2016 adopted "combination prevention" as a strategy to curb new infections. This strategy has provided a strong basis for world of work involvement in risk reduction programmes: "All employers need to ensure that all workers, both in formal and informal workplaces, should get an annual screening and testing, as well as get equitable access to prevention" (Department of Labour, 2012: 22). According to the Technical Assistance Guidelines of the South Africa Code on HIV and employment, adopted by the Department of Labour, "prevention strategies referred to include awareness programmes, education, promotion of male and female condoms, universal precautions and STI management" (Department of Labour, 2012:23).

RECOMMENDATIONS

Management commitment

- Leaders and managers' commitment and buy-in is crucial in effectively administering risk reduction strategies by internalizing condom provision in existing corporate structures (i.e. OSH units, human resource strategies etc.)

Partnership building

- Effective partnerships between public and private sectors are important to ensure sustainability of workplace programmes, in this case male and

female condom supply. In particular, partnerships and linkages with national AIDS bodies and ministries of health are important in ensuring sustainability of condom supply.

- By pooling resources, workplaces can significantly broaden their sphere of influence and improve the efficiency of their efforts. This is particularly important for small businesses that otherwise may not be able to participate due to financial and human resource constraints.

Risk assessment

- Assessment of risky behaviours and vulnerability factors that people engage in helps employees begin to understand their own risk; and for workplaces to understand their workforce risk profiles prior to the design of risk reduction programmes and strategies.

Condom promotion

- Education sessions about HIV risk prevention involving demonstrations on male and female condom use should be conducted on an on-going basis.
- Condoms should be promoted in combination with other prevention strategies.
- Education on condom promotion should include *correct and consistent* use of both male and female condoms and highlight proper ways of storing them.
- Condoms should be available at no, or subsidized cost (although some prefer more expensive ones).
- HIV prevention education and condom promotion should overcome challenges posed by gender and cultural factors and include gender-responsive strategies such as negotiating skills on condom use, promoting equal decision-making power in interpersonal relationships, and increasing male sensitization to the use of condoms and promotion of female condoms to give women more control in protecting themselves.

Peer education approach

Peer education is an effective technique for reducing risky behaviours in the workplace and can be adopted elsewhere. Some common standards in developing peer education programmes should include involvement of

PLHIV and key populations in the peer education programmes, with the goal of ensuring their participation in identifying, deciding upon, designing, implementing and evaluating programmes.

Peer educators and education programmes should also:

- Target key populations and specific workers' groups (mobile workers, informal workers, women workers etc.) according to a clear assessment of risks and needs.
- Ensure equal representation of women and men, and undertake a gender assessment to ensure gender concerns are integrated in the analysis, formulation, implementation, monitoring and evaluation of the programmes.
- Include advocacy to reduce stigma and discrimination of PLHIV, as well as promote knowledge around gender equality and workers' rights related to HIV.
- Prepare a plan to periodically track activities, with clear roles, responsibilities and targets for follow-up.
- Ensure that peer educators are selected across all levels of the organization and in a gender sensitive manner.

In addition, staff and human resource managers, including representatives from PLHIV and target populations, should be actively involved in assessing needs of workers regarding HIV and AIDS education programmes.

Effective Behaviour Change Strategies (BCC)

- Risk reduction strategies need to follow systematic steps to:
  - Develop a clear workplace profile through formative assessment
  - Identify desired behaviour change
  - Understand factors that can undermine the change (alcohol abuse, sexual harassment at the workplace, gender-based inequalities, interactions with key populations etc.)
  - Shape messages, data, information and tools that address the needs of the workforce

- Take the strategy forward, with clear roles and responsibilities, actions, targets and timelines
- Measure achievements.

- In general, workers involved in planning strategies for reducing risky behaviour and behaviour change at the workplace should:
  - Look at the epidemic in the country, assess workplace needs and workers' risks and vulnerabilities, undertake a gender assessment and identify the main drivers that fuel the epidemic and need to be addressed through BCC interventions (this can be done through a formative assessment)
  - Review and assess what works in BCC, at other workplaces and at the country level interventions (usually the country has a BCC strategy or plan)
  - Develop a workplace BCC strategy and key strategic interventions considering the audience (workers, managers, male or female, young people etc.)
  - Design risk reduction messages adapted to the needs and characteristics of target workplaces and addressing the underlying factors contributing to behaviour change
  - Adopt context specific innovative methods to maintain enthusiasm and receptiveness towards HIV and AIDS messages
  - Develop materials in a participatory way and test them well to ensure appropriateness and acceptance by workforce, and to ensure there is consideration for gender-specific differences.

Monitoring and evaluation

- Workplaces across sectors should consider extending the M&E of their risk reduction strategies beyond condom use in order to enhance sustainability and justify continuity, and include an evaluation plan for measuring behaviour change.

CHAPTER 6: GENDER INTEGRATED IN HIV WORKPLACE PROGRAMMES AND RESPONSES

Addressing gender dimensions is central to the response to HIV and AIDS. Gender inequalities are one of the most important drivers of the epidemic, notably in Africa. What are these gender inequalities, and how do they impact female workers? HIV and AIDS pose a particular threat to women and girls, not only because of their higher physiological susceptibility to HIV, but also due to gender-related disparities and disadvantages in economic opportunities, legal and social structures and related gender-based discrimination and violence. This chapter identifies the strategies and actions used in some workplaces to ensure that gender-related concerns were integrated in their HIV programmes and actions.

Gender was a key aspect in data collection from individual interviews and focus-group discussions, which produced gender-specific information that was subsequently analysed in the study. In general, workplaces have put in place a number of gender-specific measures throughout the planning and implementation of workplace programmes.

These included:

- Measures aimed at designing sessions, services and other initiatives that took into account the way in which male and female workers perceived gender roles and norms in relation to HIV and AIDS. This was done so that traditional views, social norms on the often different roles of men and women could be discussed so as to facilitate more inclusive approaches on HIV and AIDS in workplaces,
- Measures actively aimed at identifying specific risk factors and prevention needs among men and women and designing responsive strategies to address these risks and needs accordingly.

STRATEGIES AND ACTIONS

FOCUSED MESSAGING, EDUCATION AND TRAINING TO ADDRESS THE DIVERSE NEEDS OF WOMEN AND MEN IN WORKPLACES

Gender-specific messaging and education sessions were developed based on a simple situational analysis identifying the age- and sex-composition of staff. These sessions focused messaging and awareness/education efforts on gender-specific risks and potential vulnerabilities, while addressing the different needs of women and men in relation to HIV knowledge and awareness.

The education and awareness sessions were administered by both male and female personnel assigned as peer educators and trained to identify underlying social norms, misconceptions around gender relations and harmful practices and behaviours perpetuating gender inequalities that could increase susceptibility to HIV infection.

Where necessary, education sessions were administered in single-sex support groups to address gender-specific challenges. An example is the "One Man Can" and "One Woman Can" campaigns that targeted men and women separately and were aimed at addressing specific needs and issues such as men and masculinities, male and female role models and gender-based violence.

A gender-tailored approach was used to adapt messaging to the predominant sex in the workplace. For example, education sessions in mines – where the workforce is predominantly male – were packaged to address issues such as masculinities, social norms perpetuating risk factors for men and violence against women. However, this approach was seen as sometimes overlooking the needs of the very few women employed in the sector.

General training sessions and events encompassed a discussion on gender mainly in relation to biological differences, social and cultural factors and harmful practices.

At W33 in Zambia, management used the "One Woman Can, One Man Can, One Couple Can and One Family Can" approach to target messages to

these specific groups. Separate education sessions were conducted to ensure that the messages were focused towards the often different needs identified.

W47, an informal economy association in Mozambique, worked closely with COMUTRA – Women Workers Committee – to use their expertise in integrating the specific needs, risks and vulnerabilities of women, as well as male "values" regarding masculinity, in workplace HIV training. This proved particularly effective in getting to the core of gender-specific needs.

Initiatives to ensure access and use of HIV services at the workplace included:

- Establishment of single-sex support groups for HIV counselling and information served as a means of tailoring services appropriately to the different needs of clients. The support groups would address access to counselling, psycho-social support or information reflecting gender-related needs,
- Introduction of health insurance that emphasized equity in access for both women and men,
- Implementation of inclusive strategies to ensure that VCT services remained accessible to and used by women and men despite, for instance, a higher composition of staff of either sex.

W51 in Zambia introduced a support group providing gender-specific counselling and information to men and women. This ensured that participants felt comfortable in the support setting and that their needs were appropriately taken care of.

W52 in Kenya introduced a workplace health insurance for employees in which both male and female employees would equally benefit.

At W33 in Zambia, men often waited to get tested until their partner knew their own HIV status. Through a gender-specific "One Man Can" approach, men were specifically encouraged to access VCT and change their behaviour and be proactive in knowing their status rather than waiting for their partner's results. The programme highlighted the critical role of men as change agents in the response to HIV. Men were asked to understand their role in their communities, families and extended families – as fathers, sons, uncles, role models and responsible citizens. In addition, issues such as family income

security, drug and alcohol abuse and behaviour towards women were also discussed in "One Woman Can" sessions.

Provision of information on VCT to men at W53 in Mozambique, through awareness and targeted campaigns, motivated men to go for HIV testing. This addressed the same challenge cited where men put off testing until they knew their partners' HIV status. A pro-active approach targeting men showed positive results.

Accessibility and availability of gender-specific risk reduction strategies were also developed by several workplaces. They put in place risk reduction strategies (i.e. male and female condom promotion and distribution) to serve both women and men where they needed it. This implied: ensuring availability of both male and female condoms where employees could easily access them, promotion of correct and consistent male and female condom use, and holding special condom demonstrations for men and women separately, as necessary.

According to the study findings, this strategy worked in ensuring that both men and women were reached by "gendered" risk reduction messages that addressed their specific risks. They also emphasized the importance of safer sex negotiation to the empowerment of women.

In Côte d'Ivoire, W32, W42, W46, W54, and W55 used dummy sexual organs for condom demonstrations to facilitate better uptake of both male and female condoms.

W17 in South Africa educated male and female sex workers on the correct use of condoms, and female sex workers specifically on condom-negotiating skills. They also distributed brochures on health issues specific to the needs of sex workers. In 2012, W17 distributed half a million male condoms and 19,000 female condoms.

In Senegal, W43 also used dummy sexual organs to demonstrate appropriate and correct use of male and female condoms.

At W24 in Kenya, female condoms were available even though problems were raised: "Female condoms are in place too but the uptake is low as they are perceived to be 'cumbersome' to use. Nevertheless, all female staff has been through training sessions on female condom use." Woman and man, junior and senior staff, W24, Kenya.

W1, W2 and W3 in South Africa, in an attempt to empower women in condom use, provided training to staff on how to use the female condoms. A consistent supply of male and female condoms was ensured, and the companies have distributed thousands of female condoms to employees over the life of the programme.

MAINSTREAMING GENDER IN DESIGN AND IMPLEMENTATION OF WORKPLACE PROGRAMMES

Addressing and integrating gender dimensions is essential in every step of the planning, design and implementation of HIV workplace programmes. The study highlighted the need for the following strategies to ensure appropriate gender mainstreaming. Some of them were in place in the workplaces investigated; others included steps that could be taken for future workplace programming, including:

- **Gender analysis** conceptualized and undertaken at programme inception. This would include understanding the context by identifying the issues and social and cultural norms among the male and female workers and other contextual workplace factors; it will identify the needs of women and men in the workplace and help build the programmes and actions to respond to those needs. The gender analysis will also help in identifying organization partners that can have an impact and provide expertise, taking measures to address gender-related concerns and needs; and informing the development of specific sex-disaggregated indicators and targets in relation to the gender needs.
- **Inclusive policies and programmes** aimed at empowering women, promoting safer sex and addressing the barriers that prevent women or men from accessing HIV prevention, care and support at or through the workplace; establishing measures to address violence and harassment in the workplace and promoting the active participation of both women and men; and addressing sexual and reproductive health and rights.
- **Development of an M&E system** with indicators that are sex-disaggregated but also targeted to the needs identified in the gender analysis so that impact as well as access to services for both women and men are monitored and remedial measures taken to address any gaps in access.

Findings show that a gender-specific approach worked in ensuring that:

- The workplace programme reached all employees regardless of sex and there was no gender-based discrimination.
- All workplaces took gender into consideration in the design and implementation of workplace programmes (though the level and degree to which issues were addressed varied based on capacity).
- Training sessions included policies related to sexual harassment and gender equity.
- Women were empowered as change agents and leaders were trained on how to set up programmes, address specific needs of women and men, recruit new volunteers and make the programmes sustainable.

W16 in South Africa as well as W40 and W41 in Zambia put in place a training programme aimed at reducing stigma and discrimination amongst its employees of all genders. W16, where almost 65 per cent of members are women, had problems in reaching ill workers in their homes with care and support. To address this, they made a special attempt to recruit women as HIV programme managers and employ female home-based carers. Although this can be seen as perpetuating gender roles with women as care givers, the model constituted a targeted approach to get access to sick workers in their homes and helped in reaching women and better addressing their needs.

In South Africa, W1, W2 and W3 supported gender-related activities and developed specific plans on how to address gender issues and sexual harassment based on their gender analysis. They offered training on policies related to sexual harassment and gender equity. The workplaces indicated that women were receiving more fair and equal treatment than they did before the programme started.

RECOMMENDATIONS

- A gender analysis should form part of programme design and development.
- The M&E system should be built with indicators that are sex-disaggregated to better track and be able to respond to any gaps identified.

- Awareness sessions should be organized that take into consideration gender perspectives and relations within the workplace in order to enhance relevance and ownership of the programmes and ultimately contribute to greater receptiveness of HIV initiatives.
- Gender-specific approaches should go beyond providing services for women and men, and should become gender-responsive by addressing gender relations at the workplace, negotiation skills and women's empowerment.
- Equal participation of women and men in design and implementation of programme activities is essential to ensure that the programme addresses gender-specific issues and needs, social norms and stereotypes. This will boost acceptability and help generate a sense of ownership of the programme by all.
- Women and men should be empowered by the promotion of both male and female condom use and safer-sex negotiations, both of which can contribute to more effective reduction in risky behaviour.

CHAPTER 7: REDUCED STIGMA AND DISCRIMINATION[7]

Reducing stigma and discrimination is important for many reasons, not the least being that it improves the quality of life at work for PLHIV. Futhermore, acceptance of PLHIV and their continued employment not only motivates others to go for testing so they can know their own status and get access to treatment, but also improves treatment adherence, enhances livelihoods, improves the financial status of individuals and in many cases reduces their vulnerability to HIV. Yet only 14 per cent of the workplaces surveyed were able to show that their programmes had reduced HIV-related discrimination (Annex 2, Table 8). Why is this the case, and what should management and workers do about it? This section examines programmatic actions undertaken by various workplaces that reduced levels of stigma and discrimination. It includes an overview of the role of management, supervisors and workers, an examination of the value of peer educators, and an assessment of the conducive factors that facilitated the reduction of stigma and discrimination.

Figure 13 Actions taken by workplaces to reduce stigma and discrimination (per cent)

[7] Tables in Annex 6 (page 158)

MANAGEMENT COMMITMENT

An open demonstration of intolerance for stigma and discrimination by management was effective in creating an environment to facilitate their reduction. Management demonstrated clear leadership and commitment to the implementation of HIV and AIDS workplace programmes in the assessed workplaces through: investment of resources, leadership in speaking out decisively with one voice, development of non-discriminatory policies and employment practices, and workplace reliance on government and international statutes.

Strong and decisive management support led to the allocation of financial and other resources to cover tailored training, development and dissemination of IEC material, policy/programme formulation and policy implementation aimed at reducing stigma and discrimination.

In South Africa, W9 and W38 ensured that the necessary resources to cover training focussed on reducing the levels of stigma and discrimination were made available to workplace programmes. W16 recognized that it had the responsibility to educate its employees to ensure that those living with HIV are not stigmatized. To this end, it ensured that resources were available for the production and distribution of posters with non-discrimination messages during workplace campaigns.

In Zambia, W40 and W41 as well as W56 ensured that resources were available for training aimed at reducing stigma and discrimination among their employees. Tailored training was provided to employees and peer educators.

Management at W1, W2 and W3 in South Africa provided adequate resources for drafting and implementing a policy against stigma and discrimination for PLHIV.

Management and leaders can also help create a non-discriminatory workplace environment by speaking in a clear and decisive single voice. Management at W16, for example, was considered supportive for taking a clear stand against discrimination and the abuse of the rights of employees and their families living with HIV, while promoting access to treatment.

In the words of a senior management official: *"There are posters that have quotes from different leaders against discrimination and those posters were widely distributed during the campaign to all workers".*

The senior management from W9 and W38 in South Africa were praised during the study for showing support towards the implementation of their workplace programmes. Furthermore, management at W9 was viewed as taking into consideration the views of counsellors and employees during the implementation of the workplace programme.

The management of W1 in South Africa demonstrated concern about the health of employees and the management at W56 in Zambia was very supportive of the drafting and implementation of the policy against stigma and discrimination for PLHIV, who were involved in enforcing the policy.

> *"The response is really good here as management is supportive by ensuring that the wellness programmes are championed by peer educators."*
>
> ***Focus group statement, W40 & W41***

DEVELOPMENT AND IMPLEMENTATION OF NON-DISCRIMINATORY POLICIES

Another example of management commitment to intolerance of stigma was through supporting the development of HIV and AIDS policies based on the principles of non-discrimination and equality. The policies addressed perceptions, prejudices, cultural beliefs and attitudes towards HIV and AIDS and PLHIV. They also defined a workplace position on intolerance of stigma and discrimination as well as on standards and practices among employees, supervisors and management. They emphasized the need to eliminate discrimination and harassment based on real or perceived HIV status. Workplaces also reported that they had human resources and other related policies promoting non-discrimination in the workplace, and legislation such as the Employment Equity Act in South Africa.

W9 stated that it forbids any form of discrimination and does its utmost to prevent it. The company had in the past dismissed staff for discriminating against others. W3, W2, W1 and W56 adopted and implemented non-discrimination HIV and AIDS workplace policies with management support.

NON-DISCRIMINATORY EMPLOYMENT PRACTICES

Management support was also demonstrated in the area of employment practices related to recruitment, employment benefits and grievance procedures. Examples include appointing staff with the requisite knowledge, skills and experience into the organization, providing equal access for all staff to in-service training and promotion, and applying the same conditions of employment to all employees, all irrespective of real or perceived HIV status. In addition, it also included providing medical support to staff living with HIV, a non-dismissal approach to PLHIV and supporting grievance procedures and disciplinary measures regarding stigma-related complaints in the workplace.

ASSESSING STIGMA LEVELS

Initial assessments provide workplaces with the basic building blocks needed to design and implement effective HIV and AIDS programmes. Evidence gathered within the workplace makes programmes more relevant, responsive and focussed on the needs of employees—an important aspect of programme design which must not be overlooked.

This study found that the approaches by which workplaces assess levels of stigma and discrimination included the use of KABP surveys, formal assessments and reviews of existing data. In addition to demonstrating a good understanding of programme design, an initial assessment also ensures the judicious use of resources while addressing the priority issues.

As a result of the sound knowledge base, evidence-informed HIV workplace programmes helped employees confront and address their own underlying fears, prejudices or internal stigma and make their needs known. It also helped them and PLHIV know their rights, contributing to allaying fears, dispelling myths and "normalizing" HIV and AIDS within the workplace.

Baseline surveys were conducted at W9 and W38 in South Africa to assess the levels of stigma and discrimination, among others. These workplaces used scientific evidence generated from the surveys on stigma levels and types to design HIV and AIDS workplace programmes and ensure they were relevant, responsive, focused and evidence-based.

W9, W16 and W38 in South Africa reported that assessing the needs of employees living with HIV is important to ensuring those needs are accommodated in workplace HIV and AIDS policies and programmes. These workplaces also indicated that using credible scientific evidence on stigma and discrimination levels and types in the design of their programmes helped ensure effectiveness.

PEER EDUCATION, AWARENESS AND TRAINING ON RIGHTS

Peer educators play a powerful and consistent role in addressing HIV and AIDS issues. They are powerful catalysts for reducing stigma and discrimination and are usually the most common sources of information and increasing awareness in the workplace. Their effectiveness is largely due to their delivering information in a manner accessible to their peers. Across sectors, peer educators also contributed significantly to the goal of non-discrimination by encouraging employees to address their underlying fears and prejudices and make their needs known.

At W40 and W41 in Zambia, peer educators championed the programme to reduce stigma and discrimination by providing employees with accurate information through departmental health talks. The percentage of employees exhibiting a low level of stigma rose from 61 per cent to 78 per cent in the two hospitals. W40 & W41 also undertook awareness sessions for patients.

In South Africa, a sufficient number of well-trained peer educators with good interpersonal skills and training in HIV knowledge championed the programme at W9 and W38. The results for the 2009 and 2011 W9 KABP surveys showed an increase from 79 per cent to 86 per cent of employees who reported not being afraid of living close to someone with HIV. The number of employees willing to provide help and support to friends and colleagues living with HIV also increased from 87 per cent to 94 per cent. The two enterprises also provided regular training for staff and peer educators on the rights of people with HIV. At W9, print media such as codes of conduct emphasizing non-discrimination against people living with HIV were displayed on notice boards. At W38, stigma appeared to decline. The number of employees saying they believed HIV wasn't a punishment from God increased from 81 per cent in 2009 to 86 per cent in 2010, while the number indicating they were afraid to live close to someone with HIV declined from 17 per cent to 8 per cent during the same period.

Also in South Africa,W16 recognized that they had the responsibility to educate workers and other members of society against stigmatizing people living with HIV. Campaign posters quoting a wide range of leaders with non-discrimination messages were distributed to employees at work, helping them confront and address their underlying fears. Shop stewards undertook HIV non-discrimination education and awareness programmes during working hours, which were conducted primarily by peer educators and PLHIV. W1, W2 and W3 provided HIV education at all levels and called for a reduction in stigma and discrimination, thereby creating a sense of openness to HIV and facilitating its normalization.

PROMOTING ACCEPTANCE AND OPENNESS, AND INVOLVING PLVIH

The meaningful involvement of PLHIV in HIV and AIDS workplace programmes is central to programme design and implementation. Promoting acceptance and openness around HIV and AIDS in the workplace thus helps reduce stigma and discrimination and create a safe

working environment. PLHIV need to feel accepted and that they belong in the workplace.

Several approaches have been used to promote acceptance and openness around HIV and AIDS issues in the workplace through the direct and active engagement of PLHIV. Once PLHIV declared their status and were treated well within the workplace, other employees felt encouraged to undertake HIV tests. Disclosures are often a reflection of the implementation of effective HIV workplace programmes that address stigma and discrimination and protect the rights of workers living with HIV, as well as promote confidentiality and ensure continuous employment. A range of approaches used to enhance acceptance and openness towards PLHIV include opening a dialogue on HIV and AIDS issues, wellness monitoring, creating a safe environment conducive to disclosure, adopting a "caring for a care-giver" approach and establishing pre- and post-test clubs.

OPENING A DIALOGUE ON HIV AND AIDS ISSUES

People living with HIV were meaningfully engaged in dialogues in several HIV workplace programmes.

Employees living with HIV from W1, W2, W3, W9, W16 and W38 in South Africa indicated that they were able to talk freely about their HIV status with their colleagues. Their experience confirmed that being well treated within the workplace after disclosing HIV status encouraged other employees to go for HIV testing. At W3, employees went for HIV testing because of the assurance that they would not be discriminated against should they test HIV positive. The employees were proud of their peer educators and colleagues who publicly disclosed their HIV status.

These disclosures were a reflection of successful workplace policies that protected the continuation of employment for PLHIV and created working environments free from discrimination. However, disclosure is not recommended in workplace settings with high levels of stigma and discrimination.

WELLNESS MENTORSHIP

People living with HIV served as wellness mentors and this promoted their visibility and openness and built an environment supportive of PLHIV. PLHIV were promoted as positive role models to others and this contributed significantly to reducing stigma and discrimination. This also had implications for the reduction of stigma and discrimination at W40 and W41, where PLHIV "wellness mentors" helped other employees see the benefits of healthy living.

CREATING A SAFE ENVIRONMENT CONDUCIVE TO DISCLOSURE

Many of the workplaces surveyed had clear and widely communicated confidentiality policies in appropriate language that clarified the rights and duties of employees and management concerning HIV. This instilled confidence and encouraged disclosure.

W9 in South Africa had a workplace policy highlighting the rights and duties of employees and management and emphasizing the need for non-discrimination and confidentiality towards employees living with HIV. W9 created a safe environment for disclosure in order to reduce stigma and discrimination through working with an external person living with HIV, disclosing his or her status and talking to employees about HIV and AIDS. W9 also had a psychologist who provided free psychological services to employees living with HIV and their families.

Management at W56 in Zambia supported the drafting and implementation of a policy against stigma and discrimination towards PLHIV and were involved in its enforcement. If an employee discriminated against a PLHIV, they were subject to strict disciplinary action or even dismissal. In South Africa, management at W16 took a stand against discrimination and supported the rights of employees living with HIV and their families to receive treatment.

ESTABLISHING PRE- AND POST-TEST CLUBS

The formation of social clubs at the workplace provided male and female employees with an opportunity to receive psychological support and share experiences with each other. They strengthened solidarity among employees and enhanced their resolve to take positive measures in addressing HIV.

At W40 and W41 in Zambia, employees formed pre-and post-test clubs and support groups at the workplace to reduce stigma and provide psychosocial support. The support groups met to discuss and share information and experiences with each other and undertake activities such as income generation, visiting PLHIV and providing financial support for orphans of hospital staff.

Also in Zambia, W56 provided affordable assistance to its employees, including ART, home based care, reproductive health services and access to counselling and psychosocial support, as well as formation of support groups.

W16 in South Africa set up support groups and provided on-going counselling and support for group check-ups.

"CARING FOR THE CARE-GIVER" APPROACH

HIV workplace programmes should ensure that care-givers who are PLHIV receive support for the caring they provide since the art of caring can itself be draining.

W40 and W41 ensured that PLHIV receive HIV prevention, treatment, care and support services that they could then extend to other PLHIV in need of the same services. The goal was to ensure that PLHIV who play a meaningful role in HIV workplace programmes were actually supported in continuing to play that role.

A safe, supportive, resourced workplace environment for PLHIV and those affected by HIV, underpinned by the implementation of human right policies and principles that encourage equal treatment of all employees regardless of

their HIV status, contributes significantly towards the reduction of stigma and discrimination.

WELLNESS APPROACH/MAINSTREAMING

Addressing HIV and other conditions helps shift and neutralize the focus on HIV and AIDS to reduce levels of stigma and discrimination and ensure the continued motivation in accessing services. HIV and AIDS anti-stigma and discrimination messages were integrated into existing on-going structured communications, programmes and facilities (normal business) such as organizational business meetings (e.g. production meetings). An analysis across workplaces in countries with different epidemic types shows that wellness approaches were used across all the epidemic types because they were found to be better tailored to the needs of male and female workers than HIV-specific programmes.

In South Africa, W9 and W38 mainstreamed HIV prevention, care, treatment and support activities into existing programmes. This facilitated a reduction of stigma and discrimination because HIV was not isolated or treated separately from other conditions. On-going HIV information sessions were mainstreamed into organizational business meetings (e.g. production meetings) in accessible places such as the canteen at W9. In order to continue the development of the workplace programme and reduce stigma, with the help of GIZ, the workplace HIV and AIDS initiative was integrated into a comprehensive employee wellbeing initiative that included TB prevention. Six months later, this initiative became part of the overall occupational safety and health programme.

The programme at W16 in South Africa changed its name to the W16 Worker Health Programme because it extended its work beyond HIV and AIDS. Programme managers felt that the name change took away the stigma associated with HIV and AIDS.

SWHAP observed that HIV and AIDS-only interventions were becoming boring to employees. They started wellness programmes to address other health needs as a way of making the HIV and AIDS programme at workplaces more interesting, sustaining motivation in programme implementation and de-stigmatizing HIV and AIDS.

Addressing HIV and AIDS together with other health needs makes HIV and AIDS programmes more attractive, sustains motivation in programme implementation and contributes to de-stigmatization of HIV and AIDS. It also has implications for sustainability of programmes.

MONITORING AND EVALUATION

Monitoring and evaluation forms the basis of assessing progress during the implementation of HIV workplace programmes. It serves as an integral component of all HIV workplace programmes and is the means by which programme effectiveness is assessed. In many workplaces, M&E systems were used to ensure that the levels of stigma and discrimination were monitored and gaps were detected and addressed in a timely manner. The workplaces assessed conducted comprehensive HIV and AIDS analysis to ensure that non-discrimination policies were being implemented as planned and were achieving the desired outcomes. Some of the HIV and AIDS policies were modified and reviewed regularly to ensure they articulated the rights of people living with HIV and addressed the epidemiological changes with regards to HIV.

In South Africa, W9 and W38 modified and reviewed their HIV and AIDS workplace policy regularly to ensure that it clarified rights and duties and affirmed non-discrimination and confidentiality to HIV positive employees. W16's policy was routinely reviewed by its National Executive Committee in the light of new epidemiological and scientific information as part of an effort to continue to address stigma and discrimination.

SWHAP supported workplaces to regularly evaluate their policies to include emerging issues in stigma and discrimination, among others.

Beneficiary satisfaction with the programme was assessed via suggestion and complaint boxes and through union structures in W16 while at W9, W38 and SWHAP-supported workplaces this was done through conducting follow-up surveys and subsequent review of their programmes to ensure that they continuously addressed stigma and discrimination.

Monitoring of stigma and discrimination ensures that the HIV workplace programme managers are well informed, impact is monitored, and lapses are detected and corrected in a timely manner.

EXTERNAL FACTORS CONDUCIVE TO REDUCING STIGMA AND DISCRIMINATION

The reduction of stigma and discrimination across countries was also made possible by the existence of national strategies and policies, or other initiatives by stakeholders external to the workplace that were conducive to reducing stigma and discrimination.

In Zambia, the National Strategic Framework (2011 – 2015) outlines specific strategies for reducing HIV related stigma and discrimination such as creating public awareness and addressing legal barriers that prevent individuals, including key populations, from accessing and utilizing services. The National HIV/AIDS/STI/TB policy of 2005 and the Citizens Economic Empowerment Act of 2006 also prohibit discrimination based on HIV status.

In South Africa, the National Department of Health has developed a Stigma Mitigation Framework while SANAC, in collaboration with PLHIV groups, is implementing a Stigma Index. In addition, South Africa also has, among others, a National Strategic Plan on HIV, TB and STIs (2012-2016) whose fourth strategic objective is: *Protect human rights of people living with HIV*. The primary objective is to end stigma, discrimination, human rights violations and gender inequality.

The legal and policy environment in which the workplace is situated can facilitate and promote management support for the implementation of effective HIV and AIDS workplace policies and programmes. The following quotes are from interviewees in South Africa:

"When it comes to policies on HIV and AIDS in the workplace, I think a lot of brilliant policies exist and I think that government, unions, and human rights activists, etc. have done tremendous work in that sense. I think the policies exist, and they are being dispatched properly."

Male, South Africa, Government department

"If you look at the national strategic plan that's been put up by the South African National AIDS Council (SANAC) and the provincial strategic plan that's put up by the Eastern Cape AIDS Council, HIV and AIDS in the workplace is addressed…I think the national strategic plan has played an important role, I think the technical guidelines on HIV and AIDS are also playing a role."

Female, South Africa, Government department

RECOMMENDATIONS

Management commitment

Management should:

- Openly demonstrate zero tolerance for stigma and discrimination.
- Speak with one voice when addressing HIV and AIDS among employees to eliminate any doubt regarding commitment and facilitate programme effectiveness.
- Allocate resources for HIV workplace programmes including training, policy formulation and programme implementation.
- Consider the views of employees, counsellors, peer educators, etc. during programme implementation in order to strengthens trust and provide an opportunity to adjust the programme to the needs and concerns of employees.

- Play a lead role in developing, implementing and enforcing workplace policy.

Workplace programmes and policies

Workplaces are urged to:

- Take advantage of the conducive environments in which they are situated to scale up programmes that increase access to HIV services for women and men workers.
- Aim at eliminating discrimination and harassment.
- Address perceptions, prejudices, cultural beliefs and attitudes towards people living with HIV, among others, and adapt HIV workplace programmes to the needs of their constituents.
- Apply non-discriminatory employment practices covering recruitment, equal access to employment conditions and benefits, irrespective of HIV status.
- Use a number of policies, including those concerning human resources, employment equity and others, to address the issues of stigma and discrimination.
- Emulate the good and effective practices of other workplaces that provide onsite psychologists to ensure that employees living with HIV receive appropriate counselling and support where necessary.
- Review and closely monitor HIV and AIDS workplace policies periodically to ensure they are well aligned to new epidemiological changes or changes in global/regional policies on human rights.
- Identify, train and equip peer educators from all levels within the organization to carry out effective education within the workplace to ensure the reduction of stigma and discrimination.
- Reward and encourage peer educators for the important roles they play.

Assessments, monitoring and evaluation

- Assessing the levels and types of stigma and discrimination prior to commencing the HIV workplace programme provides a basis for regular

measurements against established benchmarks. Workplace programmes should not "fly blind" but must be informed by evidence.

The meaningful involvement of PLHIV

- Workplace programmes must be developed around the needs of employees living with HIV who should be meaningfully engaged at each stage of the implementation process. If PLHIV are unavailable from any particular workplace, PLHIV from other organizations or workplaces should be invited to support the programme design and implementation.
- PLHIV or employees living with HIV should be central to the development and implementation of HIV workplace programmes. There should be no exceptions.
- Some workplace programmes provide support to employees living with HIV even outside the workplace through home-based care programmes. The formation of support groups for male and female employees living with HIV is useful as it helps address psychological and psychosocial issues faced by PLHIV.

Addressing stigma and discrimination

- Addressing stigma and discrimination has some key components: strong management support; an enabling legal and policy environment; concrete programmatic actions; involvement of PLHIV; and monitoring and evaluation systems to track and guide progress.

Integrated programming

- Innovative, integrated approaches (i.e. wellness programmes), which combine HIV programming with other health programmes, increase their overall appeal, reduce boredom and stigma and enhance sustainability. Workplaces can do this in partnership with NGOs and other stakeholders.
- Integrated approaches also involve mainstreaming HIV education into on-going workplace activities, trainings or programmes. Taking HIV out of isolation is a recommended approach for workplaces as it helps reduce stigma and discrimination levels.

Link workplace programmes to the national HIV and AIDS programmes

- Workplaces and organizations should take advantage of national plans, strategies, policies and laws when developing and implementing their HIV workplace programmes. Situating the workplace programme within the country context and establishing the necessary linkages with existing strategies and initiatives contributes to effectiveness.

CHAPTER 8: INCREASED UPTAKE OF ANTIRETROVIRAL TREATMENT (ART)[8]

The life-saving aspect of antiretroviral treatment, or ART, for individuals is well known. In the world of work, accessibility to ART has benefits for both employees living with HIV and their employers. For employees, it can mean continuing to work as long as possible and fulfilling job responsibilities while prolonging their lives. For some companies, improving ART uptake makes business sense in terms of reducing absenteeism, hospitalization and other costs. How successful have workplaces been in increasing access to ART, and what challenges do they face? This chapter presents the findings of programmatic actions undertaken by some workplaces to achieve this good outcome.

Despite the proven benefits of ART, only two of the 66 workplaces investigated provided robust evidence proving they had managed to achieve an increase in its uptake among men and women employees. The two workplaces are W8 in Namibia and W39 in Senegal (Annex 2, Table 8). Programmatic actions that contributed to the achievement of this outcome included: management commitment and ART access; awareness raising about ART; wellness programmes; and monitoring ART uptake and treatment outcomes.

MANAGEMENT COMMITMENT AND ART ACCESS

Access to ART was provided by making ART available and affordable to employees, as well as through linkages with external HIV and AIDS networks of accredited service providers. Management support was demonstrated by the commitment of financial resources for ART. The rights of PLHIV were respected and employees were encouraged to come for treatment through guaranteed privacy and confidentiality regarding the disclosure of their HIV status and treatment uptake. Confidentiality was ensured by not keeping names of employees on record.

[8] Tables in Annex 7 (page 166)

The two workplaces that provided ART tended to be large and in the private sector (Annex 7, Tables 39 & 42). Informal economy workplaces may not have had the required resources (i.e. human, financial and organizational resources) to make ART accessible and were more likely to rely on public health services.

In both the workplaces, men and women living with HIV had access to ART free of charge. Peer educators emphasized the availability, acceptability, affordability and importance of ART to employees during education and HIV testing sessions.

W8, globally recognized as a leader in addressing HIV and AIDS in the workplace, was the first company in Namibia to provide ART free to permanent employees living with HIV, along with their spouses or life partners and children. W8 established a Corporate Fund of N$2m and covered all the costs of providing ART to its employees. This encouraged employees to undergo VCT as they knew that if they tested positive they would get treatment.

> *"We ensure that there is no co-payment. The company pays the entire cost so that you couldn't say 'I can't go and take treatment because I don't have the money'. Today, it's still covered 100 per cent."*
>
> ***Female, Wellness Coordinator, W8***

Another clear demonstration of management support is that W8 runs clinics and medical centres at its mine sites, where employees and their spouses, partners and children can access treatment and support services.

ART programmes at W8 were externally coordinated by Aid for AIDS – a programme offered by the Namibia Health Plan (NHP) that provides comprehensive benefits for the treatment of HIV and AIDS to its members – at no additional cost and in strict confidentiality – via a network of accredited service providers. W8 works with the government to coordinate the treatment of employees who retire or are "retrenched" (made redundant and not offered

another job) to ensure the seamless transition from its ART programme to government services. The goal is to encourage all employees living with HIV and their spouses or life partners to join a disease management programme as early as possible.

W39 is recognized as one of the only private enterprises in Senegal that provides ART. The treatment is actually supplied to the company at no charge by the national government. Meanwhile, W39 management supports the commitment of its own funds for treating other infectious illnesses that the employees may have.

> *"We do treat our patients here. We give global treatment here, no matter where he or she has done the screening test, inside the company or outside the company. The patient does not pay for ARVs because it is taken in charge by the government."*
>
> ***Male, HIV Focal Person, W39***

> *"W39 signed an agreement with the National AIDS Committee which has the obligation to intervene in the fight against AIDS and provide treatment. The National AIDS Committee is in charge of medical service programmes, and the chief-doctor is the one in charge of designing the HIV/AIDS programme in collaboration with other stakeholders."*
>
> ***Male, HIV Focal Person, W39***

> *"We, as the leading company in the fight against HIV and AIDS, we do not want to surrender. This is the reason why we are the best one and this is the only private company in Senegal which provides treatment of the HIV infection."*
>
> ***Male, Senior Manager,***
> ***Coordinator of the HIV/AIDS Programme, W39***

The study found that offering in-house, clinic-based and employer-provided ART, or contracting an external company to manage ART for eligible employees and their dependents, resulted in improved ART uptake. Providing access to ART appears to be a win-win for both employees and management. For employees living with HIV, it is therapeutic, enabling them to continue working as long as possible and to fulfil their expected job responsibilities while prolonging their lives. At the same time, management commitment to facilitating access to treatment by making ART available and affordable has significant cost and risk management benefits in terms of reducing absenteeism, hospitalization and death.

CREATING AWARENESS ABOUT ART

A wide range of communication approaches were used by W8 and W39 to motivate workers to undertake HIV testing as a step towards accessing treatment, if needed. Awareness creation through peer education resulted in increased ART uptake by sensitising people about the availability and benefits of HIV treatment. This in turn encouraged more people to be tested since they realised that having HIV was not a death sentence and treatment was available.

Both male and female peer educators were involved at W8 in advertising and promoting ART. To maintain flexibility, workplaces provided ART for both male and female employees onsite or through partnerships with local facilities free of charge.

Behaviour change communication approaches consisted of talks, posters, pamphlets, intranet communications, briefs, a gazette, site visits, participative drama activities and other creative strategies. These were used to motivate and encourage workers to undertake HIV testing and link persons who tested positive to life-saving treatment. Active groups of male and female peer educators were at the centre of these promotional efforts at workplaces, and emphasized communication and behaviour change to promote use of VCT and ART. The communication efforts focused on the benefits of ART and the fact that people living with HIV can live healthy lives and contribute

to the productivity of their companies and nations. Peer educators also explained the reinforcing relationship between treatment adherence and employment and the benefits of staying in employment while on treatment.

As stated previously, ART awareness sessions generate demand for HIV testing which then leads to treatment. However, if awareness sessions are conducted without access to ART onsite or through referrals, this may de-motivate employees and diminish the incentive for coming forward to get tested. Also, treatment uptake will be enhanced only if workers feel the principles of confidentiality and the continuation of employment are applicable even if they test HIV positive. An environment devoid of stigma and discrimination is important in facilitating treatment.

WELLNESS APPROACH

The wellness approach is key to taking HIV out of isolation and placing it within a broader health agenda. Providing comprehensive health services (e.g. one-stop clinic), whereby ART is given with treatment for other ailments, facilitated improved ART uptake in the two companies. It also contributed towards a more comprehensive approach to healthcare while lowering the levels of stigma and discrimination. The wellness approach is also more likely to reach more women and men workers in need of treatment and enhance its sustainability. The reduction in treatment costs should encourage more companies to support their employees with treatment for the opportunistic infections that arise as a result of HIV and AIDS.

A wellness approach was adopted by W8 whereby HIV awareness was integrated into the general wellness programme. Information was disseminated using many of the behaviour change communication methods cited above, as well as site visits and participative drama activities. Further, W8 took a holistic approach to HIV and AIDS aimed at maintaining both the physical and psycho-emotional wellbeing of its employees through a disease management programme. These efforts are aimed at helping those infected live a longer, healthier life and extending the duration of their productive employment. A policy related to a low-cost medical scheme, Vitality Day Care,

added a general outpatient benefit to encourage employees to seek care for other diseases beyond HIV. This included wellness advice, access to physicians, counselling and support, prophylaxis, nutritional supplements and ART.

W39 provided ART free of charge to employees living with HIV at their onsite clinics. The workplace also committed funds for treating other infectious illnesses that the employees may have. This way, employees living with HIV were able to access ART and other medicines for opportunistic infections.

MONITORING AND EVALUATION

Monitoring and evaluation was conducted to ensure the adherence, compliance and ultimately, the success of HIV treatment. The ART programme was regularly monitored using KAPB surveys and key performance indicators to understand more clearly how well the programme was doing in terms of ensuring adherence to treatment. Monitoring was done according to ART regulations and included other health check-ups such as the blood counts of patients. This ensured that quality services were being provided and guided the effective management of patients.

W8 consistently tracks and monitors treatment and adherence rates of their employees. In early 2006, W8's ART programme increased the monitoring of treatment compliance. This involves both the adherence of individuals to treatment and the effective management of patients by doctors and service providers. Key performance indicators were set to enable a clearer understanding of how well their service providers performed in getting employees to adhere to the programme.

> *"W8 has conducted or hired others to conduct a number of surveys and evaluations of their ART programme. These surveys, along with other standards set by countries or the company itself, ensure that services offered are always of the highest quality."*
>
> ***Female, Wellness Coordinator, W8***

W8's efforts have led to an increase in the number of individuals on ART. The number of employees, their family members, or dependents enrolled increased from 242 in 2007 to 316 by 2009. Now, the majority of W8 employees living with HIV are registered for treatment with 80 per cent compliance. The results of recent KAPB surveys show that 76.4 per cent of employees are aware of the ART programme, 60.6 per cent know how to access ART, and 87 per cent will enrol in the company ART programme if necessary. One of the key elements of W8's strategy is emphasising and ensuring confidentiality and non-discrimination as a matter of policy. All employees have access to treatment without needing to worry that their HIV status will be disclosed.

W39 in Senegal has a monitoring plan that is implemented by the HIV and AIDS programme coordinator. Monitoring takes place on all three sites where consultations are done by health staff. Monitoring adheres to ART regulations and includes other health check-ups. The agreement with the National AIDS Committee to undertake sensitization, screening and monitoring allows W39 to fund periodic activities in the context of the HIV and AIDS programme. The employees, community members and sex workers (who are sometimes present near the company worksites) are ensured of confidentiality as their HIV status and treatment uptake is not written in their health books. At W39, treatment is administered in consultation rooms that are like any other to avoid creating suspicions. During workplace campaigns, workers were educated about their rights and the obligation of the workplace to be discreet and confidential. The number of employees on ART has increased from two in 2010 to thirteen in 2013.

"It's me who is responsible for monitoring the five PMTCT (prevention of mother-to-child transmission) sites. We begin the treatment as soon as possible. We also ensure that monitoring includes checkup, CD4 count, assessment of viral load, etc. In the North we have three sites. We sometimes get together and discuss our respective cases, sharing documents, etc. We actually work together on the issue."

Male, Senior Manager,
Coordinator of the HIV and AIDS Programme, W39

Monitoring and evaluation ensured treatment's success, adherence and compliance. Through monitoring, the workplace was able to take corrective measures to ensure that treatment is optimized for employees living with HIV.

EXTERNAL FACTORS CONDUCTIVE TO INCREASING ART UPTAKE

The achievement of increased ART uptake was also made possible by national policies and strategies and other factors external to the workplace. In Namibia, much is being done to facilitate access to treatment. A TB/HIV technical working group is coordinating training for health care workers on co-management of HIV and TB in the private and public sectors. In addition, both ART and TB national guidelines have been revised to conform to the latest WHO recommendations. The training of medical staff has enhanced the treatment preparedness of Namibia. There continues to be a rapid scale up of ART services. The numbers of people on ART increased by 16,453 between April 2010 and March 2011, compared to 11,044 between April 2009 and March 2010. By March 2011, 92,134 people were receiving ART in the public sector while 56,835 were on pre-ART.

The success of the ART programme in Namibia is due to a number of factors, including the HIV and AIDS workplace programme, which was coordinated by the office of the Prime Minister. The workplace programme has been supported by 26 government Offices, Ministries and Agencies (OMAs), with 20 OMAs having their own workplace programmes and the other six having work plans. The mobilization of financial resources from the Global Fund to fight AIDS, tuberculosis and malaria has also contributed to the success of the Namibia HIV treatment environment.

Senegal demonstrated leadership on treatment, as the first sub-Saharan African country to establish an antiretroviral treatment programme in 1998 (Initiative Sénégalaise d'Accès aux ARV). ART is now free in Senegal. Senegal has established a National Health Policy which has been implemented through five-year plans. The share of the state budget allocated to the health sector has been steadily increasing in recent years. The priority

given to health has resulted in an increase in the budget of the Ministry of Health from CFA29 billion (USD 60 million) to CFA108.4 billion (USD 222 million) between the years 2000 and 2012.

RECOMMENDATIONS

Access to treatment

- For HIV treatment to be taken up by employees, it must be accessible, affordable and offered in a setting where privacy and confidentiality are guaranteed.
- Improved access to ART is therapeutic for employees, it enables HIV positive employees to continue working as long as possible and fulfil their expected job responsibilities, and contributes to prolonging their lives. For some companies it makes business sense to provide HIV treatment for their employees.
- Employees living with HIV should stay on treatment and be able to find jobs because of the reinforcing role between HIV treatment adherence and the employment status of an individual.

Management commitment

- In large organizations, management should show support for ART by providing it to employees through onsite clinics or linkages with public sector facilities.
- Management must set the example in encouraging its leadership to undertake VCT. CEO testing days have been used successfully to mobilize women and men workers to take the HIV test.
- Workplaces should provide financial support to cover the treatment of opportunistic infections to reduce the financial burden on employees living with HIV.
- Workplaces should take advantage of the government's role and establish linkages with their on-going national HIV programmes to ensure the continuum of care is not broken.

Peer education

- Peer education has an important role to play in promoting the benefits of HIV testing and generating demand for ART uptake. The peer educators should emphasize the link between ART and productivity.
- Where HIV treatment facilities are not onsite, peer educators must provide information to employees on all the available health facilities where HIV treatment can be accessed.

Extension of Treatment

- Large workplaces are encouraged to extend HIV treatment to spouses/life partners, families and community members as part of Corporate Social Responsibility (CSR) initiatives.
- Large enterprises that provide HIV treatment to their employees should coordinate with government services to ensure that employees who retire or are made redundant are able to continue their ART programmes to ensure continuity of treatment.
- Workplace programmes providing treatment must be flexible and give employees different options with regards to receiving their medications. In the cases studied, employees could access their medications free of charge either from the enterprise or from community pharmacy shops.

Integrated HIV Treatment

- Integrated HIV treatment programmes that combine HIV treatment with the treatment of many other ailments are less stigmatizing and discriminating. Providing comprehensive health services (e.g. one-stop clinic) whereby ART is given with treatment for other ailments facilitates improved ART uptake.

Monitoring and Evaluation

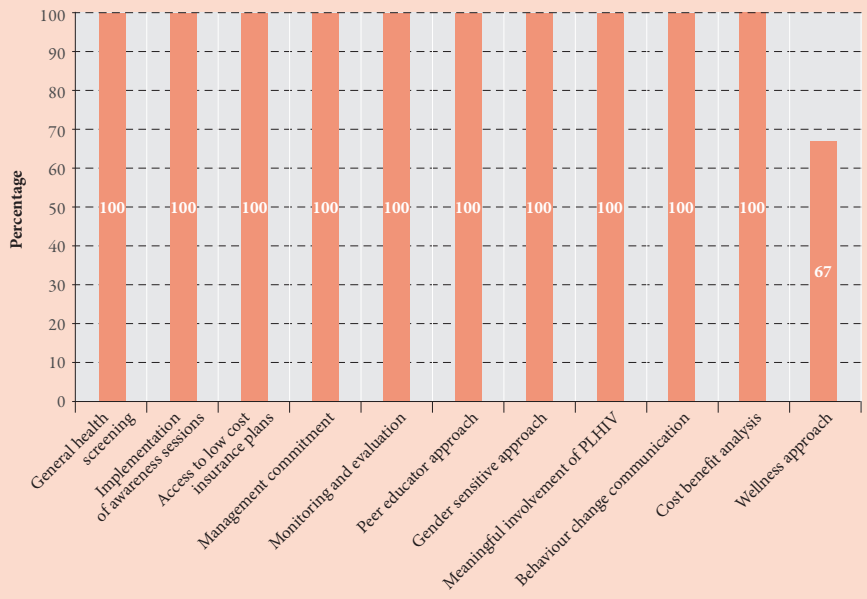
- M&E helps promote adherence, compliance and success of treatment and should be applied to both HIV workplace and treatment programmes.

CHAPTER 9: REDUCED ABSENTEEISM AND ITS COSTS[9]

Absenteeism due to illness or bereavement related to HIV and AIDS imposes heavy costs on workplaces. Yet little concrete information is available on the overall amount of HIV and AIDS related absenteeism, or its global costs. At the country, enterprise or sectoral level, how can the costs of HIV/AIDS related absenteeism, both in terms of lost productivity, as well as the workplace response, be estimated? What are some of the difficulties that face workplaces in reducing absenteeism? Conducting cost-benefit analyses can go a long way to helping management understand the costs associated with absenteeism and the benefits of establishing wellness and other workplace programmes to address HIV and other illnesses. This chapter examines strategies undertaken by workplaces to achieve reduced absenteeism and costs.

Of the 66 workplaces investigated, only 9 per cent provided evidence of having achieved the good outcome of reduced absenteeism (Annex 2, Table 8). The study identified different actions they took, including cost benefit analyses, management commitment to initiating a low cost insurance, general health screening as corporate practice and monitoring and evaluation to track absenteeism.

Figure 14 **Actions used by workplaces to reduce absenteeism (per cent)**



COST-BENEFIT ANALYSIS

Analysing costs helped in assessing the financial viability of workplace programmes. Six workplaces in three countries (Namibia, Kenya and Zambia) undertook cost-benefit analyses that provided the economic basis and justification for having HIV workplace programmes and specific interventions. This was critical in convincing management to fund HIV-related programmes despite conflicting priorities – the benefits of having a programme or the risks of losing trained staff.

Costs of specific HIV interventions were systematically collected, categorized and analysed in comparison to the costs of not having any interventions. Workplaces also assessed the benefits of investing in inexpensive insurance that could be made affordable for low-income employees.

W33 and W51 in Zambia conducted a cost-benefit analysis that helped them assess the return on investment of introducing a low-cost health insurance package for employees in terms of reduced losses due to absenteeism. It also showed the greater net benefit of having an HIV prevention programme in terms of the costs of not having one.

The cost-benefit analysis was conducted by experts during working hours using different cost typologies: human resources (counts of employees, sick leave, retirements, funerals, etc.), financial (average salaries, medical pay-outs, insurance pay-outs), management (estimates of recruitment, productivity, supervision times for new employees), HIV programme costs (salaries, management time, training costs) and medical costs (cost estimates of treatment, patient numbers, employee counts for treatment). Various methods were used to collect data, ranging from records of data available to interviewing knowledgeable employees who could describe processes relating to some of the activities mentioned above. As a result, W51 financed a medical aid scheme and established a committee to manage it. This scheme assisted with payment of medical bills for employees, thereby enabling access to health services for employees who otherwise would not have had such access.

Both W33 and W51 put policies and strategies in place to reduce absenteeism and staff turnover. The policy affirmed both companies' commitment to their

employees and the community, and offers a road map for the implementation of the HIV programme.

MANAGEMENT COMMITMENT TO INITIATING A LOW COST INSURANCE

The support and commitment from management was crucial in initiating and mobilizing interventions such as a low-cost insurance plan to reduce absenteeism. Management can be key to setting up the structures and developing the right strategic partnerships to sustain insurance schemes. In cases analysed:

- Management established a committee to manage the health insurance plan and ensure that all affected employees received help on time,
- Board members were closely involved in the initiative and monitored staff access to health insurance that reduced absenteeism significantly,
- Management also formed strategic alliances with partners to ensure effective programme management and created a supportive environment integrating HIV and AIDS into broader human resources policies.

Management commitment was behind the introduction of low-cost insurance plans in three workplaces in Namibia, W52 in Kenya and W33 and W51 in Zambia. The management of these companies sought low-cost medical insurance or subsidized the medical aid schemes because they were sustaining high costs due to absenteeism. These costs were linked to the long waiting time that employees faced before health facilities (often public) provided them with care (2-3 days away from work). Through the managers' initiative, low-cost insurance was offered to low-income employees, irrespective of the medical aid fund to which they subscribed. The medical scheme helped employees to access medical services on time before the situation got worse, hence reducing absenteeism.

Management worked together with the human resource departments, the supervisors and employees on this initiative. W51 management established a committee to manage the schemes and ensure that all affected employees

received help on time. The scheme is owned by employees. In the three Namibian workplaces, the management took the responsibility to follow up with staff on the services provided by the health insurance.

The scheme applied in three Namibian companies was managed by two NGOs and other private sector stakeholders. The NGOs and individual insurers worked with business groups to encourage companies to enrol uninsured employees in low-cost plans. The system used in the Namibian workplaces was based on a public-private partnership approach, whereby one NGO provided biomedical interventions and the othe NGO provided behavioural and psychosocial support to the workplaces.

GENERAL HEALTH SCREENING AS CORPORATE PRACTICE

Establishment of general health screening works because it provides workplaces with HIV and other disease prevalence estimates that can be used to project the rates and costs of absenteeism and serve as the basis for introducing health insurance. General health screening should be part of the broader wellness approach whereby HIV and AIDS are integrated into other health issues in order to reduce stigma. It involves screening for other diseases, i.e. testing for blood pressure, cholesterol, haemoglobin, glucose, body mass index and waist circumference. Awareness sessions are also inclusive of other health conditions versus focusing only on HIV and AIDS.

HIV testing was part of other testing practices for blood pressure, cholesterol, and haemoglobin. Employees who were interested in the programme were required to register using a bar code system. Registered workers received regular health reminders from a disease manager to adhere to the treatment, once a specific condition was identified. Employees could opt out if they did not want health screening.

All six workplaces that provided evidence for reduced absenteeism conducted general screening. General health screening provided companies with HIV prevalence estimates of their workforces to create awareness among management of the need for a low-cost health insurance package.

In three workplaces showing a reduction in absenteeism, general health screening was conducted during working hours and the workplaces had mobile vans with male and female staff who provided testing as well as pre- and post-test counselling. The screening team made referrals for employees who tested positive for any condition. The bar code system was used to maintain the anonymity of employees.

MONITORING AND EVALUATION TO TRACK ABSENTEEISM

M&E systems can be utilized to collect data on work-related injury and illness and lost productivity. Through these systems, workplaces can:

- Consistently track both rates of absenteeism and costs associated with the HIV or health programmes,
- Keep records of costs averted and performance to monitor productivity,
- Assess the good outcomes related to reduced absenteeism and costs over time.

W33 in Zambia has historically kept records of work-related injury and illness and lost productivity. A new human resources strategy to streamline and consolidate this information in a new data system was used, with accurate data available. W33 consistently tracked both rates of absenteeism and costs associated with the HIV or the health programme.

EXTERNAL FACTORS CONDUCIVE TO REDUCING ABSENTEEISM

The national policy framework in the countries has been essential in helping the private sector establish coping mechanisms for their workers, assist them in caring for workers and their families and, consequently, reducing absenteeism at the enterprise level.

Scaling up ART services in Kenya resulted in considerable non-clinical benefits, including patients' improved perception of health, emotional well-being, and labour productivity" (NACC & NASCOP, 2012:78),

strengthening national productivity, improving the quality of life for PLHIV (NACC & NASCOP, 2012:84), and is saving lives. A subsequent part of the "Sectoral Mainstreaming of HIV" in the Kenya National HIV and AIDS Strategic Plan seeks to address the impact of AIDS on productivity and labour costs, companies, employees and their families" (National AIDS Control Council, 2005:72).

"Whilst most sectoral HIV and AIDS mainstreaming initiatives in Namibia are relatively new, a number are exemplary and clearly demonstrate where these sectors can contribute to the national response in accordance with their mandate and comparative advantage, for example, providing counselling and testing (C&T) and ART to workers to avoid loss in productivity" (Republic of Namibia, 2008:7). W8 has been listed as an exemplary workplace. "In Namibia, an extensive HIV and AIDS capacity development programme – that includes a mainstreaming module – has been undertaken since 2005. In order to further roll-out mainstreaming, both middle and senior level managers highlighted the need for an additional resource to support the implementation of mainstreaming" (Republic of Namibia, 2008:1). "Furthermore, the fight against HIV/AIDS is a government priority and is central to Namibia's achievement of national goals of poverty reduction, macroeconomic growth, sustainable development and realisation of Vision 2030" (Republic of Namibia, 2008:7).

RECOMMENDATIONS

Cost-benefit analysis

- Employers should conduct cost benefit analyses to capture both direct and indirect costs of HIV and AIDS to their business and the benefits to be gained by implementing effective workplace programmes that will lead to reduced absenteeism and costs.

General health screening and wellness approach

- Workplaces should adopt general health screening as part of a wellness approach that focuses on overall health and well-being of employees

while at the same time reducing stigma attached to one disease. This approach will reduce incidence of illnesses that cause absenteeism.

Management commitment to reduce absenteeism

- Management should show commitment and leadership in building public private partnerships with outside stakeholders to secure low cost insurance schemes that can improve employee access to health services, promote healthy behaviours and improve employee commitment and morale.

Monitoring and evaluation

- On-going M&E, involving reporting throughout the chain of command with accountability to senior management, should be undertaken to provide pertinent information to determine whether the HIV and AIDS programme is attaining the goal of reduced absenteeism.

SUMMARY AND KEY RECOMMENDATIONS ON WHAT WORKS

Management commitment

- Management commitment and investment in resources, from the inception of knowledge building activities to implementation and evaluation, is central to sustaining efforts to increase knowledge about HIV and AIDS, reduce stigma and discrimination, facilitate access to HIV services and increase uptake of VCT and treatment.
- Management should work towards the institutionalization of HIV workplace programmes to enhance sustainability and take HIV out of isolation.
- Managers should take the views of employees, counsellors, peer educators and PLHIV into account at the planning stage and during programme implementation to strengthen trust and adjust the programme to the needs and concerns of employees.
- In large enterprises and workplaces, management should show support for ART by providing it to employees through onsite clinics or linkages with public sector facilities.
- Management should consider the gender dimension of HIV and AIDS, both in terms of initiating and facilitating gender-specific approaches and programmes, as well as monitoring and evaluating whether such programmes are achieving their goals.
- Management should show commitment and leadership in building public-private partnerships with outside stakeholders to secure low cost insurance schemes that can improve employee access to health services, promote healthy behaviours and improve employee commitment and morale.

Assessing changes through effective monitoring and evaluation (M&E) systems

- Assessment of HIV and AIDS knowledge levels, as well as patterns of stigma and discrimination should inform the design of knowledge building activities so they are applicable and acceptable to both male and female employees.

- Workplaces should design risk reduction programmes and strategies on the basis of an assessment of their employees' risky behaviours and vulnerability factors, to help employees begin to understand their own risk.
- Workplaces should conduct M&E on an on-going basis, and not as ad-hoc measures, to ensure that their activities remain relevant.
- Partnerships with the national AIDS coordinating bodies should be sought at the level of the ministries of labour and business and union associations to develop an M&E system across sectors (formal or informal) to consolidate HIV and AIDS world of work data at the country level, linked with the national M&E system.
- The M&E framework should include an evaluation plan for measuring behaviour change.
- The M&E system should be built with indicators that are sex-disaggregated to better track and be able to respond to any gaps identified.

Awareness raising and education for behaviour change

- Workplace HIV and AIDS education programmes that can reinforce workers' knowledge about HIV transmission and its prevention should be developed as a first step toward achievement of other good outcomes (VCT uptake, behaviour change, reduced absenteeism, ART uptake and reduction of stigma).
- As there is no "one-size-fits-all" approach in strengthening and expanding HIV and AIDS knowledge, workplaces should adopt flexible context-specific, gender-tailored approaches that accommodate their needs and programme objectives while also learning from each other.
- Peer education should be integrated into the corporate structure of companies to ensure high and sustainable impact of HIV and AIDS awareness-building activities can be easily replicated, especially in resource-constrained environments.
- Education programmes must aim to reach vulnerable workers in the hotspots where they seek entertainment or sex. Identifying all hotspots is thus integral to effective targeting.
- HIV prevention education and condom promotion must overcome the challenges posed by gender and cultural factors. Gender-responsive

strategies to condom promotion should include skills to negotiate the use of condoms, male sensitization to the use of condoms and promotion of female condoms that can provide women with more control in protecting themselves, as well as strategies to promote equal decision-making power in interpersonal relationships.

- It is important to understand that the risk reduction strategies and behaviour change approaches are the results of an iterative process, by which we move from increased demand for information about HIV and AIDS to increased knowledge about HIV and AIDS, increased self-risk assessment and, ultimately, to increased demand for services.

Mainstreaming HIV into broader wellness programmes

- Innovative, integrated approaches such as the wellness approach, that combine HIV and other health programmes, increase their overall appeal, reduce boredom and stigma, and enhance sustainability. Workplaces can do this in partnership with NGOs and others.
- Integration of HIV and AIDS knowledge-building activities into wellness, occupational health or employee assistance programmes also helps increase knowledge about HIV and AIDS. Expanding awareness sessions beyond HIV and AIDS should become part of the corporate approach in addressing HIV and AIDS. This will increase sustainability, reduce stigma and improve uptake of information sessions.
- Integrated HIV treatment programmes that combine HIV treatment with the treatment of many other ailments are less stigmatizing and discriminating. Providing comprehensive health services (e.g. one-stop clinic) whereby ART is given with treatment for other ailments facilitates improved ART uptake.
- Workplacess should adopt a wellness approach that focuses on overall health and well-being of employees while at the same time reducing the stigma attached to one disease.

Meaningful involvement of people living with HIV (PLHIV)

- Concerted efforts to move beyond stigma and put PLHIV at the centre of HIV and AIDS knowledge-building activities are needed, since doing so adds credibility to HIV awareness activities and improves their impact.

- The engagement of PLHIV in knowledge-building activities is also crucial in ensuring improved visibility around the real conditions of PLHIV and normalizing issues around HIV.
- Workplace programmes must be developed around the needs of employees living with HIV. PLHIV must be meaningfully engaged at each stage of the implementation process. If PLHIV are unavailable from any particular workplace, PLHIV from other organizations or workplaces should be invited to support the programme design and implementation.
- Some workplace programmes provide support to employees living with HIV even outside the workplace, through home-based care programmes. The formation of support groups for male and female employees living with HIV is useful as it helps address psychological and psychosocial issues faced by PLHIV.

Integrating gender in HIV programming

- Awareness sessions should be organized that take into consideration gender perspectives and relations within the workplace in order to enhance relevance and ownership of the programmes and ultimately contribute to greater receptiveness of HIV initiatives.
- On-going M&E on integrating gender-specific aspects in the HIV response, involving reporting throughout the chain of command with accountability to senior management, should be undertaken to provide pertinent information to determine whether the HIV and AIDS programme is attaining its goals.
- A gender analysis should systematically form part of programme design and development.
- Gender-specific approaches should go beyond providing services for women and men, and should become gender-responsive by addressing gender relations at the workplace, negotiation skills for safer sex and women's economic empowerment.
- Equal participation of women and men in design and implementation of programme activities is essential to ensure that the programme addresses gender-specific issues and needs, social norms and stereotypes. This

will boost acceptability and help generate a sense of ownership of the programme by all.

- Women and men should be empowered by promoting male and female condom use and safer sex negotiation, both of which can contribute to more effective reduction in risky behaviour.

Strengthening access to HIV services

- Once-off VCT awareness activities do not produce sustained increased VCT uptake. Workplaces need to promote on-going VCT activities in partnership with stakeholders in order to sustain increase in VCT uptake.
- Effective partnerships between public and private sectors are important to ensure sustainability of workplace programmes.
- Uptake of VCT services can be sustained only if linkages to health and support services are ensured in order to guarantee follow-up for workers and dependants testing positive.
- Proactively offering of VCT to employees with an emphasis on the choice to opt in or out contributes to improved uptake of VCT. The involvement of PLHIV in VCT is central to increased VCT uptake by normalizing HIV and increase acceptability among workers.
- For HIV treatment to be taken up by employees, it must be accessible, affordable and offered in a setting where privacy and confidentiality are guaranteed.
- Improved access to ART is therapeutic for the employees, enables HIV positive employees to continue working as long as possible and fulfils their expected job responsibilities, as well as contributes to prolonging their lives. For some companies it makes business sense to provide HIV treatment for employees.
- Wherever possible, workplaces are encouraged to extend HIV treatment to spouses/life partners, families and community members.
- Workplace programmes providing treatment must be flexible and give employees different options with regards to receiving their medications. In the cases studied, employees could access their medications free of charge either from the enterprise or from community pharmacy shops.

Understanding the benefits of workplace HIV and AIDS programmes on reduced absenteeism and costs

- Employers should conduct cost-benefit analyses to capture both direct and indirect costs of HIV and AIDS to their business, and the benefits to be gained by implementing effective HIV and AIDS workplace programmes that will lead to reduced absenteeism and costs.
- By assessing costs and benefits, these analyses ensure that corporate interests are taken into account. They help the company to understand and gauge the extent of the threat that HIV and AIDS poses to the employees and to the business, and to inform action that will lead to reduced absenteeism and costs.

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ANNEX 1: DESCRIPTION OF WORKPLACES

Table 1 Number of workplaces by country

Country	Total
Côte d'Ivoire	5
Ghana	5
Kenya	7
Madagascar	5
Morocco	5
Mozambique	8
Namibia	7
Senegal	6
South Africa	8
Zambia	10
Total	66

Table 2 National stakeholder in-depth interviews (IDIs) across the 10 countries, by sex

Country	IDIs		Total
	Males	Females	
Zambia	1 Ministry of Labour 1 UNODC	2 ZHECT 1 ILO 1 SHARE II 1 UNAIDS 1 Coalition of African Parliamentarians Against HIV and AIDS 1 NAC	
Sub-total	**2**	**7**	**9**
Kenya	1 KHBC	1 LVCT 2 NOPE 1 AON 1 Global Business Coalition Health 1 SWHAP	
Sub-total	**1**	**6**	7

Table 2 continued

Country	IDIs		Total
	Males	Females	
Côte d'Ivoire	1 Ministry of Labour 1 Coalition of Côte d'Ivoire against AIDS, Malaria and TB	1 RIP +, Network of PLHIV 1 Ministry of Health and Fight against AIDS 1 FHI 360	
Sub-total	**2**	**3**	**5**
Namibia	1 ILO 1 SMEs Compete, Consultancy 1 NUNW 1 SHOPS 1 Office of the Prime Minister 1 NNPLWA 1 W59	1 SMEs Compete, Consultancy 1 TUCNA 1 Pharm Access	
Sub-total	**7**	**3**	**10**
Madagascar	1 Network of PLHIV 1 Ministry of Labour 1 National Labour Council 1 Fianakaviana Sambatra (NGO) working with companies in VCT program 1 National AIDS Committee 1 AFEP 1 UNAIDS	1 Business Coalition 1 Ministry of Health	
Sub-total	**7**	**2**	**9**
Senegal	1 ILO 1 ENDA 1 Labour Ministry 1 NGO of PLHIV 1 UNACOIS 1 CNTS	1 AMES 1 CNLS 1 CNP	
Sub-total	**6**	**3**	**9**
Ghana	1 GIZ 1 Ghana AIDS Commission	1 ILO 1 GBCEW 1 UNAIDS	
Sub-total	**2**	**3**	**5**
South Africa	1 ILO 1 DPSA 1 SABCOHA 1 GIZ/AIDC EC 1 GIZ 1 UNDP 1 W17 1 PCS; PLHIV	1 GIZ/AIDC EC 1 Congress of South African Trade Unions (COSATU) 1 SWHAP	
Sub-total	**8**	**3**	**11**
Mozambique	1 ECOSIDA 1 CNCS 1 ILO 1 PSI	1 GIZ	

Table 2 continued

Country	IDIs		Total
	Males	Females	
Sub-total	4	1	5
Morocco	1 Democratic Confederation of Labor (Trade union) 1 National college of physicians	1 National Council for Human Rights 1 Labour inspection, delegation of Casablanca (Ministry of Labour) 1 Association de lutte contre le sida, and PLHIV network	
Sub-total	2	3	5
Total	41 (55%)	34 (45%)	75 (100%)

Table 3 IDIs and FGDs conducted in workplaces across the 10 countries

Country	IDIs		FGDs		Total
	Males	Females	Males	Females	
Zambia	1 W33 2 W51 1 W34 1 W49 1 W27 1 W56 1 W26 1 W25	1 W33 1 W56 1 W26 1 W25	8 W33 5 W51 4 W40 & W41 3 W49 6 W27	1 W33 3 W51 7 W40 & W41 3 W49	
Sub-total	**9**	**4**	**26**	**14**	**53**
Kenya	3 W24 3 W21 2 W58 3 W19 4 W18	3 W24 2 W35 4 W58 1 W19 1 W18 1 W52	7 W24 6 W35 3 W58 3 W19 6 W18	8 W24 4 W58 4 W19 6 W18	
Sub-total	**15**	**12**	**25**	**22**	**74**
Côte d'Ivoire	2 W42 2 W46 3 W54 1 W32 3 W55	1 W42 1 W46 2 W32	4 W42 2 W46 4 W54 6 W32 3 W55	3 W42 2 W46 4 W54 3 W32 2 W55	
Sub-total	**11**	**4**	**19**	**14**	**48**
Namibia	1 W59 1 W60 1 W61 2 W62 1 W63 1 W22 2 W8	1 W59 1 W60 1 W61 1 W62 1 W63 1 W22 1 W8	3 W62 3 W63 3 W22 3 W8	4 W62 2 W63 3 W22 1 W8	
Sub-total	**9**	**7**	**12**	**10**	**38**

Table 3 continued

Country	IDIs		FGDs		Total
	Males	Females	Males	Females	
Madagascar	1 W29 1 W28	1 W23 3 W4 2 W29 1 W28 3 W30	5 W23 5 W4 3 W29 8 W28 1 W30	2 W23 1 W4 4 W29 2 W28 6 W30	
Sub-total	**2**	**10**	**22**	**15**	**49**
Ghana	1 W5. 2 W7 1 W6 2 W15	1 W5 1 W6	11 W5 9 W7 8 W57 3 W6 6 W15	2 W5 3 W7 4 W57 3 W6	
Sub-total	**6**	**2**	**37**	**12**	**57**
Morocco	1 W11 1 W12 1 W13 1 W14	1 W10	7 W10 6 W11 6 W12 9 W13 8 W14		
Sub-total	**4**	**1**	**36**	-	**41**
Senegal	3 W39 1 W48 2 W64 1 W65 1W31 1 W43	2 W39 1 W48 1 W64 1 W65 1 W31 2 W43	8 W39 12 W48 11 W64 9 W65 3 W43	7 W39 9 W48 11 W64 2 W65 6 W43	
Sub-total	**9**	**8**	**43**	**35**	**95**
Mozambique	1 W37 1 W45 1 W44 1 W50 1 W47 1 W36	1 W47	5 W47 4 W36	2 W47 4 W36	
Sub-total	**6**	**1**	**9**	**6**	**22**
South Africa	3 W9 2 W16 3 W38 2 W20 3 W1 3 W3 3 W2 2 W17	3 W9 3 W16 2 W38 4 W20 1 W1 1 W3 1 W2 2 W17	2 W9 3 W16 3 W20	5 W9 4 W16 4 W20	
Sub-total	**21**	**17**	**8**	**13**	**59**
Total	**92 (58%)**	**66 (42%)**	**237 (63%)**	**141 (37%)**	**536**

Table 4 Size of workplaces

Country	Small (<50 employees)	Medium (50 to 499 employees)	Large (500 or more employees)	Total
Zambia	W51		W33 W40 W41 W26 W34 W49 W27 W56 W25	
Sub-total	**1**		**9**	**10**
Kenya	W35		W24 W21 W58 W19 W18 W52	
Sub-total	**1**	**0**	**6**	**7**
Côte d'Ivoire		W55	W54 W42 W46 W32	
Sub-total	**0**	**1**	**4**	**5**
Namibia		W60 W62 W63	W59 W61 W22 W8	
Sub-total	**0**	**3**	**4**	**7**
Madagascar		W23	W4 W29 W28 W30	
Sub-total	**0**	**1**	**4**	**5**
Ghana		W6	W5 W57 W7 W15	
Sub-total	**0**	**1**	**4**	**5**
Mozambique		W44	W53 W37 W47 W66 W36 W50 W45	
Sub-total	**0**	**1**	**7**	**8**

Table 4 continued

Country	Small (<50 employees)	Medium (50 to 499 employees)	Large (500 or more employees)	Total
Morocco		W11 W13 W14	W10 W12	
Sub-total	**0**	**3**	**2**	**5**
Senegal	W65		W39 W48 W64 W31 W43	
Sub-total	**1**	**0**	**5**	**6**
South Africa	W3	W9 W1	W2 W16 W20 W17 W38	
Sub-total	**1**	**2**	**5**	**8**
Total	**4 (6%)**	**12 (18%)**	**50 (76%)**	**66 (100%)**

Table 5 Types of workplaces across the 10 countries

Country	Public sector	Private sector	Informal economy	Total
Zambia	W40 W41 W56	W33 W51 W34 W26 W49 W27 W25		
Sub-total	**3**	**7**	-	**10**
Kenya	W58 W19	W24 W35 W21 W18 W52		
Sub-total	**2**	**5**	-	**7**
Côte d'Ivoire		W54 W55 W42 W46 W32		
Sub-total	-	**5**	-	**5**

Table 5 continued

Country	Public sector	Private sector	Informal economy	Total
Namibia		W59 W60 W61 W62 W63 W22 W8		
Sub-total	-	7	-	7
Madagascar		W23 W4 W29 W28 W30		
Sub-total	-	5	-	5
Ghana	W57	W5 W7 W6	W15	
Sub-total	1	3	1	5
Morocco			W10 W11 W12 W13 W14	
Sub-total	-	-	5	5
Senegal	W43 W64	W39 W48 W31 W65		
Sub-total	2	4		6
Mozambique	W66 W53 W36	W45 W44 W50 W37	W47	
Sub-total	3	4	1	8
South Africa	W20	W3 W2 W1 W9 W38 W16	W17	
Sub-total	1	6	1	8
Total	**9 (14%)**	**49 (74%)**	**8 (12%)**	**66 (100%)**

Table 6 Types of economic sectors that workplaces belonged to

Economic sector	Sub-sector categories	Workplaces	Number of workplaces
Agriculture, food and forestry (n=6)	Agriculture	W55, W45, W39, W54	4
	Breweries	W27, W24	2
Education and research (n=2)	Research & development	W64, W66	2
Energy and mining (n=5)	Mining	W33, W5, W7, W8, W4	5
Infrastructure, construction and related sectors (n=4)	Building and construction	W28, W37, W48, W31	4
Manufacturing (n=13)	Automobile	W35, W23, W9, W38, W2, W3, W1	7
	Furniture	W51	1
	Building materials	W34	1
	Canning	W21	1
	Knitwear	W29	1
	Steel	W18	1
	Unidentified	W59	1
Maritime and transport (n=13)	Transport	W15, W19, W62, W63, W22, W53, W44, W36 W10, W11, W12, W13, W14	13
Private services (n=14)	Trade unions	W16	1
	Hawker associations	W32, W47	2
	Financial services	W49, W26, W25, W6, W50	5
	Advocacy groups	W65, W17	2
	Wholesale and retail	W46, W60, W61	3
	Tourism	W52	1
Public service, utilities and health (n=9)	Government departments	W20, W57, W43	3
	Health	W40, W41, W30	3
	Water utility	W56, W42	2
	UN agencies	W58	1
	Total		**66**

Table 7 Epidemic type, by country

Country	Generalized epidemic	Concentrated epidemic
Côte d'Ivoire	x	
Ghana	x	
Kenya	x	
Madagascar		x
Morocco		x
Mozambique	X	
Namibia	X	
Senegal		x
South Africa	X	
Zambia	X	
Total	**7**	**3**

ANNEX 2: GOOD OUTCOMES

Table 8 Frequency of good outcomes achieved across 10 countries

Country	Increased knowledge	Increased VCT	Reduced risky behaviour	Increased impact on individuals, family and community	Reduced absenteeism and improved productivity	Reduced stigma and discrimination	Increased ART uptake
South Africa	W9 W38 W20 W16 W2 W1 W3 W17	W9 W38 W20 W16 W2 W1 W3 W17	W9 W38 W20 W16 W2 W1 W3 W17			W9 W38 W16 W2 W1 W3	
Sub-total	**8**	**8**	**8**	**0**	**0**	**6**	**0**
Zambia	W40 W41 W27 W33 W26 W25	W33 W34 W27 W40 W41	W40 W49		W51 W33	W40 W41 W56	
Sub-total	**6**	**5**	**3**	**0**	**2**	**3**	**0**
Ghana	W5 W6 W15	W5 W7 W57 W6 W15	W5 W7 W15	W5 W7			
Sub-total	**3**	**5**	**3**	**2**	**0**	**0**	**0**
Kenya	W18 W21 W24 W58 W19	W24 W21 W35 W58 W18	W24 W21 W58 W19 W18		W52		
Sub-total	**5**	**5**	**5**	**0**	**1**	**0**	**0**
Côte d'Ivoire	W42 W32 W46 W55	W42 W54 W32 W46 W55	W42 W54 W32 W46 W55				
Sub-total	**4**	**5**	**5**	**0**	**0**	**0**	**0**
Namibia	W63 W62 W22	W8 W63 W62 W22	W63 W62 W22		W59 W60 W61		W8
Sub-total	**3**	**4**	**3**	**0**	**3**	**0**	**1**

Table 8 continued

Country	Increased knowledge	Increased VCT	Reduced risky behaviour	Increased impact on individuals, family and community	Reduced absenteeism and improved productivity	Reduced stigma and discrimination	Increased ART uptake
Madagascar	W28 W4 W29 W23 W30	W28 W4 W29 W23 W30	W23 W28 W29 W30				
Sub-total	**5**	**5**	**4**	**0**	**0**	**0**	**0**
Mozambique	W47 W53 W37 W44 W66 W36	W47 W53 W37 W44 W50 W45	W47 W37 W50				
Sub-total	**6**	**6**	**3**	**0**	**0**	**0**	
Morocco	W10 W11 W12 W13 W14	W10 W11 W12 W13 W14	W10 W11 W12 W13 W14				
Sub-total	**5**	**5**	**5**	**0**	**0**	**0**	**0**
Senegal	W39 W48 W64 W65 W31	W39 W48 W31 W43	W39 W48 W64 W43	W64			W39
Sub-total	**5**	**4**	**4**	**1**	**0**	**0**	**1**
Total	**50 (76%)**	**52 (79%)**	**43 (65%)**	**3 (5%)**	**6 (9%)**	**9 (14%)**	**2 (3%)**

Table 9 Good outcomes, by workplace size

Good outcomes	Small (<50 employees) n=4	Medium (50 to 499 employees) n=12	Large (500 or more) n=50	Total n=66	%
Increased knowledge	4	12	34	50	76
Increased VCT uptake	4	10	38	52	79
Reduced risky behaviour	2	7	35	43	65
Reduced stigma and discrimination	1	2	6	9	14
Reduced absenteeism	1	1	4	6	9
Increased ART	0	0	2	2	3
Increased impact on individuals, families and communities	0	0	3	3	5

Table 10 Good outcomes, by workplace type

Good outcomes	Private sector (n=49)	Public sector (n=9)	Informal economy (n=8)	Total (n=66)	%
Increased knowledge	37	8	5	50	76
Increased VCT uptake	40	7	5	52	79
Reduced risky behaviour	33	5	5	43	65
Reduced stigma and discrimination	7	2	0	9	14
Reduced absenteeism	6	0	0	6	9
Increased ART	2	0	0	2	3
Increased impact on individuals, families and communities	2	1	0	3	5

Table 11 Good outcomes, by epidemic type

Good outcomes	Workplaces in generalized epidemic countries (n=55)	Workplaces in concentrated epidemic countries (n=11)	Total (n=66)	%
Increased knowledge	40	10	50	76
Increased VCT uptake	43	9	52	79
Reduced risky behaviour	34	9	43	65
Reduced stigma and discrimination	9	0	9	14
Reduced absenteeism	6	0	6	9
Increased ART	1	1	2	3
Increased impact on individuals, families and communities	2	1	3	5

Table 12 Good outcomes, by economic sector

Good outcomes	Agriculture, food and forestry (n=6)	Education and research (n=2)	Energy and mining (n=5)	Infrastructure, construction and related sectors (n= 4)	Manufacturing (n= 13)	Maritime and transport (n=13)	Private services (n=14)	Public service, utilities and health (n=10)	Totals (n=66)	%
Increased knowledge	5	2	3	4	6	13	12	5	50	76
Increased VCT uptake	6	1	3	4	11	12	8	7	52	79
Reduced risky behaviour	2	1	5	3	9	10	6	7	43	65
Reduced stigma and discrimination	0	0	1	0	2	2	1	3	9	14
Reduced absenteeism	0	0	2	0	2	0	2	0	6	9
Increased ART	1	0	1	0	0	0	0	0	2	3
Increased impact on individuals, families and communities	0	1	2	0	0	0	0	0	3	5

Table 13 Good outcomes, by components

Good outcomes	Assessment	Education and training	Management commitment	Monitoring and evaluation	Peer education approach	Meaningful involvement of PLHIV	Wellness approach	Behaviour change communication	Gender
Increased knowledge (n=50)	42	50	48	48	39	14	28	20	18
Increased VCT uptake (n=52)	19	52	52	52	42	14	19	42	22
Reduced risky behaviour (n=43)	40	43	43	42	36	0	0	36	24
Reduced stigma and discrimination (n=9)	9	9	9	9	9	9	9	9	7
Reduced absenteeism (n=6)	6	6	6	6	6	6	4	6	6
Increased ART (n=2)	0	2	2	2	2	2	2	0	0
Increased impact on individuals, families and communities (n=3)	3	3	2	3	2	3	3	2	3

ANNEX 3: COMPONENTS – INCREASED KNOWLEDGE ABOUT HIV AND AIDS

Table 14 Components used to increase HIV and AIDS knowledge, by country

Components	Côte d'Ivoire (n=4)	Ghana (n=3)	Kenya (n=5)	Madagascar (n=5)	Morocco (n=5)	Mozambique (n=6)	Namibia (n=3)	Senegal (n=5)	South Africa (n=8)	Zambia (n=6)	Grand total (n=50)	%
Assessment of knowledge levels	4	3	5	5	5	6	3	0	8	3	42	84
Creating awareness on HIV and AIDS	4	3	5	5	5	6	3	5	8	6	50	100
Management commitment	2	4	5	5	5	5	3	5	8	6	48	96
Monitoring and evaluation	2	4	5	5	5	5	3	5	8	6	48	96
Peer education approach	3	2	2	3	5	6	3	5	8	2	39	78
Mainingful involvement of PLHIV	1	3	1	1	0	0	0	2	5	1	14	28
Wellness approach	3	2	4	3	0	1	3	2	8	2	28	56
Behaviour change communication	2	3	2	2	1	2	2	1	3	2	20	40
Gender-specific messaging	3	2	1	0	0	2	0	4	5	1	18	36

Table 15 Components used to increase HIV and AIDS knowledge, by economic sector

Components	Agriculture, food and forestry n=5	Education and research n=2	Energy and mining n=3	Infrastructure, construction and related sectors n= 4	Manufacturing n= 6	Maritime and transport n=13	Private services n=12	Public service, utilities and health n=5	Totals (n= 50)	%
Assessment of knowledge levels	4	2	1	4	6	11	9	5	42	84
Creating awareness on HIV and AIDS	5	2	3	4	6	13	12	5	50	100
Management commitment	5	1	3	4	6	13	11	5	48	96
Monitoring and evaluation	5	2	3	4	6	13	11	4	48	96
Peer education approach	2	1	2	3	8	12	6	5	39	78
Mainingful involvement of PLHIV	1	1	1	0	6	2	2	1	14	28
Wellness approach	2	1	2	0	6		12	5	28	56
Behaviour change communication	4	0	2	2	3	3	3	3	20	40
Gender-specific messaging	3	1	3	1	1	1	6	2	18	36

Table 16 Components used to increase HIV and AIDS knowledge in workplaces, by workplace type (all countries)

Components	Private sector (n=37)	Public sector (n=8)	Informal economy (n=5)	Total (n=50)	%
Assessment of knowledge levels	37	8	5	42	84
Creating awareness on HIV and AIDS	37	8	5	50	100
Management commitment	37	6	3	48	96
Monitoring and evaluation	31	6	4	48	96
Peer education approach	37	6	5	39	78
Meaningful involvement of PLHIV	14	0	1	14	28
Wellness approach	25	2	1	28	56
Behaviour change communication	5	2	2	20	40
Gender-specific messaging	15	1	2	18	36

Table 17 Components used to increase HIV and AIDS knowledge in workplaces, by epidemic type (all countries)

Components	Workplaces in generalized epidemic countries (n=40)	Workplaces in concentrated epidemic countries (n=10)	Total (n=50)	%
Assessment of knowledge levels	38	4	42	84
Creating awareness on HIV and AIDS	40	10	50	100
Management commitment	38	10	48	96
Monitoring and evaluation	38	10	48	96
Peer education approach	29	10	39	78
Meaningful involvement of PLHIV	11	3	14	28
Wellness approach	18	10	28	56
Behaviour change communication	19	1	20	40
Gender-specific messaging	14	4	18	36

Table 18 Components used to increase HIV and AIDS knowledge, by workplace size

Components	Small (<50 employees) n= 2	Medium (50 to 499 employees) n= 10	Large (500 or more employees) n= 38	Total (n= 50)	%
Assessment of knowledge levels	2	9	31	42	84
Creating awareness on HIV and AIDS	2	10	38	50	100
Management commitment	2	10	36	48	96
Monitoring and evaluation	2	10	36	48	96
Peer education approach	2	2	35	39	78
Meaningful involvement of PLHIV	1	5	8	14	28
Wellness approach	1	5	22	28	56
Behaviour change communication	2	3	15	20	40
Gender-specific messaging	1	3	14	18	36

Table 19 Snapshot of specific findings for increased knowledge (selected workplaces)

Component	Workplace	What activities were done ?	When were the activities done?	Where were the activities done?	Who was involved?	How were the activities conducted?
Assessment of knowledge levels	W10 W11 W12 W13 W14 (Morocco, private, maritime and transport)	A KABP survey was conducted	In 2007: Baseline survey In 2012: follow up survey	Agadir	Implementing partner	KABP survey was conducted using questionnaires
	W15 (Ghana, informal, maritime and transport)	A KABP survey was conducted	In 2004: Baseline survey In 2006: follow up survey	At all their nationwide branches	Implementing partners	A questionnaire was administered to all employees
Creating awareness on HIV and AIDS	W39 (Senegal, private, agriculture, food and forestry)	In-house training Radio broadcasting Community outreach	W39 had radio broadcast sessions three times a week, Mondays, Wednesdays and Saturdays HIV and AIDS training took place daily	Waiting rooms at the onsite clinic	Peer educators Focal point Unions Partners Management	Mass media Multi-lingual approach Community approach Behaviour change messages Gender approach Management commitment

Table 19 continued

Component	Workplace	What activities were done ?	When were the activities done?	Where were the activities done?	Who was involved?	How were the activities conducted?
	W32 (Côte d'Ivoire, private, services sectors)	HIV and AIDS messages on pay slips Online messaging (intranet and email) Messages on notice boards and billboards	Activities were conducted annually	Abidjan	Committee of coordinators Workers' committee Peer educators Focal point	Wellness approach Gender-sensitive approach
Management commitment	W26 (Zambia, private, services sectors)	Initiated the programmes "Staying Alive" and "Living with HIV"	"Staying Alive" campaign began in 1999 "Living with HIV" campaign began in 2003	Lusaka	Management Partners PLHIV – HIV Champions Peer educators	Management support
	W53 (Mozambique, public, maritime and transport)	HIV knowledge campaigns	Campaigns are organized 3 times in a year	Maputo	Peer educators Management	Management support

ANNEX 4: COMPONENTS – INCREASED VCT UPTAKE

Table 20 Components used to increase VCT uptake in workplaces, by country

Components	Côte d'Ivoire (n=5)	Ghana (n=5)	Kenya (n=5)	Madagascar (n=5)	Morocco (n=5)	Mozambique (n=6)	Namibia (n=4)	Senegal (n=4)	South Africa (n=8)	Zambia (n=5)	Grand Total (52)	%
VCT promotion, campaigns or awareness sessions	5	5	5	5	5	6	4	4	8	5	52	100
Access to VCT	5	5	5	5	5	6	4	4	8	5	52	100
Provision of VCT as continuum of treatment, care and support	1	2	5	0	0	6	0	4	6	4	28	54
Management commitment	5	5	5	5	5	6	4	4	8	5	52	100
Monitoring and evaluation	5	5	5	5	5	6	4	4	8	5	52	100
Peer educator approach	2	1	4	4	5	6	4	4	7	5	42	81
Provider-initiated counselling and testing (PICT)	2	0	0	0	0	0	1	0	0	1	4	8
Meaningful involvement of PLHIV	0	1	1	2	0	0	0	4	5	1	14	27
Family and couple counselling and testing	1	3	4	2	0	0	3	3	6	2	24	46
Integration/mainstreaming of VCT into general health screening	0	5	2	3	0	0	4	0	2	3	19	36
Behaviour change communication approach	4	5	5	3	4	4	3	4	6	4	42	81
Gender-sensitive approach	1	1	3	2	0	6	0	2	5	2	22	42

Table 21 Components used to increase VCT uptake in workplaces, by workplace type (all countries)

Components	Private sector (n=40)	Public sector (n=7)	Informal economy (n=5)	Total (n=52)	%
VCT promotion, campaigns or awareness sessions	40	7	5	52	100
Access to VCT	40	7	5	52	100
Provision of VCT as continuum of treatment, care and support	21	5	2	28	54
Management commitment	40	7	5	52	100
Monitoring and evaluation	40	7	5	52	100
Peer educator approach	30	7	5	42	81
Provider-initiated counselling and testing (PICT)	4	0	0	4	8
Meaningful involvement of PLHIV	13	1	0	14	27
Family and couple counselling and testing	24	0	0	24	46
Integration/mainstreaming of VCT into general health screening	15	2	2	19	36
Behaviour change communication approach	30	7	5	42	81
Gender-sensitive approach	17	3	2	22	42

Table 22 Components used to increase VCT uptake in workplaces, by economic sector (all countries)

Components	Agriculture, food and forestry n=6	Education and research n=1	Energy and mining n=3	Infrastructure, construction and related sectors n= 4	Manufacturing n= 11	Maritime and transport n=12	Private services n=8	Public service, utilities and health n=7	Totals (n=52)	%
VCT promotion, campaigns or awareness sessions	6	1	3	4	11	12	8	7	52	100
Access to VCT	6	1	3	4	11	12	8	7	52	100
Provision of VCT as continuum of treatment, care and support	3	1	3	3	6	8	4	6	28	24
Management commitment	6	1	3	4	11	12	8	7	52	100
Monitoring and evaluation	6	1	3	4	11	12	8	7	52	94
Peer educator approach	4	0	3	3	9	10	7	6	42	96
Provider-initiated counselling and testing (PICT)	0	0	3	0	0	0	1	0	4	8

Table 22 continued

Components	Agriculture, food and forestry n=6	Education and research n=1	Energy and mining n=3	Infrastructure, construction and related sectors n= 4	Manufacturing n= 11	Maritime and transport n=12	Private services n=8	Public service, utilities and health n=7	Totals (n=52)	%
Meaningful involvement of PLHIV	2	0	1	2	5		2	2	14	21
Family and couple counselling and testing	1	0	3	2	9	3	4	2	24	48
Integration/mainstreaming of VCT into general health screening:	1	0	0	2	4	7	2	3	19	37
Behaviour change communication approach	4	1	2	4	7	9	8	7	42	81
Gender-sensitive approach	2	0	2	2	4	3	6	3	22	42

Table 23 Components used to increase VCT uptake in workplaces, by epidemic type (all countries)

Components	Workplaces in generalized epidemic countries (n=43)	Workplaces in concentrated epidemic countries (n=9)	Total (n=52)	%
VCT promotion, campaigns or awareness sessions	43	9	52	100
Access to VCT	43	9	52	100
Provision of VCT as continuum of treatment, care and support	19	9	28	53
Management commitment	43	9	52	100
Monitoring and evaluation	43	9	52	100
Peer educator approach	33	9	42	81
Provider-initiated counselling and testing (PICT)	4	0	4	8
Meaningful involvement of PLHIV	9	4	14	27
Family and couple counselling and testing	20	4	24	46
Integration/mainstreaming of VCT into general health screening:	16	3	19	36
Behaviour change communication approach	33	9	42	81
Gender-sensitive approach	18	4	22	42

Table 24 Components used to increase VCT uptake in workplaces, by workplace size (all countries)

Components	Small (<50 employees) n= 2	Medium (50 to 499 employees) n= 10	Large (500 or more employees) n= 40	Total (n=52)	%
VCT promotion, campaigns or awareness sessions	2	10	40	52	100
Access to VCT	2	10	40	52	100
Provision of VCT as continuum of treatment, care and support	2	7	19	28	53
Management commitment	2	10	40	52	100
Monitoring and evaluation	2	10	40	52	100
Peer educator approach	2	9	31	42	81
Provider-initiated counselling and testing (PICT)	0	0	4	4	8
Meaningful involvement of PLHIV	0	1	13	14	27
Family and couple counselling and testing	0	6	18	24	46
Integration/mainstreaming of VCT into general health screening:	1	3	14	19	36
Behaviour change communication approach	2	10	30	42	81
Gender-sensitive approach	1	5	17	22	42

Table 25 Snapshot of specific findings for increased VCT (selected workplaces)

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done?	Who was involved?	How were the activities conducted?
VCT promotion, campaigns or awareness sessions	**W16 (South Africa, trade union)**	a) Training of shop stewards b) Offering free HIV voluntary counselling and testing (VCT) c) Referrals to external facilities for ART d) Access to support services e) Use of a mobile team to provide VCT	a) During working hours	a) W16 clinics b) At workplaces, through mobile units	a) Dedicated health personnel, including trained nurses, a social worker, medical practitioners and pharmacists. b) Mobile teams c) Shop stewards	a) Use of shop stewards b) Providing ART to those who are eligible c) De-stigmatizating VCT d) Providing social support (104 employees received social worker support from the union's own social worker, and more than 10,000 home visits were conducted by the community care workers) e) Gender-sensitive approach
	W33 (Zambia, private, energy & mining)	a) On-going awareness sessions b) Road shows c) Campaigns d) Voluntary counselling and testing e) On-going monitoring of VCT uptake f) Access to ART	a) During paid working hours b) During travel to and from home	a) Onsite, within every mine section and every department b) An off-site clinic in Solwezi town c) Referrals to external facilities with which the mine had partnerships d) At a mine clinic e) In the buses to and from work	a) Peer educators b) Trained medical personnel c) Workplace social workers d) Medical practitioners	a) Through its partnerships b) Wellness approach c) Creating dialogue through 'one-family can', 'one man can' campaigns d) Behaviour change approach e) Incentives f) Leadership leading by example, during the launch of the programme g) Peer educator approach

Table 25 continued

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done?	Who was involved?	How were the activities conducted?
Access to ART/ART links	**W42 (Côte d'Ivoire, private, public service, utilities & health)**	a) Offering free ART b) Family counselling and testing c) Opt-out VCT services	a) When eligible as per National guidelines b) During working hours	a) At all the workplace clinics, in Abidjan	a) Trained medical personnel b) External service providers	a) VCT links b) Distributing IEC materials and T-shirts c) Offer VCT at the clinics
	W35 (Kenya, private, manufacturing)	a) 80/20 percent coverage medical aid, but with 100% coverage for HIV treatment b) Referral to external service providers	a) During working hours	a) Onsite b) In a tent within the premises	a) Counsellors b) Volunteer doctors	a) VCT links with external stakeholders b) Benefiting communities, customers and distributed through the 'Neighbours against AIDS' initiative c) The supply chain concept
Leadership commitment	**W1, W2 & W3 (South Africa, private, manufacturing)**	a) CEO testing campaign	a) During working hours	a) At the workplaces, Johannesburg	a) CEOs	a) CEOs of the various workplaces tested in public
Meaningful involvement of PLHIV	**W47 (Mozambique, private services sector, informal)**	a) Income-generating project	a) On-going	a) On the outskirts of Maputo	a) 45 families affected by HIV	a) Chicken-breeding project, with access to ART
	W28 (Madagascar, private, infrastructure, construction and related sectors)	a) Inviting PLHIV to give talks	a) On-going	a) At the workplace, Antananarivo	a) PLHIV from external organizations b) Employees c) Peer educators	a) Testimonies on living positively b) Educational talks c) VCT promotion
Family and couple counselling and testing	**W17 (South Africa, private services sector, informal)**	a) Sex worker and partner testing	a) Hotspots	a) Cape Town	a) Sex workers & spouses b) Employees	a) Family approach

ANNEX 5: COMPONENTS – REDUCED RISKY BEHAVIOURS

Table 26 Components adopted by workplaces to reduce risky behaviours, by country

Components	Côte d'Ivoire (n=5)	Ghana (n=3)	Kenya (n=5)	Madagascar (n=4)	Morocco (n=5)	Mozambique (n=3)	Namibia (n=3)	Senegal (n=4)	South Africa (n=8)	Zambia (n=3)	Total (n=43)	%
Sexual risk assessment	5	3	3	4	5	3	3	3	8	3	40	93
Awareness creation or condom promotion	5	4	5	4	5	3	3	3	8	3	43	100
Providing access to condoms	5	4	5	4	5	3	3	3	8	3	43	100
Management commitment	5	4	5	4	5	3	3	3	8	3	43	100
Peer educator approach	3	4	5	4	5	3	3	1	6	2	36	84
Monitoring and evaluation	5	4	5	4	5	2	3	3	8	3	42	98
Behaviour change approach	3	3	5	3	5	2	3	1	8	3	36	84
Gender-sensitive approach	3	1	5	0	0	5	3	1	5	1	24	56

Table 27 Components adopted by workplaces to reduce risky behaviours, by workplace type (all countries)

Components	Private sector (n=33)	Public sector (n=5)	Informal economy (n=5)	Total (n=43)	%
Sexual risk assessment	33	5	2	40	93
Awareness creation or condom promotion	33	5	5	43	100
Providing access to condoms	33	5	5	43	100
Management commitment	33	5	5	43	100
Peer educator approach	30	4	2	36	84
Monitoring and evaluation	33	5	4	42	98
Behaviour change approach	30	5	1	36	84
Gender-sensitive approach	20	3	1	24	56

Table 28 Components adopted by workplaces to reduce risky behaviours, by economic sector (all countries)

Components	Agriculture, food and forestry n=2	Education and research n=1	Energy and mining n=5	Infrastructure, construction and related sectors n= 3	Manufacturing n= 9	Maritime and transport n=10	Private services n=6	Public service, utilities and health n=7	Total (n=43)	%
Sexual risk assessment	2	1	3	3	9	9	6	7	40	93
Awareness creation or condom promotion	2	1	5	3	9	10	6	7	43	100
Providing access to condoms	2	1	5	3	9	10	6	7	43	100
Management commitment	2	1	5	3	9	10	6	7	43	100
Peer educator approach	2	1	3	2	4	12	6	6	36	84
Monitoring and evaluation	2	1	4	3	9	10	6	7	42	98
Behaviour change approach	2	1	2	2	6	10	6	7	36	84
Gender-sensitive approach	1	0	1	1	9	4	5	3	24	56

Table 29 Components adopted by workplaces to reduce risky behaviours, by epidemic type (all countries)

Components	Workplaces in generalized epidemic countries (n=34)	Workplaces in concentrated epidemic countries (n=9)	Total (n=43)	%
Sexual risk assessment	32	8	40	93
Awareness creation or condom promotion	34	9	43	100
Providing access to condoms	34	9	43	100
Management commitment	34	9	43	100
Peer educator approach	30	6	36	84
Monitoring and evaluation	34	8	42	98
Behaviour change approach	30	6	36	84
Gender-sensitive approach	23	1	24	56

Table 30 Components adopted by workplaces to reduce risky behaviours, by workplace size (all countries)

Components	Small (<50 employees) n=1	Medium (50 to 499 employees) n=7	Large (500 or more employees) n=35	Total (n=43)	%
Sexual risk assessment	1	7	32	40	93
Awareness creation or condom promotion	1	7	35	43	100
Providing access to condoms	1	7	35	43	100
Management commitment	1	7	35	43	100
Peer educator approach	1	7	28	36	84
Monitoring and evaluation	1	7	34	42	98
Behaviour change approach	1	7	28	36	84
Gender-sensitive approach	1	4	19	24	56

Table 31 Snapshot of specific findings to reduce risky behaviours (selected workplaces)

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done?	Who was involved?	How were the activities done?
Sexual risk assessment	**W5 (Ghana, private, mining and energy)**	a) A baseline audit was conducted	a) During working hours prior to programme initiation	a) At the workplace	a) Experts b) Management c) Employees	a) KABP surveys b) Internet-based surveys c) Monthly reviews
Awareness creation or condom promotion	**W9 (SA, private, manufacturing)**	a) Condom promotion, which started with identification of risky behaviour, then followed by education as an intervention b) Condoms were supplied, both male and female, and condom use demonstrated. c) Specific information in condom use was provided	a) During events such as women or men's month, HIV and AIDS information was provided b) Condom dispensers were replenished on on-going basis, thus condoms were available 24/7.	a) At the workplace: condom dispensers b) At events such as peer education clinics and other events c) In toilets	a) Peer educators b) External stakeholders	a) Partnerships. b) Gender-sensitive approach c) Monitoring condom uptake

Table 31 continued

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done?	Who was involved?	How were the activities done?
	Informal economy (W47); (Mozambique, informal, private, services)	a) HIV prevention talks, during which IEC materials, including caps and T-shirts, are distributed b) Provide specific information on condom male and female condom use.	a) Sessions were conducted at the market where members are (during business hours)	a) At the markets b) At hotspots where truckers, sex workers and traders congregate. 45,000 condoms were distributed during such awareness sessions.	a) Peer educators	a) Gender-sensitive approach by supplying both male and female condoms
	W46 (Côte d'Ivoire, private, services)	a) Created slogans for awareness days, during which they offered gadgets, small baskets with condoms b) Distributed condoms for free	a) Three times per year during tours b) During the caravan c) During staff weddings, where the bridal couple were offered presents which included condoms	a) Condom distribution took place at the workplace medical centres and during awareness sessions	a) Peer educators b) External stakeholders such as a business coalition provide condoms to the workplace for distribution	a) Management supported the workplace programme by making resources available b) Partners (business coalition) supplied condoms
Behaviour change approach	**W30 (Madagascar, private, services)**	a) Condom use messages	a) On-going	a) At the workplace waiting room, Antananarivo	a) Health staff b) Management c) External partners	a) Use of electronic media b) IEC materials c) Posters
Providing access to condoms	**W43 (Senegal, public service, utilities and health)**	a) Distribution of condoms	a) When going on foreign missions b) During campaign	a) In the W43 employees living quarters b) In the communities c) In various national districts	a) W43 management b) Medical personnel c) Soldiers d) Civilians	a) Gender-specific approach b) Partnerships c) Condom use strongly encouraged by management
	W40 & W41 (Zambia, public service, utilities and health)	Distribution of condoms	a) On-going	a) At the workplace b) Registry c) Toilets d) Offices e) Pharmacy f) Out-patient department, & paramedical centre	a) Peer educators b) Employees c) External partners	a) Condom-supply partnerships

ANNEX 6: COMPONENTS – REDUCED STIGMA AND DISCRIMINATION

Table 32 Components adopted by workplaces to reduce stigma and discrimination, by country

Components	South Africa (=n6)	Zambia (n=3)	Total (n=9)	%
Assessment of needs	6	3	9	100
Awareness education and training on the rights of persons	6	3	9	100
Promoting acceptance and openness about HIV and AIDS and involvement of PLHIV	6	3	9	100
Peer education approach	6	3	9	100
Management commitment	6	3	9	100
Confidentiality	6	3	9	100
Monitoring and evaluation	6	3	9	100
Wellness approach/mainstreaming	6	3	9	100
Gender-sensitivity	5	2	7	78
Access to services	6	3	9	100
Behaviour change communication	6	3	9	100

Table 33 Components adopted by workplaces to reduce stigma and discrimination, by workplace type (all countries)

Components	Private (n=7)	Public (n=2)	Informal (none)	Total (n=9)	%
Assessment of needs	7	2	0	9	100
Awareness education and training on the rights of persons	7	2	0	9	100
Promoting acceptance and openness about HIV and AIDS and involvement of PLHIV	7	2	0	9	100
Peer education approach	7	2	0	9	100
Management commitment	7	2	0	9	100
Confidentiality	7	2	0	9	100
Monitoring and evaluation	7	2	0	9	100
Wellness approach/mainstreaming	7	2	0	9	100
Gender-sensitivity	7	0	0	7	78
Access to services	7	2	0	9	100
Behaviour change communication	7	2	0	9	100

Table 34 Components adopted by workplaces to reduce stigma and discrimination, by economic sector

Components	Agriculture, food and forestry n=0	Education and research n=0	Energy and mining n=1	Infrastructure, construction and related sectors n= 0	Manufacturing n= 2	Maritime and transport n=2	Private services n=1	Public service, utilities and health n=3	Total (n=9)	%
Assessment of needs	0	0	1	0	2	2	1	3	9	100
Awareness education and training on the rights of persons	0	0	1	0	2	2	1	3	9	100
Promoting acceptance and openness about HIV and AIDS and involvement of PLHIV	0	0	1	0	2	2	1	3	9	100
Peer education approach	0	0	1	0	2	2	1	3	9	100
Management commitment	0	0	1	0	2	2	1	3	9	100
Confidentiality	0	0	1	0	2	2	1	3	9	100
Monitoring and evaluation	0	0	1	0	2	2	1	3	9	100
Wellness approach/ mainstreaming	0	0	1	0	2	2	1	3	9	100
Gender-sensitivity	0	0	1	0	2	2	1	1	7	78
Access to services	0	0	1	0	2	2	1	3	9	100
Behaviour change communication	0	0	1	0	2	2	1	3	9	100

Table 35 Components adopted by workplaces to reduce stigma and discrimination, by epidemic type (all countries)

Components	Workplaces in generalized epidemic countries (n=9)	Workplaces in concentrated epidemic countries (n=0)	Total (n=9)	%
Assessment of needs	9	0	9	100
Awareness education and training on the rights of persons	9	0	9	100
Promoting acceptance and openness about HIV and AIDS and involvement of PLHIV	9	0	9	100
Peer education approach	9	0	9	100
Management commitment	9	0	9	100
Confidentiality	9	0	9	100

Table 35 continued

Components	Workplaces in generalized epidemic countries (n=9)	Workplaces in concentrated epidemic countries (n=0)	Total (n=9)	%
Monitoring and evaluation	9	0	9	100
Wellness approach/mainstreaming	9	0	9	100
Gender-sensitivity	7	0	7	78
Access to services	9	0	9	100
Behaviour change communication	9	0	9	100

Table 36 Components adopted by workplaces to reduce stigma and discrimination, by workplace size (all countries)

Components	Small (<50 employees) n=1	Medium (50 to 499 employees) n=2	Large (500 or more employees) n=6	Total (n=9)	%
Assessment of needs	1	2	6	9	100
Awareness education and training on the rights of persons	1	2	6	9	100
Promoting acceptance and openness about HIV and AIDS and involvement of PLHIV	1	2	6	9	100
Peer education approach	1	2	6	9	100
Management commitment	1	2	5	9	100
Confidentiality	1	2	6	9	100
Monitoring and evaluation	1	2	6	9	100
Wellness approach/mainstreaming	1	2	6	9	100
Gender-sensitivity	1	2	4	7	78
Access to services	1	2	6	9	100
Behaviour change communication	1	2	6	9	100

Table 37 Snapshot of specific findings to reduce stigma and discrimination (selected workplaces)

Component	Workplace	What activities were done?	When were the activties done?	Where were the activities done? (one or + location/s)	Who was involved?	How were the activities conducted?
Assessment of needs:	**W9 (South Africa, private, manufacturing)**	a) Assessed the needs of its employees through a KABP survey	a) In 2009: baseline survey b) In 2011: follow-up survey	a) Uitenhage	a) Peer educators b) PLHIV c) Management	a) KABP surveys used question-naires
	W56 (Zambia, public service utilities and health)	a) KABP survey	a) In 2008: baseline survey	a) Lusaka	a) Management b) Experts	a) KABP surveys used question-naires
Awareness education and training	**W40 & W41 (Zambia, public service utilities and health)**	a) Distribution of IEC b) In-house training c) Pre-and post-test clubs	a) During lunch breaks	a) Onsite clinic b) Ndola, Livingstone	a) Peer educa-tors b) Management c) Employees and their spouses d) PLHIV as wellness mentors	a) Behaviour change messaging such as drama, poetry etc. b) Promoting acceptance and openness about HIV and AIDS
	W1, W2, W3 (South Africa, private, manufacturing)	a) HIV education	a) During working hours	a) Johannesburg	a) Peer educators b) Wellness Committee c) PLHIV d) Management	a) Gender-sensitivity activities included ladies' days, special events for men and women as well as gen-der training b) Partnerships c) Wellness approach
Meaningful involvement of PLHIV	**W9 (South Africa, private, manufacturing)**	a) Social dialogues by PLHIV b) Created a safe space for disclosure	a) Activities took place during working hours	a) At the canteen b) Uitenhage	a) PLHIV b) Psychologist c) Employees	a) Management commitment to intolerance of stigma and discrimina-tion
	W40 & W41	a) Safe environment for disclosure	a) During working hours	a) Workplaces: Ndola, Livingstone	a) Management b) PLHIV c) Employees	a) Management commitment to intolerance of stigma and discrimina-tion
Management commitment	**W56 (Zambia, public service utilities and health)**	a) Putting an anti-stigma and discrimi-nation policy in place	a) During programme implementa-tion	a) Lusaka	a) Management	a) Supportive environment

ANNEX 7: COMPONENTS – INCREASED ART UPTAKE

Table 38 Components adopted by workplaces to increase ART uptake, by country

Components	Senegal (n=1)	Namibia (n=1)	Total (n-2)	%
Awareness creation	1	1	2	100
Providing access to ART for employees who test positive, care and adherence support	1	1	2	100
Management commitment	1	1	2	100
Confidentiality	1	1	2	100
Monitoring ART uptake	1	1	2	100
Meaningful involvement of PLVIH	1	1	2	100
Wellness approach	1	1	2	100

Table 39 Components adopted by workplaces to increase ART uptake, by workplace type (all countries)

Components	Private sector (n=2)	Public sector (n=0)	Informal economy (n=0)	Total (n=2)	%
Awareness creation	2	0	0	2	100
Providing access to ART for employees who test positive, care and adherence support	2	0	0	2	100
Management commitment	2	0	0	2	100
Confidentiality	2	0	0	2	100
Monitoring ART uptake	2	0	0	2	100
Meaningful involvement of PLVIH	2	0	0	2	100
Wellness approach	2	0	0	2	100

Table 40 Components adopted by workplaces to increase ART uptake, by economic sector (all countries)

Components	Agriculture, food and forestry n=1	Education and research n=0	Energy and mining n=1	Infrastructure, construction and related sectors n= 0	Manufacturing n= 0	Maritime and transport n=0	Private services n=0	Public service, utilities and health n=0	Totals (n=2)	%
Awareness creation	1	0	1	0	0	0	0	0	2	100
Providing access to ART for employees who test positive, care and adherence support	1	0	1	0	0	0	0	0	2	100
Management commitment	1	0	1	0	0	0	0	0	2	100
Confidentiality	1	0	1	0	0	0	0	0	2	100
Monitoring ART uptake	1	0	1	0	0	0	0	0	2	100
Meaningful involvement of PLVIH	1	0	1	0	0	0	0	0	2	100
Wellness approach	1	0	1	0	0	0	0	0	2	100

Table 41 Components adopted by workplaces to increase ART uptake, by epidemic type (all countries)

Components	Workplaces in generalized epidemic countries (n=1)	Workplaces in concentrated epidemic countries (n=1)	Total (n=2)	%
Awareness creation	1	1	2	100
Providing access to ART for employees who test positive, care and adherence support	1	1	2	100
Management commitment	1	1	2	100
Confidentiality	1	1	2	100
Monitoring ART uptake	1	1	2	100
Meaningful involvement of PLVIH	1	1	2	100
Wellness approach	1	1	2	100

Table 42 Components adopted by workplaces to increase ART uptake, by workplace size (all countries)

Components	Small (<50 employees) n=0	Medium (50 to 499 employees) n=0	Large (500 or more employees) n=2	Total (n=2)	%
Awareness creation	0	0	2	2	100
Providing access to ART for employees who test positive, care and adherence support	0	0	2	2	100
Management commitment	0	0	2	2	100
Confidentiality	0	0	2	2	100
Monitoring ART uptake	0	0	2	2	100
Meaningful involvement of PLVIH	0	0	2	2	100
Wellness approach	0	0	2	2	100

Table 43 Snapshot of specific findings to increase ART uptake (selected workplaces)

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done? (one or + location/s)	Who was involved?	How were the activities conducted?
Awareness creation	**W39, (Senegal, private, agriculture, food and forestry)**	a) Training dedicated staff b) HIV talks & IEC materials c) Use of electronic media	a) Daily, during working hours b) Broadcast Three times/ week		a) Peer educators b) External partners c) Management (financial support)	a) Wellness approach b) Multilingual approach c) Community approach d) Electronic media approach e) Targeting vulnerable groups f) Behaviour change messages

Table 43 continued

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done? (one or + location/s)	Who was involved?	How were the activities conducted?
Providing access to ART for employees who test positive, care and adherence support	**W8 (Namibia, Private-public, energy and mining)**	a) Providing ART for free to permanent employees, spouses and children	a) ART was made available to employees when they became eligible for treatment as per national guidelines	a) Onsite clinics and medical centres	a) Peer educators advertised and promoted ART b) External partners who coordinated external ART programme via a network of accredited service providers, the collaboration between the workplace and government for treatment of retired employees c) Leadership supported the programme by, inter alia, establishing an HIV and AIDS operating committee, which coordinated and communicated best practices	a) Holistic approach which addresses both physical and psycho-emotional well being
	W39, (Senegal, private, agriculture, food and forestry)	a) Providing free ART	a) Free ART was provided to employees when they became eligible as per national guidelines	a) Onsite clinics	a) Management commitment through engagement of dedicated staff, including trained nurses and a doctor b) External partners, such as CNLS, who have dedicated staff, including a chief doctor, who is in charge of coordinating the programme in collaboration with other stakeholders	

Table 43 continued

Component	Workplace	What activities were done?	When were the activities done?	Where were the activities done? (one or + location/s)	Who was involved?	How were the activities conducted?
Management commitment	**W8 (Namibia, private-public, energy and mining)**	a) Made funds available to facilitate providing of free ART	a) On commencement of the programme	a) At the workplace	a) Management	a) Partnerships with external stakeholders
Ensure confidentiality and non-disclosure	**W39, (Senegal, private, agriculture, food and forestry)**	a) Provided ART to employees while ensuring confidentiality and not disclosing the HIV status	a) On-going	a) At the workplace, St Louis Province	a) Management b) Clinic staff/ health workers	a) Not writing the HIV status of clients in the health book in order to ensure confidentiality
Monitoring adherence	**W39, (Senegal, private, agriculture, food and forestry)**	a) Monitoring adherence to treatment and treatment outcomes	a) On-going as per national guidelines	a) At the workplace clinic b) At the three worksites and the health district	a) Coordinator of HIV/AIDS programme	a) Collecting and monitoring blood test results b) Health team members meeting to discuss cases and sharing documents

ANNEX 8: COMPONENTS – REDUCED ABSENTEEISM AND COSTS

Table 44 Components adopted by workplaces to reduce absenteeism and costs, by country

Components	Namibia (n=3)	Kenya (n=1)	Zambia (n=2)	Total (n-6)	%
General health screening	3	1	2	6	100
Cost-benefit analysis	3	1	2	6	100
Implementation of awareness sessions	3	1	2	6	100
Access to low-cost insurance plans	3	1	2	6	100
Management commitment	3	1	2	6	100
Monitoring and evaluation	3	1	2	6	100
Peer educator approach	3	1	2	6	100
Gender-sensitive approach	3	1	2	6	100
Wellness approach	3	1	0	4	67
Meaningful involvement of PLVIH	3	1	2	6	100
Behaviour change communication	3	1	2	6	100

Table 45 Components adopted by workplaces to reduce absenteeism, by workplace type (all countries)

Components	Private sector (n=6)	Public sector (n=0)	Informal economy (n=0)	Total (n=6)	%
General health screening	6	0	0	6	100
Cost-benefit analysis	6	0	0	6	100
Implementation of awareness sessions	6	0	0	6	100
Access to low-cost insurance plans	6	0	0	6	100
Management commitment	6	0	0	6	100
Monitoring and evaluation	6	0	0	6	100
Peer educator approach	6	0	0	6	100
Gender-sensitive approach	6	0	0	6	100
Wellness approach	6	0	0	4	67
Meaningful involvement of PLVIH	6	0	0	6	100
Behaviour change communication	6	0	0	6	100

Table 46 Components adopted by workplaces to reduce absenteeism, by economic sector (all countries)

Components	Agriculture, food and forestry n=0	Education and research n=0	Energy and mining n=2	Infrastructure, construction and related sectors n= 0	Manufacturing n= 2	Maritime and transport n=0	Private services n=2	Public service, utilities and health n=0	Total (n=6)	%
General health screening	0	0	2	0	2	0	2	0	6	100
Cost-benefit analysis	0	0	2	0	2	0	2	0	6	100
Implementation of awareness sessions	0	0	2	0	2	0	2	0	6	100
Access to low-cost insurance plans	0	0	2	0	2	0	2	0	6	100
Management commitment	0	0	2	0	2	0	2	0	6	100
Monitoring and evaluation	0	0	2	0	2	0	2	0	6	100
Peer educator approach	0	0	2	0	2	0	2	0	6	100
Gender-sensitive approach	0	0	2	0	2	0	2	0	6	100
Wellness approach	0	0	1	0	1	0	2	0	4	67
Meaningful involvement of PLVIH	0	0	2	0	2	0	2	0	6	100
Behaviour change communication	0	0	2	0	2	0	2	0	6	100

Table 47 Components adopted by workplaces to reduce absenteeism, by epidemic type (all countries)

Components	Workplaces in generalized epidemic countries (n=6)	Workplaces in concentrated epidemic countries (n=6)	Total (n=6)	%
General health screening	6	0	6	100
Cost-benefit analysis	6	0	6	100
Implementation of awareness sessions	6	0	6	100
Access to low-cost insurance plans	6	0	6	100

Table 47 continued

Components	Workplaces in generalized epidemic countries (n=6)	Workplaces in concentrated epidemic countries (n=6)	Total (n=6)	%
Management commitment	6	0	6	100
Monitoring and evaluation	6	0	6	100
Peer educator approach	6	0	6	100
Gender-sensitive approach	6	0	6	100
Wellness approach	4	0	4	67
Meaningful involvement of PLVIH	6	0	6	100
Behaviour change communication	6	0	6	100

Table 48 Components adopted by workplaces to reduce absenteeism, per workplace size (all countries)

Components	Small (<50 employees) n=1	Medium (50 to 499 employees) n=1	Large (500 or more employees) n=4	Total (n=6)	%
General health screening	1	1	4	6	100
Cost benefit analysis	1	1	4	6	100
Implementation of awareness sessions	1	1	4	6	100
Access to low-cost insurance plans	1	1	4	6	100
Management commitment	1	1	4	6	100
Monitoring and evaluation	1	1	4	6	100
Peer educator approach	1	1	4	6	100
Gender-sensitive approach	1	1	4	6	100
Wellness approach		1	3	4	67
Meaningful involvement of PLVIH	1	1	4	6	100
Behaviour change communication	1	1	4	6	100

Table 49 Snapshot of specific findings for reduced absenteeism and costs (selected workplaces)

Component	Workplace	What activities were done ?	When were the activities done?	Where were the activities done? (one or + location/s)	How were the activities conducted?
a) General health screening/ wellness approach	**W52 (Kenya, private, services sector)**	a) Activities included testing for blood pressure, cholesterol, etc.	a) Since 2007 to date, during working hours	a) Onsite clinic b) In Nairobi	a) A wellness approach was adopted
	W59, W60 and W61 (Namibia, private, manufacturing, services sector, services sector)	a) Activities included testing for BP, haemoglobin, diabetes and other non-communicable diseases	a) During working hours	a) Mobile vans with 2 units – testing unit and screening unit b) Windhoek	a) Wellness approach
b) Cost benefit analysis	**W59, W60 and W61 (Namibia, private, manufacturing, services sector, services sector)**	a) Invested in a well-ness programme for employees b) Health insurance cost for employees	a) During management meetings	a) Workplace - Windhoek	a) Management commitment – financial incentives
	W52 (Kenya, private, services sector)	a) Health insurance cost for employees	a) During working hours	a) Workplace – Nairobi	a) Management commitment – financial incentives
c) HIV and AIDS awareness sessions	**W33 (Zambia, private, energy and mining)**	a) Awareness sessions covering topics on health	a) On Fridays, weekly	a) At the worksite	a) Peer education approach
	W52 (Kenya, private, services sector)	a) Sessions on topics such as opportunistic infections, active lifestyles, good nutrition, healthy lifestyle choices and health promotion b) A theme is chosen each month and topics are then developed	a) During working hours	a) Workplace – Nairobi	a) Peer educator approach

Table 49 continued

Component	Workplace	What activities were done ?	When were the activities done?	Where were the activities done? (one or + location/s)	How were the activities conducted?
d) Management commitment	**W51 (Zambia, private, manufacturing)**	a) A subsidized medical aid scheme b) HIV and AIDS policies and strategies with emphasis on staff retention	a) During programme implementation	a) Workplace – Livingstone and Lusaka	a) Financial incentives
	W59, W60 and W61 (Namibia, private, manufacturing, services sector, services sector)	a) Implementation of low cost health insurance	a) During programme implementation	a) Workplace – Windhoek	a) Financial incentives

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ISBN 978-92-2-128769-8