Workplace action on HIV/AIDS:
identifying and sharing best practice

**Background report for
Tripartite Interregional Meeting on Best Practices
in HIV/AIDS Workplace Policies and Programmes**

15-17 December 2003, ILO, Geneva

PREFACE

The global HIV epidemic reduces the supply of labour, and undermines the rights and the livelihoods of millions of workers, and those who depend on them. The loss of skills and experience in the workforce reduces productivity and diminishes the capacity of national economies to deliver goods and services on a sustainable basis. HIV/AIDS threatens every aspect of the Decent Work Agenda and the ILO's strategic objectives.

The ILO's response has therefore been to combine the mainstreaming of AIDS-related issues throughout the Office with the establishment of a dedicated programme to catalyse and coordinate action. Because AIDS is such a sensitive issue and so far removed from the traditional concerns and experience of the ILO's constituents, one of the first initiatives of the new Programme was the development of a *Code of Practice on HIV/AIDS and the world of work*. This provides practical guidance to governments, employers and workers, as well as other stakeholders, for developing national and workplace policies to combat the spread of HIV/AIDS and mitigate its impact. An education and training manual has been prepared to complement the Code and guide its application at national and enterprise levels.

The ILO is now promoting the active implementation of the Code as a framework for workplace action, with an emphasis on strengthening the capacity of its tripartite constituents. Training and advisory services are being provided for governments and the social partners on integrating workplace issues in national AIDS strategies, on revising labour laws to address HIV/AIDS, and on the development of workplace policies and programmes in over 50 countries.

A key part of this process is analysing what makes good practice, sharing lessons learned and distilling experience into guidelines for action. To this end the ILO Governing Body allocated resources to an **inter-regional tripartite meeting on best practices in HIV/AIDS workplace policies and programmes**, taking place at the ILO in Geneva from 15 to 17 December 2003. We see this meeting as a crucial step in the process of implementing the Code of Practice and promoting effective action at the workplace. The present report draws on the analysis of key issues, summarizes selected case studies and presents a number of the lessons learned. It is the working paper for the meeting, and reflects the themes that will be examined in greater depth in working groups. The ILO intends to take the proceedings and conclusions of the meeting to produce a comprehensive reference and guidance document on workplace action to combat HIV/AIDS. We look forward to rich discussions at the meeting, drawing on a wide range of experiences, to provide the heart of what we believe will be an extremely useful document.

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Contents

List of abbreviations

AIA	American International Insurance
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
CARICOM	Caribbean Community
CEE/fSU	Eastern Europe and the countries of the former Soviet Union
CRIS	UNAIDS Country Response Information System
DCSA	DaimlerChrysler South Africa
DOTS	Directly observed treatment strategy
DNO-SA	Democratic Nursing Organisation South Africa
DSSP	Decentralized systems of social protection
GAMET	World Bank's Global AIDS Monitoring and Evaluation Support Team
GDP	Gross Domestic Product
GGML	Geita Gold Mine Ltd.
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German technical cooperation agency)
HAART	Highly active antiretroviral treatment
HIV	Human immunodeficiency virus
HMIS	Health and micro-insurance schemes
ICFTU	International Confederation of Free Trade Unions
IDUs	Intravenous drug users
ILC	International Labour Conference
ILO	International Labour Organization
ILO/AIDS	ILO Programme on HIV/AIDS and the World of Work
ILO STEP	ILO Programme on Strategies and Tools against Social Exclusion and Poverty
IOE	International Organisation of Employers
IPEC	ILO's InFocus Programme for the Elimination of Child Labour
KAPB	Knowledge, attitudes, perceptions and behaviours
MAP	World Bank's Multi-Country HIV/AIDS Program (MAP) for Africa
MBAs	Masters of Business Administration
MDGs	Millennium Development Goals
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NGOs	Non-governmental organizations
PLWHA	People living with HIV/AIDS
SACTWU	South African Clothing and Textile Workers Union
SMEs	Small and medium-sized enterprises
SSA	Sub-Saharan Africa
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TAPWAK	Federation of Kenya Employers and Association of People Living with AIDS
TB	Tuberculosis
TBCA	Thailand Business Coalition on AIDS
TPAA	Transatlantic Partners Against AIDS
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNGASS	UN General Assembly Special Session on HIV/AIDS (June 2001)
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
USDOL	United States Department of Labor
VCT	Voluntary counselling and testing
WHO	World Health Organization
YEN	Youth Employment Network

INTRODUCTION

This report is the synthesis of a number of processes, including the drafting of a concept paper, thematic papers, and numerous consultations. The thematic papers cover prevention, care, ethics, legal instruments, data collection, the informal economy, and gender. They will be published, in whole or in part, in conjunction with the report of the proceedings of the meeting on best practices in HIV/AIDS workplace policies and programmes.

The case studies that form the basis for the analysis of best practice – and the lessons that may be drawn from them - are contained in chapter IV of the report. Chapter V examines ways of using these lessons to take forward, strengthen and sustain good practices in workplace action. Chapter III explores the concept of best practice, emphasizing that it is not used in the sense of a superlative – 'the best' – but as a practical tool for identifying and replicating effective workplace responses. Chapters I and II provide a context for the discussion of best practice, including an overview of the current state of the HIV epidemic and its implications for the world of work.

CHAPTER I: A GLOBAL EPIDEMIC

Only late in the day has the world begun to realize the scale of the disaster that it faces due to HIV/AIDS, which is both a humanitarian crisis and a threat to sustainable development. At the end of 2002, 42 million people were living with HIV/AIDS, and five million more people - 800,000 of them children - became infected during that year alone. Since 1980, more than 20 million people are estimated to have died from HIV-related illnesses. UNAIDS predicts that by 2020 the number will swell to 68 million, unless prevention and treatment programmes are expanded.

Clearly, HIV/AIDS is not one epidemic but many, and the brief regional overview that follows is intended to bring out the differences both within and between regions and countries. The scale of the epidemic varies greatly, as do the causal factors that drive HIV transmission. Understanding the problem in the cultural, social, political and economic context of each particular country is crucial if there is to be an appropriate policy and programme response.

What is clear is that present efforts to develop and implement effective responses are not adequate to the task. In part, this reflects an ongoing lack of understanding of the threat posed by the epidemic for societies and for economies. It also reflects a lack of resources for addressing underlying causal factors, such as poverty, unemployment and gender inequality. At the present time, the epidemic remains concentrated in sub-Saharan Africa - with 70% of global infections - but, as experience demonstrates, the level of HIV prevalence can increase at frightening speed once the virus is present in susceptible populations.

Hence, the need to put in place effective and sustainable multisectoral polices and programmes in all countries and in all regions. Current projections indicate that the targets of the Declaration of Commitment on HIV/AIDS (UN, 2001) and the Millennium Development Goals (MDGs) are most unlikely to be achieved. Until recently, it appeared that the goal to provide antiretroviral therapy (ART) to three million people living with HIV by 2005 would, in fact, reach less than one-third. But the intensified efforts by WHO in this respect (the "3 by 5" initiative) now look set to make a measurable difference. The tasks ahead remain challenging, but it is possible to make real progress even in the face of financial and human resource constraints. In part, the challenge is to apply the experience of what works to situations where the lessons are relevant, effective and sustainable. What has increasingly become clear is that workplace programmes are an essential part of the global response. People aged 15-49 – the age group most affected by infections in all regions in the world - are also those who can be reached most directly through action at the workplace.

Sub-Saharan Africa

Within the past few years, concern has increased about the impact of the HIV epidemic on the achievement of sustainable development in sub-Saharan Africa. Nearly two and a half million people died of AIDS in 2002 alone. The region accounts for an increasing proportion of the world's poorest people, and its living standards have generally fallen over the past two decades. Many of the social and economic indicators used to measure performance have actually regressed – in part as a result of the effects of HIV and AIDS on populations. The most telling general statistic concerns life expectancy, which is falling in many countries in the region, thereby widening the gap in comparison with the developed countries. UNAIDS estimates that life expectancy has fallen to less than 40

years in Malawi, Botswana, Mozambique and Swaziland, while for the region as a whole it is 47 years compared with an estimated 66 years before AIDS took hold[1]. Several other countries in Southern Africa have joined Botswana with HIV prevalence rates in excess of 30%. Indeed, within countries, some cities have even higher rates of HIV prevalence amongst adults, although exceptional, even in excess of 50%. In most countries of SSA, urban/rural differentials in rates of HIV in the population continue. However, although rural populations have lower rates of HIV, in absolute numbers most of those infected are found amongst the rural population. A striking feature of the epidemic, which has persisted over time, is that more women are infected than men, and that women typically get infected at much earlier ages than men.

South Africa now has the largest absolute number of people infected with HIV – over 5 million in 2002 - and it is worth recording the data available on trends in HIV prevalence over the past decade as evidence of the speed with which the virus can move through the population. Between 1990 and 1998, HIV prevalence soared from 0.7% to 22.4%.

Eastern Europe and Central Asia

In Eastern Europe and the countries of the former Soviet Union (CEE/fSU), the HIV epidemic displays widely different characteristics at both sub-regional and country level. What is clear is that the HIV epidemic is now demonstrating explosive growth in some countries, and in some cities within countries. This region is now one of the areas in the world where HIV incidence is growing fastest.

UNAIDS estimates that as of December 2001 there were one million HIV infections in CEE/fSU. This number includes 250,000 new infections in the year 2001 alone, which is more than three times the total of new HIV infections reported in North America and Western Europe combined. Within specific identified populations (e.g. in prison and military populations), HIV infection is increasing rapidly, in spite of attempts in some countries to contain transmission.

One of the consequences of the economic and political changes over the past decade has been an increase in economic hardship and unemployment in many countries of the CEE/fSU. Increased levels of poverty and unemployment, rising inequalities in terms of income and wealth, higher levels of labour mobility, and increasing evidence of family disintegration, are all conditions conducive to an expansion of risky behaviour (such as drug-injecting or sex work) that facilitates the transmission of HIV. Women have been disproportionately affected by the social and economic changes that have taken place (i.e. persistent discrimination in employment, unequal pay, sexual harassment and violence).

Asia and the Pacific

The HIV epidemic continues to spread in the region in spite of many well-focused national programmes. Low average prevalence rates may conceal serious localized epidemics in several areas: China and India, where large numbers of people are infected, are evidence of the degree to which low national rates can be misleading. In fact, excepting Africa, the Asia/Pacific region has more people living with HIV/AIDS than any other area of the world – an estimated 7.2 million at the end of 2002, with one million children and adults infected in that year. Both India and China show enormous diversity in the evolution

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[1] AIDS Epidemic Update, WHO/UNAIDS December 2001

of the epidemic, both within and between states. What is most worrying is the presence of the factors that increase rapid transmission of HIV, including poverty, gender inequality and large-scale movements of population. Huge numbers of people will be at risk if the virus shifts from its present localized distribution into the population as a whole.

Elsewhere in the region the experience is varied. In some countries (e.g. Myanmar, Nepal, Bangladesh, Viet Nam and Thailand), a serious localized epidemic is associated particularly with injecting drug use and the widespread sharing of needles.

The outlook is bleak, unless national programmes are better resourced. Many lessons from SSA can usefully be transferred to this region, not least in terms of mobilizing a truly national and multisectoral response. There are also encouraging signs of what can be achieved through effective policies. In Thailand and Cambodia, for example, the course of the epidemic seems to have been successfully changed; in the Philippines, prevalence has been kept at low levels in spite of significant levels of risk for HIV infection among some segments of the population. However, success is a relative term and the costs of rolling back the epidemic once it gets started can be very significant. Thailand, for example, has allocated resources for an effective response to the epidemic over the past decade, undoubtedly saving millions of lives as a result.

Latin America and the Caribbean

In Latin America and the Caribbean, the epidemic is long established and in danger of spreading more widely in the absence of more effective responses. There are an estimated 1.9 million adults and children living with HIV - a figure which includes 210,000 new infections in 2002. Of this total, approximately 440,000 are in the Caribbean, where 12 countries (including Belize and Honduras in Central America) have an estimated HIV prevalence in excess of one percent. Certain countries in this region have the highest rates of HIV prevalence of any countries in the world outside SSA (e.g. Haiti at 6.5%, Bahamas at 4% and Dominican Republic at approximately 2%).

In the Caribbean, the epidemic is firmly rooted in the general population, and is largely driven by sexual transmission. The region as a whole is characterized by extensive poverty and unemployment, together with related high rates of labour mobility. These are conditions in which the epidemic thrives with particular severity amongst adolescent girls and young women. Governments in the region are increasingly turning their attention to the issues, as manifested by various Caribbean initiatives coordinated by CARICOM.

One example of an early and effective response is in Brazil, where prevention programmes for intravenous drug users (IDUs) and extensive condom promotion (including much reduced prices) figure strongly and where HIV prevalence has sharply declined. Brazil has also acted to extend access to antiretroviral therapies (ART), thereby dramatically reducing HIV-related morbidity and mortality. The Brazilian case demonstrates what can be achieved through improvements in care, support and treatment, including ART, for significant numbers of people living with HIV in resource-constrained situations.

Middle East and North Africa

Levels of HIV remain low in these countries, with estimated infections of around 550,000 in 2002. Nevertheless, as in other regions, the trend of infections is resolutely upwards, although for the moment confined to certain countries and population groups. Sudan and Djibouti, for example, have more widespread epidemics, although rates are still low by the standards of SSA. Evidence on causal factors is hard to gather although in the

most affected countries in the region it appears as if a combination of socioeconomic disparities and large-scale population mobility associated with political instability is important.

Most countries in the region have reported HIV transmission through injecting drug use. The evidence, while sparse, confirms that the problem is present in all countries including some of the largest (e.g. Algeria, Morocco and Iran). What is only too evident is that most governments in the region have still not accepted the potential seriousness of the problem, with the result that national responses continue, at best, to be health-focused. There is a clear need to shift from the present restricted focus to a broader-based and expanded response, with a focus on young people, IDUs, mobile populations and those displaced by military and other crises.

High income countries

These countries have largely managed to avoid the escalation in HIV transmission that has occurred in many other regions, although in 2002 an estimated 1.6 million people were infected with HIV and an additional 75,000 became HIV positive. The most significant change in the past few years relates to the large number of people receiving ART (about 500,000 in 2001). But there is no place for complacency. Unsafe sex continues among young people in many countries while the lessons of past experience among men who have sex with men (MSM) are being ignored. In addition, increasing evidence of resistance to ART in both Europe and in North America raises the threat that drug-resistant strains of the virus may be transmitted.

In Western Europe, HIV infection rates are increasing among injecting drug users as well as due to heterosexual transmission. In the UK, for example, approximately half of new infections appear to result from unsafe sexual behaviour. Particularly worrying is the fact that marginalized populations are increasingly infected and affected by HIV. In the USA, although African-Americans make up 13% of the population, they accounted for 54% of new HIV infections in 2000. Almost one third of new HIV infections in 2000 in the USA were amongst women.

What is also evident is that, in many industrialized countries, the HIV epidemic remains closely linked to the global epidemic. Movement of people between countries, whether for immigration, employment or recreation, and the displacement of populations due to war and political instability, are all favorable to HIV transmission. In Western Europe, a significant proportion of sexually acquired infections (STIs) occur in individuals who have lived in or visited high prevalence countries. Furthermore, the expanded use of drugs can be partially explained by the worsening conditions of life in many parts of the world that encourages their production and trade. Addressing global economic and social inequality, thus, becomes an urgent and effective way to reduce the costs of HIV/AIDS to the rich countries.

A global emergency

In the light of these issues and their implications for all countries, at a special session of the UN General Assembly in June 2001, 189 heads of state adopted a Declaration of Commitment on HIV/AIDS, where they concluded that

the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines

social and economic development throughout the world and affects all levels of society – national, community, family and individual.

Two key commitments recognized the need to expand the global response into the world of work:

By 2003 to develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at greater risk of HIV/AIDS, in consultation with representatives of employers and workers, taking into account of established international guidelines on HIV/AIDS and the workplace (para 49).

By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS (para 69).

The Declaration is an important commitment to a global and multisectoral response. However, to be effective, it requires sustained leadership and the mobilization of resources. Its effectiveness also means building on what has been shown to work and taking such practices to scale in all countries. Hence, we need to exchange lessons learned and best practices in workplace programmes, now seen as essential in both extending and intensifying national efforts.

CHAPTER II: THE ECONOMIC AND SOCIAL IMPACT OF HIV/AIDS IN THE WORLD OF WORK

The impacts of the HIV epidemic cut across all sectors of economic activity and all areas of social life. The following is a brief summary of some of the most important aspects of the effects on sustainable economic and social development. The emphasis throughout is on those aspects of HIV regarding the loss of labour and the implications of lost human resources in sustaining economic activity. As will be shown, the epidemic's effects are not only generalized but have the potential to cumulate over time, with effects on long-term growth and development.

The macroeconomic impact of the HIV/AIDS epidemic

The key fact that the epidemic has its primary impact on the working age population means that those with important economic and social roles – both men and women – are prevented from making their full contribution to economic development. The effects are not confined to a simple calculus of lost labour, but have much deeper implications for the structure of families, the survival of communities and longer-term issues of sustaining productive capacity.

The HIV epidemic erodes the savings capacity of households, formal and informal productive enterprises, and of government, through its *direct* effects on income flows and levels of expenditure. Reduced rates of savings will, over time, lead to slower growth of aggregate output, with the likelihood of declining per capita income. Thus, UNAIDS estimates that annual per capita income of half the countries of sub-Saharan Africa is falling by 0.5-1.2%, and that GDP in the hardest hit countries may decline by 8% by 2010.

Already, lower levels of household savings are having effects on investment in children's education, with obvious consequences for the future. Public services in the worst affected countries in SSA are facing widespread attrition of trained and experienced staff and are unable to replace losses due to budget and other constraints. Similarly, in directly productive activities, such as mines and plantations, personnel losses are occurring at an accelerating rate.

The impact on the growth of GDP is greatest where lost labour is concentrated amongst those with scarce skills and higher professional and managerial training. In many developing countries, these capacities are already so inadequate that the loss of human resources due to HIV and AIDS will have a major impact on development.

The HIV epidemic is eroding the capacity for economic growth and development through its myriad effects on labour supplies, saving rates, national security and social cohesion. Early action to restrain the rate of transmission of HIV would be immensely beneficial, given the scale of the impact on economies once the epidemic is generalized as is presently the case in many countries of sub-Saharan Africa.

Growing recognition of the long-term economic impact of AIDS

A research report by the World Bank and the University of Heidelberg (July 2003) into the macroeconomic costs of AIDS shows that these will be more damaging than previously thought. It argues that most studies of the long-run costs of AIDS have failed to pay enough attention to the ways in which human knowledge and potential – key channels influencing long-term growth – are created and can be lost. "In countries facing an HIV/AIDS epidemic on the scale of South Africa, for example, they could face economic collapse within several generations, with family incomes cut in half."

Effects of HIV/AIDS on labour supply and human capital

Loss of labour represents a loss of both private and social investment for all countries, rich and poor, although the impact is greatest where human capital is a significant constraint on sustainable development. The effects of the epidemic are compounded in countries where HIV infection rates rise with social and occupational status, e.g. among doctors, teachers, engineers, and so on.

The ILO has estimated that in ten to fifteen years' time, the labour force will be between 10 and 34% smaller in high-prevalence countries, as a result of AIDS. But what is also worth noting is that the remaining workforce will contain proportionally younger workers who are less experienced and less well educated than the present cohort. The implications are still unclear, but it seems inevitable that changes of this magnitude must affect levels of productivity and of incomes across the whole economy.

Within the category of 'labour' is a range of capacities which may be undervalued by conventional classification. Tasks that can be classified as "organizational" – e.g. those undertaken by supervisory workers who often play key roles in production, whose skills derive from years of experience and who are particularly difficult to replace – are particularly relevant. The probability is that losses of key personnel with job-specific skills and organizational experience will cause disruption to production and losses of product/service quality.

Economists' attempts to measure these losses through valuations based on average wages or some other indicator are likely to significantly underestimate the social and economic value of the losses of human capital experienced in many countries, and across both formal and informal activities.

It is not simply a matter of costs that are directly identifiable such as those caused by absenteeism/sickness and related disruption of production, medical and other related costs (including funeral costs, pensions and other financial payments), recruitment of new staff and training costs, etc. These costs are important for many enterprises in both the formal and informal economy, but they are in no sense a total summary of all of the costs borne by society as they exclude those that fall directly and indirectly on households, and more generally on the public sector (e.g. government health expenditures). In the aggregate, the costs of the HIV epidemic are very, very significant. Certainly, they considerably exceed the estimates of the costs in terms of losses of GDP that are presently estimated by UNAIDS and others.

Impacts of HIV/AIDS on agriculture, households, child labour and the informal economy

One set of related and very important issues include the way skills and knowledge are passed on to children informally as well as formally, and other problems related to the gendered nature of tasks in smallholder agriculture and household production. In the worst affected countries, it is unclear how the production of food and other crops will be sustained, and how households can continue as viable social and economic entities.

This is crucially important since, in all societies, households perform the critical task of preparing the future labour force. Changes in their capacity to perform this task have wide implications for the whole of the economic and social system.

All forms of agriculture in the worst affected countries, both smallholder and commercial forms of production, face increasing constraints due to the loss of labour caused by HIV/AIDS. Smallholders, whose labour is being lost due to HIV-related morbidity and/or diverted into caring roles, face impacts on labour productivity and

associated reductions in income. Commercial agricultural producers face significantly higher costs and lower profitability; consequently, increasing numbers of enterprises are investing in workplace programmes.

The informal economy, a dynamic source of employment and income growth in all developing countries over the past several decades, is under similar pressure. Here too the impact of HIV/AIDS is pervasive, and complex. Morbidity and mortality place a great strain on the sustainability of informal sector enterprises that are highly dependent on internal generation of flows of savings for their survival. Savings are threatened by the demands falling on revenues for higher levels of health expenditures. Also serious are the losses of experience and management/technical skills which are so essential for survival in small, labour-intensive enterprises.

One of the greatest costs of the HIV epidemic, and one that is directly relevant to the world of work, is the impact on children, and more specifically on child labour. It is estimated by UNICEF/UNAIDS that by 2010 in sub-Saharan Africa the total number of orphans due to AIDS will be 20 million – 12% of all children. In the worst affected African countries AIDS orphans are projected to be more than 20% of all children by this date. The implications of increasing numbers of children growing up in households and communities where the HIV epidemic is undermining social and economic structures is profound – both for the children themselves and for society as a whole. Some households are headed by children as young as six.

The pressures on households affected by HIV/AIDS are immense, and their reactions to increasing shortages of labour due to morbidity and mortality have complex implications in terms of intergenerational poverty and the characteristics of the future labour force. There is clear evidence that increasing numbers of children from HIV-affected households are not being enrolled or are being taken out of school in countries with a mature epidemic of HIV – this is especially true for girls, but boys are also affected. Households also seek ways of sustaining income through the labour of children, for reasons that are understandable, but which have effects in the long-term on the quality of the labour force, and thus the conditions determining economic growth and employment. Children may also be exposed to economic and other forms of exploitation. These developments have clear implications for the ILO's tripartite partners in terms of policies for social protection and poverty reduction, and require specific attention in all workplace policies and programmes.

ILO's InFocus Programme for the Elimination of Child Labour (IPEC)

IPEC has conducted several studies to establish the links between HIV/AIDS and child labour, and has also applied the concept of 'good practice' in its work. The studies cover child labour and HIV/AIDS in South Africa, Tanzania, Zambia, and Zimbabwe, with a synthesis report including recommendations for action covering sub-Saharan Africa as a whole. Also of interest is the report '*Good practices: Gender mainstreaming in actions against child labour*'.

Systemic impacts

Economic and social systems depend on all parts functioning normally and efficiently. The HIV epidemic disrupts this smooth functioning in ways that magnify the initial disturbance. For example, the epidemic not only reduces the *stock* of those with higher level professional and managerial training, the skilled and the unskilled, and levels of experience in the working population, it also reduces the capacity to maintain the *flow* of those with needed skills and training. Thus, in the most affected countries in Africa the problem is not only that employees with scarce skills and experience are being lost due to HIV/AIDS, but that the capacity of schools, universities, technical and other training institutions, etc., to re-supply these needed education and skills is also being reduced. We

need to ensure that all sectors develop the required policies and programmes for sustaining human resources. Taking account of systemic relationships, and building a broad-based response that involves government, employers, employees and communities, is essential if workplace programmes are to be fully effective.

Facing the challenge – establishing comprehensive workplace programmes for HIV/AIDS

Countries experiencing a mature epidemic of HIV face a double task: first, to mitigate the social and economic impact that threatens to overwhelm their coping capacity and, at the same time, to strengthen their response to HIV/AIDS. Central to their response is sustaining human resource capacity through implementing effective workplace programmes.

The task is much harder for countries in the midst of a mature epidemic in that productive capacity has already been lost due to the effects of HIV/AIDS. Countries that have not yet experienced a generalized epidemic of HIV still have a window of opportunity for putting in place a response that is multisectoral and multidimensional. All countries urgently need to extend their activities relating to the world of work, and to ensure that all employees and their dependents, irrespective of gender and status, have access to comprehensive workplace programmes. It is not only essential to respond to losses of human resources that have already occurred due to HIV/AIDS, but also to ensure that existing human resource capacity is sustained through programmes of prevention, care and support and treatment.

The workplace response is one that the ILO's constituents are well placed to lead, and the ILO promotes and supports appropriate policy development by government in consultation with the social partners. At the global level, the International Organisation of Employers (IOE) and the International Confederation of Free Trade Unions (ICFTU) have taken action both separately and together to strengthen the workplace response. The IOE, for example, has mobilized its membership through sensitization seminars in Africa and the Caribbean, and the development of an *Employers' Handbook on HIV/AIDS: A Guide for Action*. This documents HIV/AIDS initiatives taken by employers' organizations and their member enterprises that are designed to minimize the impact of the pandemic and to maximize prevention efforts. The ICFTU's Africa Region has produced a training manual for shop stewards in conjunction with a programme in six countries to train peer educators and union officials. A global union campaign against AIDS is in preparation. In May 2003, both organizations took the significant step of issuing a joint statement at the ILO pledging themselves and their members to collaborative and intensified action against HIV/AIDS.

The ILO response to HIV/AIDS in the world of work

The International Labour Organization brings together governments, employers and workers in common action to improve social protection and conditions of living and work throughout the world. The ILO took action to respond to the HIV epidemic in recognition of the threat it poses to the health, rights and livelihoods of its constituents, the obstacle it poses to the achievement of the Organization's decent work agenda, and the potential of the workplace to prevent the spread and mitigate the impact of the epidemic. The principles of social justice and equality, the process of tripartism, and core labour standards underline the rights-based approach of the ILO's involvement in the global effort against HIV/AIDS.

The ILO's contribution to the global response may be summarized as:

- its tripartite structure, making it possible to mobilize governments, employers and workers against HIV/AIDS

- a central presence at the workplace

- nearly a century of experience in guiding laws and framing standards to protect the rights of workers and improve their working conditions

- a global network of field offices and technical cooperation projects

- specialist expertise in many relevant sectors, from occupational safety and health to social security

- a well-established record of research, information-dissemination, education and training.

The ILO Programme on HIV/AIDS and the world of work

The ILO's involvement in the global response to HIV/AIDS dates from 1988, when it held a consultation with the World Health Organization and issued joint guidelines for dealing with the epidemic in the workplace. In the early 1990s, studies were undertaken of the impact of HIV/AIDS on labour markets in three East African countries and a sub-regional consultation was held in Uganda. Later in the decade, mounting concern on the part of constituents, especially in Africa, resulted in a Regional Tripartite Meeting in Windhoek, Namibia, in 1999, which drafted a *Platform of Action on HIV/AIDS in the context of the world of work in Africa*. The 88th Session of the International Labour Conference (ILC) in June 2000 passed a resolution recognizing that "HIV/AIDS threatens decent work in an all-embracing manner" and requesteing the Director-General to expand the capacity of the Office to respond. The creation of a global ILO Programme on HIV/AIDS and the World of Work (ILO/AIDS) in December 2000 was the response to the resolution.

The challenge for the new programme has been to pursue a focused agenda while maximizing the comparative advantages of the Organization and promoting the mainstreaming of the issue throughout the Office. In view of the enormous potential of the tripartite constituents to contribute to national efforts against HIV/AIDS, the main thrust of the programme has been to strengthen the capacity of the social partners. A strategic and ILO-specific agenda was developed by listening to the concerns, experience and needs of the constituents, and supporting their ability to respond. In line with the ILC resolution, the objectives of ILO/AIDS are to:

- Increase understanding of HIV/AIDS as a labour and development issue;

- Mobilize the commitment and resources of the constituents locally, nationally and globally;

- promote a systematic response to HIV/AIDS through workplace policies and programmes; and,

- Enhance the capacity of the constituents to plan and develop these activities.

The main areas of activity are, therefore, research and policy analysis; awareness-raising and advocacy; advisory services, policy guidance and training; building partnerships at national and international levels with an emphasis on collaboration in technical cooperation; and the documenting and disseminating of good practices from national experience. The improved availability and affordability of antiretroviral treatment and growing awareness of the business costs of human resource losses have provided the impetus for including elements of care, treatment and social protection in workplace programmes.

As the UN Agency with special responsibility for the world of work, the ILO became the eighth co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in October 2001. The ILO's particular contribution to the UNAIDS partnership is its tripartite membership in 177 member States, its workplace presence, and the social dialogue process to promote effective collaborative action.

The UN General Assembly Special Session on HIV/AIDS (June 2001) recognized the role of the workplace in HIV/AIDS prevention, rights protection, and care, and established goals for national and international efforts in a Declaration of Commitment on HIV/AIDS. Two of these goals – set out in paragraphs 49 and 69 (see Chapter I) - are of particular relevance to the ILO and endorse its contribution to the global effort. The ILO is working with UNAIDS to monitor and report on progress in meeting these goals.

International guidelines for workplace policies and programmes

The ILO's commitment to help its constituents respond to HIV/AIDS was strengthened by the drafting of the *ILO Code of Practice on HIV/AIDS and the world of work*, which has become a milestone in the Office's expanded and intensified response to the epidemic. The Code provides practical guidance to governments, employers and workers, as well as other stakeholders, for developing national and workplace policies to respond to the spread of HIV/AIDS and mitigate its impact. The Code is based on widely accepted ILO standards and principles, and covers the key areas of prevention and behaviour change, protection of workers' rights and benefits, and care and support (see Annex 1 for a brief statement of its core principles). It applies to all employers and workers in the private and public sectors, and all aspects of work, formal and informal.

Policy-makers and workplace partners in over 60 countries have been using provisions of the ILO Code as the basis for their own national action programmes, enterprise policies and collective agreements. The Code has been instrumental in strengthening the involvement of the private sector in action against HIV/AIDS, guiding the extension of workplace programmes to the community level, and bringing the workplace perspective and issues into national AIDS programmes and global efforts.

To complement and guide the application of the Code, the ILO has produced an accompanying document, *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual*. The emphasis of the manual is on practical activities and guidelines to help users apply the ILO Code to national strategic plans and workplace policies and programmes. Together, the Code and manual are being used to provide technical assistance and needs-based training to constituents, as well as develop institutional capacity in all regions.

Other projects being implemented by ILO/AIDS include workplace programmes to prevent HIV and combat discrimination in 24 countries (USDOL); action-research into the labour and socio-economic impact of AIDS in selected African countries and the legal/policy framework for workplace action (Italy); HIV prevention in the transport sector and informal economy in 11 African countries (Sweden); the promotion of public-private partnerships in the provision of care at the workplace (France); extending and strengthening workplace policies and programmes on HIV/AIDS, including sharing examples of good practice (Germany). Annex 2 provides a brief review of recent and planned activities.

Knowledge management: impact monitoring, advocacy and information dissemination on good practice and lessons learned

The complexity of the HIV/AIDS phenomenon, its emergency status, and multidimensional implications make it necessary to take action along a number of fronts simultaneously. This highlights the importance of knowledge management in documenting and disseminating information on the changing impact of HIV/AIDS in the world of work and supporting advocacy. The regular newsletter, *Workplace Action*, the ILO/AIDS website (www.ilo.org/aids), working papers and technical meetings all contribute to this end.

Policy-oriented research has focused on the labour market, employment and human capital costs of the epidemic. Methodological and conceptual issues pertaining to monitoring the social and economic impact of HIV/AIDS have been elaborated, and modules are now being developed within the Office to incorporate HIV/AIDS concerns into standard ILO surveys. For example, the ILO social budget model has been applied to the HIV/AIDS situation in Russia to assess the impact and projected expenditures in the government social budget attributed to HIV/AIDS.

Within the framework of UNAIDS, the ILO has a particular responsibility to provide information on the epidemic's impact and related trends in the world of work. ILO/AIDS is developing indicators and putting in place a database to monitor and evaluate the status and impact of workplace initiatives. The Programme is also part of the UNAIDS Country Response Information System (CRIS) and cooperates with the World Bank's Global AIDS Monitoring and Evaluation Support Team (GAMET). In parallel, the ILO has strengthened links with the World Economic Forum's Global Health Initiative, the Global Compact, the Global Business Coalition on HIV/AIDS, and Harvard University's AIDS and Enterprise initiative - plus various regional and national business coalitions - to promote and support workplace action.

Challenges and opportunities

In striving to ensure an extraordinary response to AIDS and its impact on the world of work, the ILO is still confronted with challenges in mobilizing the tripartite constituents, strengthening their capacity to sustain effective action, and mainstreaming HIV/AIDS in its own programmes and activities. Priorities for implementing the Code of Practice on HIV/AIDS in the context of the Decent Work Agenda relate to the following areas of the ILO's mandate where decent work deficits are caused or worsened by HIV/AIDS:

- Labour protection and occupational health and safety;

- Social security and income protection;

- Rights at work and gender equality;

- Labour market monitoring and employment planning;

- The transfer of skills and human resource development;

- Sector-specific activities;

- Child labour.

Building links between the workplace and community and extending initiatives into the informal economy are also priority areas for action.

Experience gained to date and lessons learned from the tripartite partners reinforce the need for the ILO to continue to advocate the importance of the workplace as a venue for awareness-raising, prevention, care, and the protection of rights. The contribution of the social partners to national efforts strenghtens the global response. The ILO Code of Practice is a powerful and adaptable instrument that has received an unprecedented level of support. It has provided the Office and the constituents with a sound basis on which to initiate and extend action in the world of work. It has also paved the way for the development of an instrument with legal force. Much interest is being expressed by constituents in all regions in the possibility of an ILO Convention on HIV/AIDS and the World of Work, the culmination of the process which began in June 2000 when the ILC unanimously adopted the Resolution on HIV/AIDS and the world of work.

CHAPTER III: BEST PRACTICE: ISSUES FOR WORKPLACE POLICIES ON HIV/AIDS

What is best practice?

'Best practice' is about establishing which ideas work in the real world and learning from the experience of their implementation. It means that lessons can be transferred so that other governments, employers and workers can be more effective in responding to issues and acting on agreed principles and standards. By providing clear information on successful experiences, best practice helps practitioners address their own particular and unique situations with the benefit of other peoples' hindsight. It also allows knowledge and understanding of what works to be refined over time (Box 1). It is not, however, about absolute statements, definitions of the ideal or 'off the peg' models – best practices need to be adapted to the specifics of each situation and owned by those who use them.

Box 1. A working definition of best practice

Best practice is a means of systematically building on effective approaches to any given issue by examining existing experiences and processes that work, understanding them in the light of agreed values, expert opinion and the best available evidence and extracting from them lessons that can be applied in the context of different social, economic and cultural settings. [2]

Best practice can refer to "*any* type of practice, small or large ... from broad policy-level activities to … the grassroots" that "actually has been tried and shown to work" [3]. This means that any company or organization which individually or jointly takes successful action towards tackling HIV/AIDS in the workplace can regard that as a best practice, provided it is consistent with accepted values and respects the latest and best available evidence. The point of a best practice is that, if properly understood and recorded, it can be shared with others and provide them with lessons about what might work for them. Over time best practices can be built upon and improved and will form a catalogue of organizational memories of what works and what doesn't and why.

Identifying best practices

Best practice is not about ideas on paper. A best practice must have actually been tested in the workplace. It is most appropriately identified at the level at which it happens and in consultation with as many of the workers and managers concerned as possible because the people directly involved are ideally placed to determine what actually works and to describe the how and why of a practice. The approach should be inclusive, although some selection is required. Key, too, is that it is made clear how 'established' the practice is and the extent to which it has been applied and evaluated.

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[2] The website of the United Kingdom Department of Trade and Industry, www.dti.gov.uk, was particularly useful in developing this definition.

[3] *Good Practices, Identification, Review, Structuring, Dissemination and Application* (IPEC, ILO, 2001).

Best practice should reflect generally accepted values and principles, such as those set out in the ILO Code of Practice, and be evidence-based with systematic evaluation built in. It should also meet locally appropriate criteria of effectiveness, efficiency and sustainability. An intervention that cannot be shown to work or that it is value for money or that needs constant external donor support to function is not best practice. It must be ethically sound, and the idea of relevance is absolutely central. Best practice cannot be imposed in all situations without reference to what is specific and different in each nation, region, organization and culture. Best practices are not prescriptions of what to do, nor are they models to copy. Above all, they do not imply that a practice is *the* best of all possible alternatives. Rather, they provide ideas and pointers. They must always be reviewed, tailored and customized to meet the circumstances in which they are to apply and then evaluated again to establish that they work. Practitioners identifying best practice should include these criteria in their deliberations, and a simple checklist should be able to guide them through this 'assessment' or 'appraisal' stage (Box 2).

Box 2. A possible checklist for identifying best practice

- Does this 'best practice' reflect generally accepted values and principles such as those in the ILO Code of Practice?
- Does it reflect expert opinions, guidelines and the best available evidence?
- Is it relevant? Does it tackle the problem faced? Does it 'fit' with the company or organization, country and culture?
- Is it effective? Does it work here?
- Is it efficient? Does it cost more than it should or is it value for money?
- Is it ethically sound? Does it meet local standards for compassion, tolerance, respect, confidentiality, empowerment and participation?
- Is it sustainable or will it need support from outside to keep going?
- Does it have systematic evaluation designed in? Can its successes be quantified?
- Has it been shown to work well at multiple sites? Has it been 'replicated'?
- Has it been positively evaluated at one site only? Was it 'successfully demonstrated'?
- Has it been shown to work and to be sustainable somewhere else or is it an innovation?

How does best practice help to tackle HIV/AIDS in the workplace?

Best practice is a relatively simple and eminently sensible tool for sharing what works. If customized and used properly, it can help companies and organizations avoid the painful and futile process of reinventing the wheel and can promote appropriate and culturally sensitive responses to HIV/AIDS at work. It has a number of overlapping, cross-cutting uses and can:

- provide inspiration and ideas for those facing new challenges and flag up important issues;

- serve as an advocacy tool, persuading key players that they have a stake in responding to HIV/AIDS at work, demonstrating the advantages of action (in terms of the bottom line or staff morale) and creating a point of entry for involving stakeholders;

- highlight opportunities for partnership and the advantages of consultation and collaboration, not just in combating HIV/AIDS but in meeting wider organizational objectives;

- allow projects to be designed in light of what worked or didn't in the past, communicating lessons and pointers (although not definitive answers) and helping to identify factors that confer success on an intervention or hinder its uptake;

- help stakeholders think through an issue or a process holistically, regardless of conventional labels, helping to trace critical pathways and mapping how different social partners might interact in responding to complex challenges;

- contribute to the public good by passing on knowledge and evidence which can feed into the review of goals and objectives.

The huge range of innovation that have already taken place in response to the scale and seriousness of HIV/AIDS means that the issues faced are rarely unique. Provided best practice is recorded and communicated, it is possible to learn from what has gone before. Whether the issue is guarding against direct, day-to-day occupational risks, or developing policy to address the structural factors that make workers more vulnerable in particular economic sectors, best practice examples will be useful. Companies and organizations do not have to work out for themselves how to channel education and information, how to provide care and treatment, or how to involve the informal sector in prevention in a wider setting. Best practice examples of peer education, of dealing with stigma, of acting through networks of contractors and of facilitating outreach to families and communities can all guide their approach.

Its strengths and its range of uses notwithstanding, best practice has limits. It follows on from the definition of goals through social dialogue - it does not determine them. It fits into a hierarchy of measures as a way of describing systematically the actions that have been taken to fulfil the objectives and targets already in place and as part of a comprehensive package of responses by social partners.

Using best practice – from understanding to action

Best practice needs to be identified (see above), and then documented and promoted. This demands the development of agreed approaches to classifying and indexing experience, and of standard formats that will capture case studies and benchmarks and help disseminate them. The ultimate goal of this investment is to help develop responses to HIV/AIDS at work. This does not mean 'pushing' any given model as if it were a blueprint to be copied, but fostering an approach to designing and delivering initiatives for action that makes the most of past experience.

Learning best practice lessons

Experience of best practice in other sectors and settings has a lot to teach practitioners tackling HIV/AIDS (Box 3). It demonstrates that success is achieved by involving the staff concerned as early as possible, consulting from the outset on what they feel fits the circumstances they operate in and ensuring that they trust the source of best practice recommendations. It also means sustained efforts to involve them in and give them control over the development of the best practice and the way it is customized for use. This helps gain workers' commitment and increases identification, motivation and satisfaction, all of which promote success. It also begins to establish a culture of sharing which, in turn, will support the uptake of the new practice and help change to be embedded in the company or organization.

Box 3. Factors that support the implementation of best practice

- **Early consultation:** involving the workforce from the outset
- **Credible 'evidence':** agreeing with staff the basis and rationale for change
- **Time:** allowing workers time to develop best practice and for training
- **Leadership:** top-level commitment to launching and sustaining best practice
- **Internal dissemination**: providing clear explanations and sharing knowledge face-to-face
- **Ongoing participation:** allowing workers to meet, discuss and control development
- **Cultural change:** team-building and efforts to share responsibility and sustain commitment
- **Staff motivation:** addressing and supporting the satisfaction and confidence of staff
- **Recognising achievements:** acknowledging individual and group inputs
- **Feedback:** providing ongoing information and sharing evaluation. [4]

Engaging workers as real stakeholders requires time to be set aside for their inputs and suitable training, guidance and internal dissemination. Face-to-face contact is particularly important when situations are complex, as is some kind of continuing feedback (whether top-down, bottom-up or through peer assessment) which allows for new knowledge to be shared and for individual efforts to be recognized. These steps help to sustain behaviour change and effective outcomes.

Another clear and fundamental lesson is the importance of leadership and top-level commitment in launching and sustaining best practice based improvements. This has consistently been shown to be key and must inform thinking on best practice in tackling HIV/AIDS at work.

Applying best practice lessons

Initial considerations for companies and organizations hoping to improve their practice on HIV/AIDS will include whether existing examples of best practice can help them confront particular concerns and whether a given model or approach is right for them. There are, of course, a variety of ways to review this. One approach would be to work systematically through a series of questions starting with whether or not the case study is pertinent to the situation at hand and if it, in general, conforms to the ILO Code of Practice and values. It would also be worth checking whether the practice is evidence-based, if new information or values have emerged since the case was generated and if any evaluations have been carried out of its effectiveness, efficiency and sustainability. These steps overlap with those to identify a best practice in the first place (Box 2), but the decision on the feasibility of replicating it must include quite different elements.

The next stage would be to review whether or not the practice could be implemented successfully. Companies or organizations need to identify the cost of the new practice and the demands it would be likely to make on processes, workers and managers and be sure that these could be met. They also need to check that it will not conflict with national or regional legislation and that an adequate policy framework to support the practice is in place or could be created. If using the best practice seems appropriate, feasible and

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[4] Drawn from several sources including Dixon, N. *The Organizational Learning Cycle: How we can learn collectively* (Gower, Hampshire, England 1999); Nahapiet, J; and Ghosal, S. *Social Capital, Intellectual Capital and the Organizational Advantage* (Templeton Working Paper, Oxford, England 1998); Schein, E. *Organizational Culture and Leadership* (Jossey-Bass, San Francisco, USA 1992); and Nystrom, H. 'Organizational Innovation' in *Innovation and Creativity at Work, Psychological and Organizational Strategies*, West, M. and Farr, J. eds. (Wiley, Chichester, England 1990)

sustainable, then the capacity and other resources that are needed to make it work in practice must be considered.

This means identifying internal obstacles to success, including any economic constraints and the institutional or process elements that tend to block change. Involving all stakeholders as early as possible (including in the initial review stages) has been shown to be key. If there is no established workers' forum, however, or if shift patterns preclude staff meetings, then participation may be inhibited. There are, of course, steps that can address obstacles, including confidence and capacity-building initiatives and training. Facilitating factors – which might be as varied as existing non-discrimination policy, the falling price of ARVs, or even individuals who can effectively mobilize their colleagues - encourage the acceptance of change and need to be harnessed and built into best practice plans.

It is also important to think about how monitoring and evaluation will be handled. If there is no obvious way of instituting a straightforward, structured and systematic review of the success or otherwise of the best practice, this may suggest it is not as workable as it seems. It may prove helpful to develop indicators of success and to draft an evaluation framework at the outset.

Once it is clear that a best practice is relevant and will be useful to the company or organization, consideration should turn to customizing it to meet specific, local needs. Customization means more than adapting the details to the particulars in the company or organization. It involves tailoring the whole development process leading to implementation to reflect conditions and to involve stakeholders 'on the ground'. A hybrid list derived from experiences in different sectors provides a provisional checklist of the steps a company or organization may want to consider (Box 5).

Box 4. Possible steps in customizing a best practice

1. **Specify problem and identify possible solutions:** Map the issues involved and 'maturity' of the epidemic and organization, and review and learn from relevant best practices.
2. **Consult:** Involve all stakeholders - managers, unions etc. and talk to them. Begin to share ownership widely from the outset.
3. **Build partnerships and alliances:** Work with social partners to agree on the practice. Identify facilitating factors and build them into plans.
4. **Address leadership:** Ensure visible top-level commitment and links to wider values and culture
5. **Assess risks:** Review and address sensitivities that will affect uptake and potential blocks to progress (including stigma). Examine the legal and policy framework and lobby for changes needed.
6. **Establish policy:** Put in place clear and appropriate policy (that is, ethical and in line with the ILO Code of Practice). Communicate it widely and effectively, ideally transferring ownership.
7. **Include education:** Build education and information into the practice as a way of minimising stigma and fostering prevention.
8. **Launch the practice:** Use high-profile activity to motivate and combat stigma
9. **Invest in and maintain progress:** Make sure the project is appropriately funded and supported. Employ a programme manager if appropriate. Invest in the tools needed.
10. **Monitor and evaluate:** Continually review progress in management and union meetings to keep the practice on the agenda. Plan for evaluation and feedback. Report back to stakeholders.

Finally, experience demonstrates that sustaining interest in the practice helps maintain achievements. This means investing in staff and tools, keeping progress on the agenda and ensuring that evaluation is fed back into planning and management and to all the staff involved.

CHAPTER IV: IMPLEMENTING BEST PRACTICE
– THE LESSONS OF EXPERIENCE

The reality of HIV/AIDS is enormously complex. Responding to the challenges posed requires a concerted and integrated series of reactions ranged along the continuum of prevention, treatment, care and support, based on the protection of rights. It also demands that the continuum of individual, family, community, workplace and economy be fully reflected in designing and delivering initiatives to tackle HIV/AIDS through workplace action.

Box 1. HIV/AIDS in context – locating responses on more than one continuum

- Protection of rights ↔ Prevention ↔ Practical support for behaviour change ↔ Treatment ↔ Care and support
- Individual ↔ Family ↔ Community ↔ Government
- Informal economy ↔ Formal economy
- Branch/Department ↔ Company/Organization ↔ Industry/Sector
- Local ↔ Regional ↔ National ↔ International
- Home care ↔ Community care ↔ Primary care ↔ Workplace programmes ↔ Secondary health care ↔ Tertiary health care ↔ Peer support

No rigid boundaries can separate innovations in treatment from the whole process of prevention, or confine successful models of communication to the formal rather than the informal sector of economies. Education and training, non-discriminatory policies, sensitive and confidential testing, and the availability of more affordable and manageable treatment, all combine to support prevention strategies and to ensure the provision of appropriate care and support. Consultation, participation, trust and leadership are all as central to successful collaboration at a national and tripartite level as they are in delivering a single project that tries to reach out to sex workers in a particular locality.

This chapter reviews best practice lessons being generated by practical experience in the workplace and beyond, looking across sectors and at all stages of the process. For the sake of convenience it groups case studies and lessons, albeit loosely, despite the fact that each case study is multi-dimensional and the inter-connections between each should be recognized. There are five sections, followed by a summary of cross-cutting issues and lessons:

1. Policy and legal frameworks

2. Workplace policies and programmes: prevention

3. Workplace policies and programmes: care, support and treatment

4. Links beyond the formal workplace

5. Knowledge and evidence: data analysis, monitoring and feedback

The chapter examines just a few of the best practice examples generated in the world of work for each of these themes. The case studies selected reflect the diversity of workplace settings and their variation in size, structure, organizational and institutional capacity, finances, ties to community, and culture. It flags learning points and highlights the links between thematic areas, between social partners, the general rights and

responsibilities of governments, employers and workers and their respective organizations and with the key principles set out in the ILO Code of Practice.

Section 1. Policy and legal frameworks

Formally recognizing and structuring responses to HIV/AIDS is key to mobilizing societies and to moving from innovative individual efforts to a concerted response to this enormous global threat. Frameworks for action in the workplace are central in coordinating this response. These frameworks can be enormously varied and range from statements at the international level, like the UNGASS Declaration of Commitment on HIV/AIDS, through detailed agreements in sectors like mining which involve companies and unions, to legal provision protecting the rights of workers affected by HIV/AIDS. Reviewing the experience at all levels highlights the evidence of what works and what does not, and generates lessons that can support other initiatives.

A. Policy framework – government-led national response

The following example shows how extensive and effective a response at the national level can be, and emphasizes the key role of government in establishing an environment that is conducive to multisectoral action, including the world of work. The role of the Office of the President in Botswana, and of the Philippines legislature in passing the AIDS Prevention and Control Act (1998), are further examples of national policy promoting a workplace response to HIV/AIDS. In Barbados, the national response to HIV/AIDS has been coordinated through the office of the Prime Minister since 2000, and the Ministry of Labour has been identified as a key line ministry. The *Barbados Policy on HIV/AIDS in the Workplace* was developed in consultation with the social partners and embraces the philosophy of respect and equal treatment for infected workers. It is complemented by a protocol on HIV/AIDS, based on the ILO Code of Practice.

Brazil's National STD/AIDS Programme: The Government of Brazil has exercised leadership at the national level through its recognition of HIV/AIDS as an issue that affects all areas of Brazilian life, including its economy and labour markets. It has introduced a comprehensive, integrated programme providing for a package of prevention, treatment, care and support. This programme has provided an essential framework for Brazilian employers, such as Volkswagen do Brazil and VARIG, to respond effectively. It promotes education, training and communication through a wide range of media; provides ARVs for those who cannot afford treatment, negotiating special prices or producing affordable generics; and decentralizes management and service delivery to involve partners like Social Service Industry of Brazil. It addresses discrimination; targets interventions for the vulnerable; and works with NGOs and PLWHA, all within a rights-based approach.

Lessons include:

- Regarding HIV/AIDS as above party politics and establishing broad, crosscutting support for government initiatives in the area can ensure long-term policy coherence.

- Working with different levels of government, regional and local, ensures that recognition of a national issue is translated into action throughout the system.

- Decentralizing authority and accountability to the 'lowest' appropriate level builds a sense of local ownership, facilitates implementation and enhances sustainability.

- Acknowledging the role of government as an employer as well as a policy-maker maximizes opportunities to protect workers and to promote best practice amongst those delivering services to PLWHA.

- Producing generic drugs, and taking an active role in debates on international trade agreements, has helped in the provision of affordable ARVs for PLWHA in Brazil and globally.

B. Legal framework

Legislation can play an important role in underpinning government policy and in supporting national, sectoral or workplace agreements. It can be used to protect the rights of workers affected by HIV/AIDS, ensure workplace prevention as well as social protection. Different legal initiatives can be used to help fight the epidemic in the world of work including specific HIV laws, labour legislation, disability laws, equity laws and social protection laws. The use of one instrument does not preclude the use of other instruments; rather, the opposite is often true. A multifaceted approach ensures that every issue is covered under the respectively relevant instrument. Legislation is particularly crucial in prohibiting discrimination on the grounds of (real or perceived) HIV status, banning mandatory testing of workers and job applicants, and protecting the confidentiality of HIV-related data. The protection of human rights is essential, not only to preserve the human dignity of people affected by HIV/AIDS, but also because the violation of those rights are major blocks to HIV/AIDS prevention.

i) Example of specific law on HIV/AIDS

Specific HIV/AIDS laws have the advantage of allowing a comprehensive and coordinated approach. The fact that most of the provisions covering AIDS issues are included in the same document can make it easier to understand the protection provided by law. Furthermore, HIVAIDS laws are often more detailed and thus can prevent definitions of fundamental issues rather than being left to the interpretation of tribunals.

Cambodia, Law on the prevention and control of HIV/AIDS, 2002: This law involved consultation before implementation, and covers testing, confidentiality, non-discrimination and education and guarantees access to free health services. It specifies the need to be gender sensitive and establishes fines and custodial sentences for breaking the law.

Lessons include:

- Consulting with a full range of stakeholders before legislation is passed strengthens it and encourages compliance. The authority and impact of legal provisions depends significantly on the culture in the country concerned.

- Including budget appropriation in the legislative framework can help ensure funds for implementation.

- Overly harsh punishment may be counterproductive, making it more likely that breaches of the law are overlooked by enforcement agencies.

ii) Example of adapted labour legislation

Labour law is widely used both to regulate employer-employee relationships and to establish the framework for workers and employers to regulate their relationship through

collective patterns of interaction, such as collective bargaining. It also represents a clear reminder and guarantee of fundamental principles and rights at work.

> **Bahamas, Employment Act No. 27, 2001:** was developed in full consultation with tripartite partners. It contains a very comprehensive provision prohibiting discrimination against employees or job applicants on the grounds of HIV/AIDS and bans HIV testing without consent. In case of unfair dismissal, the person can be reinstated or obtain a compensation award.

Lessons include:

- Integrating provisions prohibiting HIV discrimination and screening into labour legislation can help protect the rights of HIV-positive persons at work, an environment where much discrimination occurs.

- Consulting on legislation with tripartite partners before it is passed strengthens it and encourages compliance.

- Protection against unfair dismissal can help people living with HIV to work as long as medically fit.

iii) The use of disability legislation

Many disability laws aim at protecting people with disability against discrimination and integrating them as much as possible into society. To ensure equal treatment, these laws often contain detailed provisions on the obligation of employers to make reasonable accommodation to help disabled persons remain in work as long as possible. Therefore these laws can be very useful to provide protection for persons who have started to develop HIV-related symptoms but are still fit for work. However, the protection of asymptomatic HIV-positive persons is uncertain. It depends of the definition of disability given in the laws and its interpretation by the tribunals.

> **China, Hong Kong Disability Discrimination Ordinance, 1995:** includes asymptomatic HIV and protects all the associates of people living with HIV/AIDS. It makes it the employer's responsibility to ensure that the workplace is free of harassment and to provide any reasonable services or facilities to help the employee perform the job. It also provides guidance on implementation, as well as providing for a tribunal and assistance in appealing discrimination.

Lessons include:

- It is important that legislation covers 'healthy' HIV-positive workers, particularly as ARVs become increasingly available and workers stay symptom-free for longer

- Making employers responsible for the way employees treat their HIV-positive colleagues creates real incentives for companies and organizations to establish a non-discriminatory working environment.

- The obligation for employers to make reasonable accommodations to help the employee perform the job, helps positive workers to remain in work as long as possible.

All the above initiatives, and many other examples of best practice, implicitly recognize that "HIV/AIDS is a workplace issue and should be treated like any other serious illness/condition in the workplace" (ILO Code of Practice). This is not a neutral statement. It insists that the world of work is a crucial starting point in tackling HIV/AIDS and that governments, employers and workers should not permit HIV status being used as an excuse to isolate or stigmatize those affected.

C. Tripartite framework and social dialogue

Responding to HIV/AIDS means going beyond traditional divisions of responsibility to involve all social partners in national, sector-wide and workplace agreements. It means building on tripartite links to create a wider social dialogue involving NGOs, international agencies, representatives of PLWHA and other stakeholders. The following three cases are not the only examples of social dialogue – on the contrary, this has been a criterion of selection throughout – but they encourage us to look specifically at collaborative processes and structures.

i) Sectoral agreement between multinational and trade unions

Because of the economic threat posed by the epidemic, large, multinational corporations have often been at the forefront of workplace responses to HIV/AIDS. Trade unions, particularly in South Africa, have been all too aware of the impact of HIV/AIDS on their members. This case study illustrates the extent to which these groups can define common ground and work together to establish a framework, which is in the common interest.

> **Anglo Gold South Africa, and the NUM, MWU-S, NETU, SAEWA, UASA:** Anglo Gold has reached a comprehensive collective agreement of a framework for action with five unions covering management of HIV/AIDS at work. It builds on best practice, draws on international codes, and creates an ongoing partnership. Placing the issue in the collective bargaining sphere is appropriate in some settings but not others, and is not the only way of formulating workplace policies.

Messages that can inform new initiatives include:

- Explicitly defining the aims, rights and responsibilities of different parties allows partners to be clear about where they stand in relation to each other and their commitments.

- Including specific references to best practice and quality standards allows for effective monitoring of progress and review of ethical standards.

- Integrating commitments on HIV/AIDS into the arena covered by collective bargaining does not mean that funds for prevention and care should be seen as interchangeable or 'in competition' with funds for pay or other remuneration or benefits.

- Extending partnerships between social partners to include NGOs and technical experts strengthens credibility and can be key in extending initiatives to the community.

ii) Employer and worker organizations at national level

Action may begin at the level of the workplace or of the company. It may also require a national grouping of unions or employers to come together to prompt action. Neither

approach precludes the other, but where top-level agreements between social partners have been made they have often galvanized responses at the level of the workplace. The Federation of Kenyan Employers, the Trade Union Congress of the Philippines, and the Thailand Business Coalition on AIDS provide further notable examples of the mobilization of national memberships.

> **National Confederation of Eritrean Workers and the Employer's Federation of Employers:** The workers' and employers' organizations of Eritrea have gone beyond joint discussions and joint statements to merge their national AIDS committees. This creates a long-term or 'standing' link between the two and ensures ongoing coordination of initiatives on HIV/AIDS.

Lessons include:

- It can sometimes be easier for employers and workers to find common ground at a national rather than a local level, and identify areas of mutual interest outside the dynamics of specific workplaces.

- Merging institutional structures forces the kind of proximity and communication that have been shown to confer success on team performance.

- Moving from separate to combined structures involves sensitivity and concessions as the number of 'roles' inevitably reduces, leaving some key figures without a formal position.

iii) Tackling stigma and discrimination – building trust between the partners

The stigma and discrimination around HIV/AIDS are not only contrary to human rights but represent a major obstacle to successful workplace programmes. The fear of rejection, shame and discrimination undermines efforts to promote behaviour change, inhibits people from using VCT services or obtaining treatment, and prevents their seeking care for opportunistic infections. The non-discrimination policies noted above may help to create a non-judgemental and supportive culture, but extra steps are needed to make workers secure enough to address the issue.

> **Illovo Sugar, South Africa:** Illovo Sugar has a combined prevention and care programme, which has involved a multi-stakeholder, multi-disciplinary approach. The company worked with unions, management, occupational health services and medical and academic experts to ensure that the programme was properly embedded in the organizational culture and could inspire trust. It provides access to condoms, educational activities, and care and support.

Lessons include:

- Involving stakeholders, and particularly unions, as early as possible helps build trust.

- A committee that actively involves all parties sends a clear signal that the initiatives undertaken are trustworthy and intended to support all workers.

- It is not necessary to create new structures where suitable vehicles already exist (e.g. a health and safety committee) as long as commitment to the new agenda is genuine.

- Making explicit commitments to confidentiality from the outset by the committee is important.

- Mass meetings that directly involve workers supplement the union's role and provide an additional route for information and a public statement of commitment and openness.

Section 2. Workplace policies and programmes: prevention

Prevention is of fundamental importance. It demands a combination of strategies, not least the provision of information and education so that people have the knowledge of how to protect themselves. Knowledge however, is not enough. There is powerful evidence that what people know in theory does not always determine how they behave in practice. They need support to really change their behaviour, both as individuals and in the context of the communities and societies of which they are members.

It is essential that issues such as stigma and discrimination be addressed if people are to avail themselves of the help available, and to protect themselves and their families. The workplace is doubly important in that policies can reduce discrimination, and at the same time be formative in changing the norms of group behaviour. The latter is critical in that evidence shows that behaviour change is hard to achieve except under conditions where group behaviour and norms are also modified appropriately.

A. Education and information

All social partners have a responsibility for education. The ILO Code, for example, charges governments with prevention and health promotion, employers and workers' representatives with information, education, and training. All are expected to identify needs and deliver responses. Education delivered by peers has in many settings been found to have more impact than more formal and hierarchical methods. Evidence about education programmes, particularly those using peer educators, is plentiful, providing ample best practice case studies that can be adapted to fit new national and institutional settings, avoiding the need to reinvent the wheel.

i) Education and information with the involvement of peer educators

> **PHILACOR, Philippines:** The Philacor Corporation works with trade unions to address HIV/AIDS at work and within the framework of the national AIDS Prevention and Control Act (1998). It has developed a very specific, tailored prevention and peer education programme that reflects the fact that 96% of staff are male. It trains trainers from amongst its staff team, uses specialized seminars and training, and also incorporates issues into existing programmes like orientation for all new employees.

Lessons include:

- The selection of peer educators should reflect their credibility with colleagues and their commitment to confidentiality and best practice, as well as their communication skills.

- Integrating training on HIV/AIDS policy into routine and on-entry training for new staff minimizes stigma and builds an accepting and non-discriminatory culture.

- Delivering training during work time makes messages more palatable.

- Making sure education and related campaigns are based on accurate and up-to-date information is important if credibility is to be sustained.

- Designing appropriate education and training materials is easier with a homogenous target group. Materials should be gender-sensitive, whether the group is male or female.

ii) Education and information – peer educators in informal settings

The informal economy accounts for high levels of employment, and in many high-incidence countries the vast majority of workers pursue informal economic activities. These workers often live at the margins of poverty, have little education and little capacity to cope with illness or the illness of a family member. Women in particular have little control over their own lives and are especially susceptible to HIV infection due to social, cultural and economic factors. Typically, working conditions are poor, wages are low and unstable, and little health care or insurance is provided. In addition, informal economy workers have almost no formal representation and very few organizations are available to voice their concerns.

> **Pilot peer education amongst garage-owners and hairdressers, Ghana:** A two-stage pilot project identified and trained peer educators to address HIV/AIDS amongst garage-owners, hairdressers and their apprentices in a rural and an urban setting. Educators were selected on the basis of communication skills and attitude and in consultation with the leadership of the groups involved. They were trained to work with their peers using a range of techniques.

Lessons include:

- Building on existing informal sector organizations helps ensure the 'right' peer educators are selected and the 'right' materials are developed. It confers credibility and gives access to workers.

- Not all peer educators should be sub-sector or community leaders. Younger workers and apprentices will be most effective at reaching their contemporaries.

- Time is a major constraint for workers in the informal sector and this needs to be taken into consideration in planning training activities and in making demands on peer educators.

- Small amounts of funding can enable informal sector workers to spend time on peer education, including outreach work beyond their immediate circle of contacts.

- Activities in the informal economy must consider the context, the impact of poverty and the lack of health services. Including business skills in training programmes and linking projects to micro-finance schemes, can help attract interest and address wider issues such as employment creation, especially for youth.

iii) Education and information – peer educators and the community

Peer education is effective not only at work but in moving beyond the confines of the workplace to tackle risks that workers face in their own communities. This is particularly relevant in sectors where single men are concentrated in isolation from their families.

Geita Gold Mine Ltd. (GGML), Tanzania: GGML has had a workplace prevention programme that includes peer education for its own personnel and as part of a community outreach initiative. Volunteer educators reach sex workers and cover life-skills training and advocacy, linking education to a package of services including care for TB and malaria, in partnership with local government. The company has trained managers and involved a local steering committee to ensure commitment.

Lessons include:

- Delivering targeted interventions to susceptible populations through a mixture of relevant (informal) settings, like fod and recreation facilities, helps reach vulnerable groups.

- Tailoring training to use appropriate language and a variety of media or techniques and to reflect the knowledge, culture and sensitivities of the target audience is crucial.

- Selecting peer educators with an appropriate background confers credibility on them.

- Integrating efforts to address gender issues and vulnerability factors with wider health promotion and community campaigns reinforces messages.

- Linking peer education to a wide range of issues, including TB, malaria, water, sanitation, and sexual and reproductive health, increases the effectiveness of prevention activities.

- Training for top management is a successful way of building commitment, and of signalling to the wider community the importance of the initiative.

B. Strengthening behaviour change

HIV transmission is preventable but this depends not just on an understanding of the processes of HIV transmission but also on individual action to prevent infection. There are many reasons why people do not take action to protect themselves and their families. As noted above, the scope for individual action is often constrained by social and other conditions. Workplace initiatives can support and empower individuals to make changes. Participatory education programmes, and practical supportive measures, can help people assess their risk, become aware of their attitudes, and change their behaviour.

i) Behaviour change – personal risk assessment and change strategies

BMW South Africa: BMW has a comprehensive programme to tackle HIV/AIDS, based on a policy agreed with the unions and supported at the highest level of management. It involves a range of elements, including the provision of Highly Active Antiretroviral Treatment (HAART). It also places considerable emphasis on prevention using a comprehensive communications strategy and various awareness-raising formats (workshops, events, theatre). BMW facilitates personal risk assessment for staff, particularly women, which empowers them by allowing them to review their own behaviour and exposure to risk, and to identify the elements they may want to change, as well as the blocks to and enablers of change.

Lessons include:

- Working in women (or men) only groups helps individuals express themselves with confidence and learn from each other.

- Personal risk assessments should include practical sessions addressing the reality of risk and issues like negotiating condom use, discussing HIV status with a partner and so on.

- Tools like role-play that allow people to 'practice' how to handle difficult situations are useful ways of allowing people to rehearse how they will respond to sensitive situations.

- Peer educators can facilitate risk assessment but need to be supported themselves, ideally through regular support sessions and through additional training.

- Trust is crucial to success and prioritizing privacy and confidentiality builds confidence.

- Providing HAART creates a significant incentive for VCT uptake and sustaining safer sexual behaviour.

ii) Behaviour change – self-help groups and partnerships for change

South African Clothing and Textile Workers Union: SACTWU has its own HIV policy and has trained shop stewards to be aware of the issues and to implement policy appropriately. It provides ARV treatment to prevent mother-to-child transmission (MTCT) and is developing policy for home care and orphan support. It works with employers and is actively involved in a series of partnerships with not-for-profit and non-governmental organizations. It collaborates with education specialists in designing and delivering training, with health NGOs to see that TB is addressed through the DOTS initiative, and supports the Treatment Action Campaign, which is lobbying for national ARV provision. Its support to community, workplace and campaigning groups facilitates self-help initiatives by PLWHA, which empower individuals and promote behaviour change.

Messages generated by experience with self-help strategies include:

- Those affected by HIV/AIDS or with a common interest can be highly motivated. Mobilizing them through self-help groups is effective in sponsoring behaviour change.

- Self-help groups are often most effective when focused on issues on which members have a direct stake and which play to their strengths.

- Incorporating self-help groups into multisectoral coalitions ensures that partnerships are informed by stakeholders' views and understand what is involved in changing behaviour.

- A forum for sharing the 'big picture' will help ensure that all players (not just those at the 'centre of the web') can see how they fit in and can pool relevant information.

iii) Behaviour change – condom use

Migrant female factory workers, Thailand: An initiative was designed to address the concerns of single, migrant women working in factories in North Thailand. These women believed that HIV/AIDS was a threat only to sex workers and was not relevant to the 'romantic' kind of relationships in which they were involved. They also felt that learning about prevention would damage their own reputations and create the impression that they were in some way 'immoral'. Peer educators worked to transmit knowledge about infection, to distribute condoms and also to help the women develop skills in negotiating condom use.

Lessons include:

- Condom distribution benefits from being set in the context of a communication and education programme.

- Any intervention to encourage condom use must be based on an in-depth understanding of the cultural perceptions around condoms.

- Distribution of condoms must be accompanied by efforts to help individuals negotiate their use if the programme is to be effective.

- Providing condoms 'on site' can ensure they are available to migrant/mobile workers who may not be registered with health care services or have other entry points to formal systems[5].

iv) Behaviour change – safe use of needles at work

Much of the focus on behaviour change has been on safe sex and harm-reduction in intravenous drug use but it is also an issue of direct relevance to safety in the workplace. The ILO Code of Practice calls for a healthy work environment and includes in this a supportive setting in terms of physical and mental health and adaptation of work to the needs of PLWHA. It also demands that Universal Precautions are observed in workplaces where workers come into contact with human blood and body fluids.

The Democratic Nursing Organisation South Africa (DNO-SA): In seeking to promote a healthy working environment, the DNO-SA has highlighted the employers' responsibilities for ensuring that people change the way they work in contact with blood, and has actively sought to promote change around the handling of sharps. It has also made the links with prevention and non-discrimination.

Lessons include:

- Introducing messages about safe working practices as early as possible in training helps change cultures and habits.

- Workers need time and resources if they are to change established practices and follow new safety guidelines.

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[5] Reports from South Africa suggest that 'illegal' migrant workers are afraid to take advantage of condom distribution through the health system, as they fear being identified and deported.

- Any training or demands for behaviour change which touch on the risk of HIV/AIDS may provoke unexpected resistance because of stigma.

- Any measures to encourage uptake of Universal Precautions is an opportunity to widen discussion and tackle broader prevention issues.

C. HIV prevention and gender

Gender is a factor in the probability of becoming infected if exposed to the virus (i.e. physiological differences) and in determining the ability to control behaviours which exposes people to the risk of infection. Women are particularly vulnerable on both counts: they face multiple risk factors, including a lack of economic power and a lower social status, which translates into the inability to negotiate the terms of sexual relationships. However, men also face gender-specific risk factors, some of them related to occupational requirements, such as the mobility expected of transport workers. There is thus a need for gender-sensitive approaches to all aspects of prevention.

i) The gender dimension – making space for men and women

> **Stepping Stones, Uganda:** Stepping Stones is an educational programme and a series of tools developed by Action Aid Uganda which works with age and gender-separated groups in order to give people "private time and space with their peers to explore their own needs and concerns". Stepping Stones is based on the analysis of experience and includes a number of sessions and participatory techniques based on very specific cultural understanding, which are seen as precursors to effective dialogue between men and women.

Lessons include:

- Involving one partner only is ineffective, but that working with partners separately before bringing them together can significantly enhance the dialogue that takes place.

- Educating men about sexual and reproductive health allows them to support their partners better and to be more effective in addressing their own needs.

- Peers are the main source of information about sexual matters, which amplifies the benefits of holding separate sessions for men and women.

- Abstinence is not a useful 'prevention' strategy or message in societies that value fertility, and where there is a tradition of monogamy only amongst women.

ii) The gender dimension – men's concerns

> **Ho Chi Minh City Labour Union, Vietnam:** The Ho Chi Minh City Labour Union, together with the Vietnamese National University, the National AIDS Committee, the Horizons Programme and the Population Council, targeted male workers in the construction industry who were highly mobile and deemed to be at particular risk of HIV infection. The initial phase, using female student social workers as health communicators and to distribute condoms, proved to be inappropriate and unsustainable. A revised approach proved to be more cost-effective.

Lessons include:

- Gender sensibilities need to be taken into consideration in designing interventions.

- 'Same-gender' peer-educators are more effective than 'expert' staff in many communication tasks, particularly where the issues being raised are sensitive, and that a match between educators and workers is more appropriate.

- 'Same-gender' peer-educators are a more sustainable source of education and condom-distribution because they can be expected to stay in touch with the target population for long enough to establish trust and to give a return on the investment in their training.

- Mobile workers can be effectively targeted at work, using participatory techniques.

iv) The gender dimension – women's concerns

> **Tata Iron and Steel Co. Ltd., India:** Tata Iron and Steel is a company with a wider involvement in social responsibility. It tackles issues of urban and rural deprivation and has now included HIV/AIDS on its agenda. It has designed an approach to development work with women, which uses a 'Ladies Core Group' to carry out activities in support of family clinics and on HIV awareness. The Group is made up of the wives of local chief executive officers who are seen as having a greater ability to reach the marginalized, to engage in dialogue and to overcome inhibitions because, as women, they can access the target group.

Lessons include:

- Women will respond better to awareness-raising by other women, particularly in societies where the gender 'gap' is marked.

- Volunteers can play a useful role in prevention activities.

- Differences in status and caste ought to be considered in designing interventions.

All the case studies described match the ILO Code of Practice's understanding that HIV infection is preventable, particularly if culturally and gender-sensitive strategies are combined to change attitudes and behaviour. The evidence of successful action bears out the belief that social partners working together are more effective in combination than in isolation. Furthermore, the programme showed that action in the workplace helps to create an environment for sustained behaviour change.

Section 3: Workplace policies and programmes: care, support and treatment

The workplace is a logical entry point for care and support. People living with HIV/AIDS, when they are appropriately supported, can continue to have active working lives, to contribute to the national economy and to support themselves, their families and their communities. Occupational health services (particularly in countries with a poor public health infrastructure) provide a vehicle for VCT, for the management of opportunistic infections and for ensuring compliance with HIV/AIDS treatment regimes. The workplace is also a useful setting for implementing social security and health insurance schemes. Providing care, support and treatment helps alleviate stigma and promote care-seeking behaviour, and can be targeted at vulnerable groups to address issues such as gender inequality.

A. Stigma and discrimination – confidentiality for prevention and care

Confidentiality policies are widespread, and in line with the ILO Code they tend to protect job applicants and workers, and all personal data relating to a worker's HIV status. These issues are more complex in an informal setting where self-employment and casual employment are commonplace: records will rarely be held, but personal confidences may be made and should still be bound by rules of confidentiality. The most useful learning points now tend to revolve around how to ensure employees feel that their confidentiality will be respected in practice and not just on paper.

De Beers, South Africa: De Beers provides HAART to workers and their partners as part of their comprehensive Wellness Programmes. Making treatment available has increased the uptake of VCT but misconceptions about HIV/AIDS and fears about the company's motives in offering testing initially prevented the expansion of the programme. Workers receiving HAART also had concerns that complying with the rigorous treatment schedule would make it obvious to their colleagues that they were HIV-positive. This interfered with effective treatment, and has raised the spectre of growing drug resistance due to non-compliance. To offset these concerns, the company made confidentiality a priority.

Lessons:

- Confidentiality policies must be clear and widely communicated in appropriate language.

- Adapting facilities within the company to allow for private discussions can help instil confidence (a finding borne out at BMW – see earlier case study).

- Providing medical services through a network of practitioners outside the company can help workers feel that their privacy and confidentiality are assured. It can also help encourage compliance in those who have left the company due to ill health or retirement.

Additional activities are needed to convince workers that they should inform their partner/s so that they, too, can be included in testing and treatment programmes.

B. Voluntary counselling and testing

The ILO Code is clear that HIV/AIDS screening should never be required of workers or job applicants, and should not be a condition for contract-renewal. On the other hand, voluntary testing and counselling (VCT) is a key element in HIV prevention and is, as such, encouraged by many workplace programmes. Testing is, in fact, often the entry point for the provision of ARV and other therapies. Policy to protect workers from unwarranted testing is now widespread, but there is still much to learn from best practice in promoting VCT uptake.

i) VCT – increasing uptake of services

Eskom, South Africa: Eskom has a long-standing HIV/AIDS programme but found that stigma was having a major impact on the uptake of VCT. The company used a detailed workplace study to understand workers' responses and to plan adjustments to their use of peer educators and community outreach initiatives to allay the fears.

Lessons include:

- Plans to introduce testing must be mindful of the fact that a positive diagnosis means people acknowledging that they may have a fatal infection - an extremely painful realization.

- Linking VCT to the provision of ARVs or HAART is a major incentive for testing, but accepting treatment may open an individual and family to discrimination and stigma.

- Addressing workplace discrimination is not enough, as workers may fear stigma more than losing their jobs and may face secondary stigma and discrimination at home and in the community. Outreach work in communities will, therefore, enhance the success of testing at work.

- Women face stigma even more than men, so efforts to increase VCT uptake should pay particular attention to addressing their specific concerns.

- Despite their complexity, VCT programmes are undoubtedly effective in terms of budgetary and other savings for enterprises.

ii) VCT and preventing mother-to-child transmission

> **Chevron, Nigeria:** Chevron provides ARVs (which prevent a significant proportion of mother-to-child transmission (MTCT)) to all pregnant women whether they are workers or the spouses of workers. VCT is a preliminary to this kind of prophylactic treatment and is now all but universal for pregnant women. However, the uptake of VCT for the remainder of staff is only 1%. Some clear messages come out of this programme, although the appropriate response is less clear.

Lessons include:

- Pregnant women in this case study clearly prioritize the health of their unborn children above the effects of stigma, secondary stigma, and discrimination on themselves.

- The fact that pregnant women are willing to be tested to avert MTCT does not imply that women in general and other male workers are likewise prepared to be tested.

- The internal marketing of VCT to pregnant women by Chevron is demonstrably successful. But the 'selling' of testing to the wider workforce is apparently much less compelling.

- Despite low uptake of VCT, wider initiatives to provide education and encourage condom use can be very successful, as evinced by falling rates of STIs at Chevron.

Testing, whether linked to the provision of ARVs or not, may generate problems, causing fear and exposing people to stigma and discrimination. Even where treatment is available (and despite its significant benefits) people are often reluctant to have their status confirmed, unless they are pregnant and understand that doing so will protect their child. Reducing stigma is important, therefore, for expanding VCT (as is improving communication about what VCT entails).

C. Treatment possibilities at the workplace

Treatment through occupational health services at the workplace includes programmes to provide ARVs and HAART, but it is not limited to antiretroviral therapy. The treatment of opportunistic infections, such as TB, and of STIs and other concurrent infections is also important. Similarly, the workplace can provide the setting for ensuring good nutrition which delays HIV progression, for delivering pain control and palliative care, and, when needed, for offering the psychosocial support that helps compliance with treatment. One of the objectives of activities under resource-constrained conditions is to ensure as far as possible that PLWHA are assisted in living positively.

i) Treatment – responding to opportunistic infections through partnership

> **Pfizer – South Africa Alliance** (Diflucan ® Partnership): Pfizer and the South African Ministry of Health have mounted a public-private partnership[1] to address life-threatening, opportunistic fungal infections. The company donates treatment and supports training initiatives to ensure its proper use while the Ministry maintains the infrastructure for distribution and delivery. The experience provides lessons about partnership and about treating conditions linked to HIV/AIDS.

Lessons include:

- Access to drugs and the most up-to-date therapy is crucial to initiatives to treat opportunistic infections.

- Treatment is most effective when supported by a package of measures including advice on healthy living and nutrition.

- Workers often go to the health service as a result of opportunistic infections, and the contact established can usefully be exploited to address wider issues including VCT, the risk to family members and others, and prevention. When workers are not HIV positive, treating other infections can help reduce their risk of contracting HIV.

- Provision of drugs without appropriate training of staff can be counterproductive. Training should address treatment regimes and how to handle wider HIV/AIDS issues.

- Public-private partnerships benefit from a clear agreement on the responsibilities of each stakeholder, contingency plans to cover potential problems and regular meetings to update and adjust programmes.

ii) Treatment – a comprehensive approach to care

> **Volkswagen do Brazil:** Volkswagen in Brazil provides comprehensive prevention and care for all workers and their dependents, and covers extended families and retirees. Prevention includes education and promoting condom use. Care and support includes giving access to relevant tests, providing ARVs and specialist help, covering hospital admission, nutritional advice, psychosocial support and home care. The company also helps reintegrate employees living with HIV/AIDS into the workplace and society. The successful programme is in line with (and may have been prompted by) government guidelines, although many other private sector firms have ignored their responsibilities.

Lessons include:

- Investment in early and systematic treatment can actually cut the direct costs of care by leading to a fall in hospitalization and other costs of treatment.

- Providing treatment contributes to significant indirect savings by allowing staff to remain active and symptom-free (in this case, 90% of those being treated by the company are healthy), reducing absenteeism and allowing workers to apply their skills and experience.

- Programmes that are seen to be caring and supportive of PLWHA increase employee satisfaction and improve the company's public image.

- Building on existing self-managed medical plans is an efficient way of delivering care.

- Combining centralized management, specialized technical personnel (a medical coordinator with occupational health expertise, specialists in infectious diseases, marketing and education experts) and technical protocols to standardize care maintains efficiency, provided there is some flexibility for responding to individual needs.

D. Care, support and reasonable accommodation

Helping employees living with HIV/AIDS to stay in work may require 'reasonable accommodation', meaning that affected staff are switched to lighter duties or helped to work more flexibly, given additional sick leave, and allowed more time for breaks as needed. Ensuring continuity of employment in this way is consistent with the ILO Code of Practice, which calls for PLWHA to "be able to work for as long as medically fit in available, appropriate work." It is also a way of helping companies and organizations to benefit from the skills and experience of their workforce for as long as possible.

Heineken International in Burundi, Ghana, Nigeria, the Democratic Republic of Congo and Rwanda: Heineken has a comprehensive protection and prevention programme, treats STIs and provides condoms. It links VCT with ARVs and makes HAART available to staff at those sites with testing in place (and where drug supply can be maintained). Treatment is integrated into the company Health Support Programme and uses a directly observed approach combined with self-managed treatment at weekends, to promote compliance with drug regimes. The decision to provide ARV treatment was prompted by falling drug prices, the granting of private sector access to cheap ARV supplies, and a thorough review of the evidence on effectiveness. Treatment is linked to reasonable accommodation and to vigorous company policy on non-discrimination, confidentiality and parity of HIV/AIDS with other serious conditions.

Lessons include:

- Adjusting working conditions to allow staff to take their medication and to attend locally appropriate counselling are important aspects of accommodating affected workers, and could be usefully applied even where employees are being treated outside the workplace.

- Requiring workers who receive treatment to make a 'reasonable' personal financial contribution (a small proportion of disposable income only) can encourage compliance with the treatment regime.

- Accommodating treatment at work can create conflicts. It raises challenges in terms of confidentiality[6] and creates dilemmas around continuity, particularly in terms of restructuring. There may be a tension between reshaping the workforce and maintaining treatment, although continuing treatment after redundancy (as Heineken provides) resolves this.

- Transferring staff to lighter duties, allowing them time-off, and, in the case of women in particular, allowing time to care for relatives, all help extend useful employment. On the other hand, such measures are harder for small enterprises to manage.

- Ensuring access to social benefits and protection reinforces accommodation programmes.

VCT, treatment, care and support are all part of a continuum and all the best practice examples combine measures to keep PLWHA as healthy as possible for as long as possible. Acting early and using various entry points to reach workers (including STI and other clinics) and combining services enhances the effectiveness of interventions and keeps costs down. Links to communities and community-based programmes also enhance efforts to ensure appropriate provision of care. Taken together, these initiatives respond to the ILO Code and the commitment that "solidarity, care and support should guide the response to HIV/AIDS in the world of work". However, they cannot guarantee the "affordable health services" and the access to "benefits from statutory social security programmes and occupational schemes" that are desirable – which is why the government's role remains a necessary constant in the total equation.

Section 4: Links beyond the formal workplace

Just as it is impossible to neatly separate the world of work from the communities that provide its workers and make up its markets, so it is impossible to draw neat lines between the responsibilities of government, employers and employees at work and beyond. Prevention, mitigation, care, support and treatment need to be extended from the conventional or formal sector workplace to less formal settings. This is not just a way of reaching 'hard to access' networks of suppliers and distributors, but also helps to reinforce efforts by companies and organizations to protect their staff, since workers are at risk when interacting with the communities around them. This is particularly true in sectors where workers are isolated from their families, and interact with shifting communities of casual and migrant workers. These conditions open up the possibilities of sexual networking that are powerful forces in the spread of HIV between communities.

A. Links from the formal to the informal economy

In some countries, 90% of people working are involved in the informal economy, often in activities at the margins of poverty. The kinds of work they do range from farming, trading and small scale-enterprises, to casual factory work and construction, and home-based work. There is little in the way of legal protection, few or no structures to ensure non-discrimination or confidentiality, and almost no worker representation. There are some organizations that attempt to represent informal workers but these tend to be concentrated in urban areas and around the more skilled or semi-skilled occupations.

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[6] De Beers facilitates treatment through networks of practitioners in the community in an attempt to support compliance with treatment and maintain confidentiality.

Most informal workers have little voice and very little control over working conditions. They often have to combine a mixture of types of work and women are particularly vulnerable. Many women are heads of households living in poverty, and while they are not sex workers they may have to trade sex for money or favours, and are unlikely to have the possibility of insisting on safe sex. Initiatives to support workers in the informal sector are described in earlier case studies. Projects that attempt to link formal workplaces to informal ones and to government initiatives are set out below.

i) Managing the transition from formal to informal

Placer Dome Western Areas Joint Venture: The Placer Dome Western Areas Joint Venture workplace programme for the South Deep Gold Mine originally sought to help staff made redundant through reorganization. It now helps staff as they become increasingly unwell from AIDS to take on other economic activities. The initiative follows on from comprehensive efforts at prevention, care and accommodation. The intention is to help them find other, less arduous means of income-generation so that they can make a dignified transition from work[1]. It provides training, business planning and loans to help 'retrenched' or 'medically repatriated individuals' to find more suitable employment or to start up small, entrepreneurial or income-generating activities whether in the formal or informal sector.

Lessons include:

- The initiative is made particularly effective if employees who are too ill to benefit from the programme are able to nominate a relative (male or female) to take up the training and so ensure that the family has some income-generating capacity.

- Paying attendance allowances makes it possible for individuals to participate in the initial training and counselling.

- Integrating a home-based care project (and the provision of monthly medical kits) with efforts to support income-generation helps ex-employees with AIDS stay economically active, and their families remain economically viable even after the death of the ex-worker.

- Involving local leaders and traditional healers helps ensure acceptance of the programme.

- Finding micro-finance to support small enterprises is extraordinarily difficult.

- Building a consortium (in this case of eight mining companies) and using a per capita funding model can help fund innovative initiatives and attract external and government partners, but it does take time for partnerships to establish effective ways of working.

ii) Informal structures – extending social protection

ILO Programme on Strategies and Tools against Social Exclusion and Poverty: The ILO STEP programme has tried to extend decentralized systems of social protection (DSSP) and health and micro-insurance schemes (HMIS) to informal sectors of the economy including those affected by HIV/AIDS. The model relies on solidarity and on mobilizing contributions from those who traditionally have no access to health insurance. Mutual health funds and HMIS are being created by cooperatives and community associations to protect workers and households without access to statutory systems of social protection. Although the health scheme is contributory, it does need some state subsidy to top up inputs from self-employed workers and those in the informal economy.

Lessons include:

- DSSP and HMIS are not just a form of financing but can also play a significant social and prevention role, building community capacity to take action for prevention and care.

- Workers in small enterprises and the informal economy actively want DSSP and HMIS.

- Funding is more difficult to secure and sustain than the initial model suggests.

B. Links from the workplace to the community

Outreach work to involve communities is key to prevention on a national level as behaviour and attitudes are formed there, and most care is delivered there. It is also important to companies and organizations (and to governments in their capacity as employers) as most of workers' exposure to risk is in a community setting. Initiatives and the entry points they use will vary just as communities are different in terms of culture and social organization. Reaching out to and involving communities is essential for reducing the risks facing workers and their families and, ultimately, for the success of workplace activities.

i) The community – encouraging local entrepreneurship

> **Kahama Mining Corporation, Tanzania:** Kahama Mining has a large number of expatriate staff who are isolated from their families and at risk in the community. The company runs a combined programme of prevention and care and has taken particular trouble to engage in community development. It sponsors a programme of education and support, which targets women and youth and provides them with information on how they can protect themselves, combined with sexual and reproductive health services. It also helps women find alternatives to sex work by supporting small business development (including the production of mosquito nets), helps to improve small-scale agriculture (through training and support to infrastructure) and trains them in life skills. It sponsors home ownership initiatives to allow workers to live with their families.

Lessons include:

- Providing women with the skills to support themselves is more effective in curtailing sex work than moral exhortation or prevention messages. Nonetheless, further support may be needed to create financial autonomy and protect women from exploitation.

- Consultation with all stakeholders is key to effective links with the community.

- Leadership commitment within the company is essential for securing the resources needed to bring meaningful workplace community links into being.

ii) The community – treatment for STDs and social outreach

> **The Lesedi project:** The Lesedi project is sponsored by Harmony Gold Mining and attempts to extend services to sex workers to encourage prevention and to break the cycle of HIV infection. It provides sex workers with clinics and peer educators to promote condom-use, and works with unions to encouraged acceptance of condom-use amongst workers. There is presumptive treatment of

STDs, with antibiotics prescribed without establishing that individuals are infected as prevalence is high and testing is difficult. The implications of this practice are being monitored.

Lessons include:

- Consultation and leadership are, as always, key and must include unions throughout.

- It is essential to monitor approaches that provide antibiotics as a rule of thumb, for they may lead to resistance and ultimately (and ironically) undermine condom use by creating a false sense of security in sex workers about HIV infection.

- Nurse practitioners should be given prescribing rights.

- Health Departments should be involved throughout, not least because they can help in removing constraints on nurse practitioners and also because they have a crucial role to play in monitoring and evaluating the chosen strategy.

- Initiatives to address health issues are more effective when integrated with social uplift schemes that include micro-finance schemes for alternatives to sex work.

C. Links to isolated or vulnerable groups

Targeting isolated or vulnerable groups is another entry point for linking with communities and can help address inequality issues and, in particular, inequities in access to prevention services, care, support and treatment. It is also an essential complement to generalized public health messages and strategies.

i) Vulnerable groups – sex workers

Sonagachi project, India: The Sonagachi project has much in common with the case studies above but was not linked to a single employer or group of employers in quite the same way. It took place in an area housing some 370 brothels and 4,000 sex workers, most of whom (at the outset of the project) were illiterate and had never used condoms. Peer educators were trained to promote safe sex and condom use. Health care services were provided as part of the initiative but the emphasis was on empowerment and on enabling women to negotiate condom use. The model has been successful in reducing the rate of STIs and massively increasing condom use.

Lessons include:

- Solidarity between sex workers is important in insisting on condom use, at least in the absence of client-focused interventions. Building a sense of unity and identity (through group meetings) should, therefore, be built into project plans.

- Including literacy skills and training on legal rights reinforces prevention messages and empowers women to protect themselves despite class, gender and social inequalities.

- Including social and economic assistance, savings and loan schemes, and childcare programmes in health promotion initiatives reduces isolation and encourages sex workers to assert themselves when it comes to safe sex.

- Initiatives to support sex workers can and should be adapted to help identify young women at risk so as to protect them from entry into the sex industry.

ii) Isolated and vulnerable groups – people living with HIV/AIDS

Federation of Kenya Employers and Association of People Living with AIDS (TAPWAK): This partnership between the employers' organization and PLWHA (plus unions) has created a joint forum for sharing ideas and discussing proposals. Quite apart from its practical contribution to planning and debate, it provides a very public signal that HIV status is no grounds for discrimination and stigma.

Lessons include:

- Symbolic gestures, particularly on the part of respected and high profile individuals, can have a significant impact on attitudes.

- The mobilization of PLWHA draws on the experience of those affected (who often have many years of education and/or experience) and develops their abilities to represent and negotiate on behalf of a wider community.

- A personal message from an individual with HIV can be more powerful than advocacy or education based on facts and figures.

iii) Vulnerable groups – young people

The Youth Employment Network (YEN): Young people often have real difficulties accessing the formal economy and are forced into work that increases their vulnerability. The UN, World Bank and ILO have therefore agreed (under the umbrella of the Millennium Development Goals) to focus attention on youth employment. This focus will involve a wide range of partners, including youth and a high-level expert panel in the priorities of employability, equal opportunities, entrepreneurship and employment creation. HIV/AIDS is included within the remit of those addressing equal opportunities and within the commitment to integrate the principles of decent work across the initiative. Egypt, Indonesia, Namibia, Senegal and Sri Lanka will act as YEN "champions" in the first phase and will lead the way in carrying out national reviews of youth employment and in developing and implementing national Action Plans.

Lessons include:

- Integrating commitments on HIV/AIDS and the vulnerable into a comprehensive development framework and making 'cross-cutting' connections maximizes their impact.

- Inter-agency negotiation can ensure that opportunities for collaboration are taken up.

- Broad-brush international commitments are most effective when linked to concrete actions at the national level.

- Involving expert panels and practitioners in developing policy directions enhances the validity of the recommendations made, and involving the target group enhances their appropriateness and acceptability.

iv) Vulnerable groups – mobile workers

> **The Shell Company of Thailand:** Shell in Thailand identified petrol stations as high-risk locations because of the number of truck drivers using them. They launched a peer-education initiative that uses pump staff to provide education to drivers and to the sex workers attracted to these locations. The initiative was successful in delivering messages to vulnerable groups and in increasing staff morale within the company, and lead to other oil companies also adopting it.

Lessons include:

- Outreach to vulnerable groups needs to be based at sites that are used spontaneously.

- Training materials should be designed to be accessible and to engage the interest of the target group. They may need to be updated and renewed to sustain interest.

- The selection of peer educators should reflect the investment involved, and should identify and train staff grades with low turnover to maximize continuity and sustainability.

- Having peer educators create personal development plans helps sustain their motivation.

- Ongoing support is key to effective peer education, and running regional meetings for educators is a cost-effective approach to monitoring, evaluating and supporting small, dispersed teams.

These case studies support the assertion in the ILO Code of Practice that "women are more likely to become infected and are more often adversely affected" than men, particularly in societies where gender discrimination is common. The Code calls for "more equal gender relations and the empowerment of women" - this demands initiatives targeted at men as well as women, and the inclusion of gender in the planning and execution of all programmes designed to prevent the spread of HIV infection and to provide care and support. It also demands greater attention to the role of women as unpaid care-givers, and to their needs for education, employment opportunities and greater economic autonomy.

Section 5: Knowledge and evidence: data-analysis, monitoring, and feedback

Best practice must, by definition, be evidence-based. This implies considerable investment in research, analysis and dissemination in such areas as epidemiology, virology, demographics, economics, communications and public health. Much of this knowledge-generation can be shared as a public good, and will often fall within the government's remit for maintaining clinical guidelines and clinical and behavioural research. However, in order to implement effective interventions, understanding of local conditions is needed, as well as the ability to determine which programmes are working and which are not. Data-collection on socio-economic conditions, situation and financial analysis, monitoring of trends in relation to the epidemic including HIV surveillance and other information, are all essential functions. Regular evaluation and feedback at project level are also key to getting best practice right.

A. Data collection and situation analysis

Data-collection and situation analysis are vital not as part of academic studies for publication but as ways of ascertaining practical needs and of identifying the stakeholders

who must be involved in designing responses to those needs. Large organizations are well placed to conduct surveys (and need them because of the complexity of the multinational working environment) although they may be disproportionately expensive for SMEs. Small companies may be able to benefit from larger scale studies by other companies, universities and research organizations, NGOs and government.

i) Situation analysis – understanding what is needed

Daimler Chrysler South Africa (DCSA): DCSA initiated a prevention and care programme in 1991, but it was not effective and infection rates and costs to the company continued to rise. A baseline survey of Knowledge, Attitudes, Perceptions and Behaviours (KAPB) found that people knew little about HIV infection or the services provided. This data helped in designing the response, including peer education, HAART provision, reasonable accommodation and guaranteed social security benefits, with evaluation built into the project. The revised approach was both more successful and more cost-effective, protecting the business better and creating opportunities to link with contractors in the informal sector and with the community.

Lessons include:

- Survey work can help identify why service uptake does not meet expectations (in this case because of fears about confidentiality and a lack of 'marketing' of the help provided.

- A KAPB survey can guide detailed responses (how best to design and communicate features related to confidentiality) and provide a baseline for monitoring.

- Union involvement and top-level support help ensure open responses to KAPB surveys.

- Stigma is a major factor in discouraging VCT and seeking care, and needs to be better understood if information, education and communication campaigns are to combat it effectively.

- Setting specific targets for VCT, TB cure and STI recurrence can be useful for monitoring performance and for keeping costs under control.

B. Financial Data

Financial information is clearly important to companies and other organizations that are the main funding source for activities in prevention, care and support. The direct and indirect costs of activities, and their benefits, need to be evident. In addition, financial data can be a tool for engaging with stakeholders, including the possibilities for cost-sharing between employers and the workforce and between enterprises and government. Opportunities are increasingly opening for such joint financing arrangements, and it is important in terms of best practice to address how to move forward with innovative financing mechanisms in areas such as increasing access to ARV treatment.

i) Financial data – balancing financial incentives and 'doing the right thing'

> **American International Insurance, Thailand:** The AIA insurance company has a background in philanthropic work on HIV/AIDS in partnership with NGOs. It wanted to build on this background and to integrate a response to HIV/AIDS into its core business. It hoped to do this by persuading its group-life insurance clients to take an active role in educating their staff about HIV/AIDS. AIA worked with the Thailand Business Coalition on AIDS (TBCA) to set up an evaluation and accreditation programme to test and acknowledge when companies had appropriate HIV/AIDS prevention policies in place. Companies that secure accreditation and continue to pass prevention policy audits are given discounted group-life insurance premiums. This initiative works and companies have improved their policies between audits. The attitudes and knowledge of employees change for the better (both in terms of understanding risk behaviour and in their thinking about PLWHA). However, it was more difficult to 'roll out' than anticipated, and lessons were not all predictable from the outset.

Lessons include:

- Financial data and monetary incentives for best practice uptake should be used with caution. They attract attention, but may also provoke suspicion on the part of the target group who may see the incentives as a marketing ploy.

- The sense of 'doing the right thing' is a powerful motivating factor. Appeals to companies should reflect this as well as (or instead of) offering financial incentives for recognizing HIV/AIDS as a workplace issue.

- The extension of innovative ideas to companies is time-consuming and labour-intensive.

- The personal networks of senior staff and board members can be key in 'recruiting' collaborating organizations.

C. Monitoring and feedback

No initiative can be designed without flaws or room for improvement, and no situation will remain static over time. Monitoring and feedback are, therefore, crucial if adjustments and adaptations are to be made which will allow best practice to move beyond the innovation stage. Lessons of best practice need to be documented if this experience is to be available to others who are contemplating workplace activities. It is, thus, essential that programmes have defined and assessable objectives and that systems for monitoring these objectives be established from inception.

> **The Ministry for Public Service and Administration, South Africa:** The Ministry has some 140 departments and over a million staff. It recognizes the importance of HIV policy, particularly in terms of the impact of staff losses on its ability to carry out its core functions, as demands increase with the epidemic. There has been an attempt to identify core service areas, scarce skills and key posts and protect them through priority programmes. The policy development phase has opted for the creation of a set of minimum mandatory requirements to be incorporated into Public Service Regulations. Each of these requirements (including education, links with health promotion, establishment of an HIV/AIDS committee per department, non-discrimination, testing and confidentiality) is linked to a monitoring obligation and a set of annual reports.

Lessons include:

- Baseline information is needed before monitoring methods can be put in place.

- Setting tangible targets for deliverables and monitoring progress against those targets is a highly effective management tool that prompts action and highlights shortcomings.

- Setting too many overlapping targets can complicate monitoring and undermine efforts to track and enhance performance.

- Arranging for reporting intervals of a year detracts from the usefulness of monitoring tools. A straightforward set of indicators can be easily updated and can provide day-to-day management information (although more detailed annual reviews are also useful and worthwhile).

- Evaluation should involve all stakeholders, including unions/ workers' representatives, and should combine quantitative and qualitative elements if it is to be credible. Feedback must be clear and transparent if it is to inspire change.

- Governments can encourage monitoring, evaluation and feedback through example (as in this case) and by making their support of (or partnership in) any project conditional on proper monitoring and reporting measures being put in place.

Cross-cutting lessons: key messages for effective workplace action

The case studies above are only a brief selection of the huge range of best practice examples being developed by practitioners tackling HIV/AIDS in the world of work. They generate a number of lessons that overlap with each other and which allow some generalized statements to be made about how best to work across the continuum of prevention, behaviour change, treatment, care and support. These elements are grouped together below under headings which cut across the thematic divisions above.

i) Partnership, social dialogue and links across sectors

Initiatives are most effective when they involve all social partners, and partnerships are most effective when:

- Stakeholders are involved early.

- The definition of stakeholders is a broad one, including unions/ worker representatives, different levels of management, PLWHA and others who are not direct beneficiaries of the project.

- Public-private partnerships are specifically promoted, through government action, enterprise initiatives, the ILO's tripartite structure and/or international mechanisms like the Global Fund which encourages co-investment at country level.

ii) Consultation – involving workers and their knowledge

Initiatives informed by the experience of the target group have a higher chance of success. The fact that workers and/or community groups are consulted also helps build commitment from the outset, provided that:

- Consultation is seen to be genuine and those consulted believe they can exert influence on the design or implementation of the initiative being planned.

- The rules on confidentiality are clear and convincing and people being consulted feel secure expressing their views without risk of being stigmatized or discriminated against.

- Communities are helped to take part by proper attention to their sensitivities and by providing a suitable setting and adapting the tone of the consultation to meet the level of education and confidence of the group.

iii) Trust and ownership

Developing trust and ownership contributes significantly to the success of efforts to tackle and treat HIV/AIDS and, in particular, can help create conditions in which workers will use VCT and treatment provision. Particular lessons are that:

- Confidentiality procedures must be in place and be seen to be completely reliable by staff so that no one seeking testing or treatment can be exposed to stigma.

- Independent researchers can play a role as 'honest brokers' and help convince staff that evidence on testing and treatment is credible.

- Providing treatment (reliably and consistently) for opportunistic infections, for HIV/AIDS and to prevent MTCT, and accommodating the needs of PLWHA, are the ultimate tools in creating trust and will encourage people to address their HIV status and their behaviour.

iv) Leadership

Leadership contributes to the successful development and delivery of projects and of partnerships. It is clear that:

- Government leadership can motivate companies and organizations and shift societal norms.

- Top-level executive support communicates that a company or organization is serious about a scheme and expects managers and staff to take it seriously.

- The leadership of senior staff and the co-option of their personal networks can help ensure the success of an initiative.

- Union leadership can reassure workers, convey credibility, and support community outreach.

v) Communication and dissemination

Putting messages across so that they can be understood is central to the success of information and education campaigns. Effective communication means that:

- Messages state their purpose and are accurate, consistent and reliable, reinforcing other information initiatives.

- The language chosen is the right language and the level is tailored to reflect the literacy of the target group, their cultural and gender sensitivities.

- The entry point for communications are varied to include formal and informal settings, clinics, schools, community centres, bars, market places and sports facilities.

- Peer educators recruited to communicate prevention and behaviour change messages closely reflect in experience, age, seniority and gender the composition of the target group.

vi) Building on structures already in place – adapting to change

There is an enormous value in drawing on the systems and structures in place but it is also necessary to adapt structures and systems to reflect the specifics of the new epidemics. Experience suggests that:

- 'Piggy-backing' on HIV/AIDS services with existing occupational health services and structures is cost-saving and effective provided that there is a clear HIV specific focal point and a commitment to confidentiality.

- Involving health and safety committees in HIV/AIDS prevention can provide ready-made networks of management and shop stewards with appropriate skills to address the issues involved.

- Integrating HIV/AIDS issues into collective bargaining may be appropriate in a number of cases, although there may be initial resistance to moving in this direction.

- Incorporating training on prevention and non-discrimination into upon-entry training courses signals from the outset that the culture of the company or organization is supportive of workers living with HIV/AIDS while upgrading existing grievance and disciplinary procedures to prevent discrimination or victimization is a straightforward means of responding to new legislative demands. Many other training settings exist, from labour colleges to MBAs, where a component on HIV/AIDS could be included.

vii) Equity considerations: ensuring access for those in need

HIV/AIDS tends to hit the most disadvantaged the hardest. Targeting responses can help tackle inequality as long as:

- There is monitoring of who receives care and other services.

- The issue of which dependents receive coverage reflects the way definitions of family differ across cultures, although sustainability is of course a legitimate consideration.

- Care and support is extended following the termination of employment due to ill health and includes (where feasible) bereavement counselling for families and help in establishing them in some income- generating activity.

- Contractors and suppliers in the informal sector are included in efforts to tackle HIV/AIDS.

- Community outreach specifically addresses disparities in care, perhaps in conjunction with national programmes and/or international donors.

viii) Gender considerations

Gender is profoundly linked to the risk factors for HIV infection, and the way the epidemic affects individuals and families is also mediated by gender. This link is especially true for women, who are often expected to undertake most of the care of those infected and, thus, face intensified home and workplace responsibilities. Incorporating a gender dimension in all workplace activities is essential, and it is crucial to:

- Address women's economic position, through efforts to provide business skills, life skills and support for establishing small businesses like mosquito net production or agricultural cooperatives.

- Tackle the isolation of male migrant workers from their families by providing housing for families wherever possible, for example at mining sites.

- Use same-sex peer educators and self-help groups to share accurate knowledge and challenge misconceptions.

- Work with men and women (initially in single-sex groups but ultimately jointly) to understand and shift the power relationships in societies, which give women little or no control over their own bodies and make men subject to macho pressures.

- Provide health services that reflect the needs of men and women of reproductive age and allow for the cultural construction of fertility and sexual behaviour.

- Ensure that there is proper accommodation in the workplace to the needs of women, in terms that make if possible for them to remain productive and actively engaged in work despite increasing demands on their time.

CHAPTER V. WORKPLACE PROGRAMMES: LESSONS OF EXPERIENCE AND THE WAY FORWARD

The previous chapters have identified some of the main lessons to be drawn from global efforts to develop and implement workplace programmes as part of a multisectoral response to HIV/AIDS. It is important to recap what these lessons have been, before addressing the very important issue of how best to move forward with an expanded response. Workplace programmes have only been recognized as an essential element relatively late in the response to the HIV epidemic, and lessons are still being accumulated as to how best to develop and implement relevant programmes. It is also unclear as to what strategies governments, donors, employers and unions should adopt in moving forward and how best to combine their efforts in their search for effective outcomes.

Building on the experience of effective workplace programmes

A number of broad general conclusions stand out from the review of best practice presented in this report, and these can form the basis for building on this experience in moving forward These conclusions are as follows:

- Workplace programmes are an effective instrument for responding to the HIV epidemic, and clear benefits to all stakeholders have been identified as a result of their development and operationalization.

- Workplace programmes, to be effective, require the collaboration of many partners, including government, enterprises, unions, donors and civil society organizations. Each has an essential role to play in the formulation and delivery of workplace programmes and all need to be included in the further development of such activities globally.

- Workplace programme activities need to be expanded beyond their existing, fairly limited application to other sectors of economic activity. At the present time, workplace programmes are generally confined to larger enterprises in the private sector, and have restricted regional and country coverage.

- The challenge, therefore, is to build on the experience of best practice and to expand workplace programmes throughout the private sector and beyond the existing concentration (in areas such as mining), to other private sector enterprises, and to public utilities (such as, water, electricity and telecommunications).

- The problems are especially severe in the public sector where, in spite of the fact that this sector often accounts for a very significant proportion of the formal labour force and has high levels of education and experience, there has been a general reluctance to establish comprehensive programmes for its workforce. In some countries, innovative attempts to develop and implement workplace activities do exist but these attempts are the exception. In general, slow progress in this area means that countries with mature epidemics, many in sub-Saharan Africa, face the disruption of essential services due to the loss of human resources.

- Problems of coverage and effectiveness also relate to small and medium enterprises, especially vulnerable to losses of human resource capacity and where financial and other constraints make it difficult to establish workplace activities. Yet the informal economy is a source of dynamism and innovation, as well as

employment growth. Strengthening workplace programmes in the varied circumstances facing SMEs will require targeted and creative responses.

- Finally, most of the population in developing countries is still rural. It is unclear how best to address the needs of this most vulnerable and susceptible segment of the labour force who are involved in food and non-food production. For certain production structures (e.g. plantation production), it is possible to develop workplace programmes and it is important to move forward with activities for this workforce. But the majority of the rural population will inevitably be left outside the reach of conventional workplace programmes and will remain the responsibility of more general country-based responses and initiatives focused on informal settings.

There are other substantive lessons to be drawn from the review of best practice and of country and enterprise experience, and the more important of these are worth recalling at this point. Four conditions are essential:

1) An enabling environment of laws and rights

The effectiveness of workplace programmes depends critically on the presence or absence of an enabling environment of laws and rights. This condition, often absent in many countries and locations, is vital for the establishment and operationalization of workplace programmes, in the same way as it is for effective general responses to HIV/AIDS. While the international community has understood the vital role of human rights and supportive legal arrangements for effective responses to HIV/AIDS, as represented by the Human Rights Guidelines of the UN (*HIV/AIDS and Human Rights*, 1998), it is still the case that many countries have yet to put in place supporting legal structures, and some countries still seem to believe that repressive legal systems hold out effective solutions.

It is worth repeating one of the most important statements from the Human Rights Guidelines,

The protection of human rights is essential to safeguard human dignity in the context of HIV/AIDS and to ensure an effective, rights-based response to HIV/AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards.

That is to say that the protection of human rights is not only a matter of principle, but of practical necessity in effective prevention and care. The state has a critical role in ensuring that laws and their implementation reflect what is known about supportive systems, in general, and, more specifically, what is needed to move forward effective workplace activities. It follows that strengthening workplace programmes has a prior policy dimension: governments need to review existing legal and other provisions relating to employment, to ensure that they are supportive of activities relating to prevention, care and support and access to treatment.

2) Building and sustaining conditions of trust and non-discrimination

Empirical information demonstrates that even where supportive legal frameworks are present and where enterprises have established broad-based workplace programmes, activities are often less than fully successful. This state of affairs seems to be common across enterprises large and small, even in working environments with strong personnel and other policies supportive of workplace programmes. Examples of the latter include

workplaces within the UN system and large enterprises such as some South African mines, where impressive formal policies do not always translate into uptake of services for workers or a stigma-free environment.

The fear stigma and discrimination seems to be the cause of the weak take-up of essential services such as VCT and treatment, even where it is free. It follows that building a supportive environment is not simply a matter of laws and formal representation of rights in workplace policies, but also one of changing cultural attitudes and other deep-seated behaviours. This is often as important as formal structures and, unless directly addressed through workplace activities, will impede the effectiveness of programmes. How to bring about these changes is much more problematic and much harder to identify in terms of best practice solutions. It is clear that workers' representatives need to be vigilant, and to make use of all legal provisions, even if not HIV/AIDS specific. The unions also have an important educational role as stigmatization and rejection by colleagues is as widespread as discrimination by employers.

3) Integrating the workplace in family and community structures

Workplace activities need to reach beyond the workplace if they are to be effective, most obviously in extending services to families and, where possible, to communities. Work is a community activity, not least in terms of the income generated which supports families both directly and indirectly through economic and social linkages. The most successful workplace programmes recognize how important these links are to communities and to community-based structures and have sought out ways to strengthen them through active involvement in workplace development, and access to related services such as VCT, MTCT, home-based care and so on.

Of obvious importance to the success of such programmes are links, not just to immediate workplace communities, but also over the longer term to workers and their families who may have ceased an employment relationship. It follows that workplace activities need to see their role as broader in objective than simply the immediate needs of employees and employers. The programmes become in effect ways of mitigating the impact of the epidemic more broadly on societies and economies, and should be seen as instruments for social mobilization in the response to HIV/AIDS.

4) Building a continuum of prevention, care and support, and access to treatment

This has long been the fundamental objective of national responses to the HIV epidemic but it is one that has, in general, not been attainable except in the richest countries. Attempts to develop workplace programmes have foundered in part because improving access to VCT has not led to take-up of services nor to general changes in behaviour. In part, this failure reflects ongoing issues of stigma and discrimination and a lack of trust in the employment relationship. It is also due to the fact that knowledge of one's status has not brought with it access to effective treatment.

These conditions radically changed with the fall in the cost of ARV drugs and the increased flow of financial resources from the World Bank and the Global Fund to poor countries to strengthen access to treatment. While many other factors still need to be put in place to ensure effective workplace programmes (see above), it is now the case that such activities for the first time hold out the possibility of fully comprehensive programmes that integrate all aspects of an effective response. A response that it is now realistic to assume will have a greater long-term effect on behaviour change and thus lead to a reduction of new infections. This is essential since the objective of workplace programmes should not

simply be to mitigate economic and social impact, important though this is, but over the medium to long-term to change underlying conditions and thus the incidence of HIV infection.

The case for inclusion of access by workers and their families to ARV treatment is now overwhelming even in the poorest countries where per capita incomes may be low and labour supplies apparently plentiful. The benefit streams from improving access to ARVs must now considerably exceed the costs, even when both are narrowly defined. This has been recognized by increasing numbers of companies who now include ARV treatment as part of their workplace programmes.

The challenge is to extend the boundaries of access as part of both workplace programmes and of more general provision by governments. But it is crucial for effective response to the epidemic at all levels of economic activity to ensure that access to ARVs is integrated in comprehensive programmes, and not simply seen as a separate activity.

Mobilizing resources: public-private partnerships

It is increasingly recognized that an effective response to HIV/AIDS in all of its dimensions requires not only much greater levels of resources but also effective partnerships between all of the social partners. This reflects in part the fact that capacities, skills, expertise, funds, leadership and insight are unequally distributed, and that there is synergy to be derived through shared responses to what is a highly complex problem. The case studies have detailed many examples of shared activities between governments, enterprises, unions, civil society organizations and donors. In part this collaboration reflects the increasing understanding that competences and capacities to respond are to be found in many institutions, and that mobilizing these resources is essential for an effective response to HIV/AIDS.

There are increasing examples of partnership responses to the HIV epidemic. For example, Anglo American, which is already an innovator in ensuring access to ARV treatment for its labour force in South Africa, proposes to establish a 30milliion rand programme, together with other resources, to support access to primary health care in six of the areas where it has operations. The new programme will thus widen access beyond Anglo's immediate workplace programme, in collaboration with the Department of Health, the Global Fund, the Henry J. Kaiser Foundation, the Nelson Mandela Foundation and loveLife (a South African NGO). In announcing this programme the CEO of Anglo made the following statement in October 2003,

> *"the next frontier in the effort to establish a comprehensive national AIDS management programme is to ensure community-level access to the full range of services required to effectively prevent the further spread of HIV and to provide treatment and care for those already infected."*

In a similar vein the recent meeting (September 2003) of the business, labour and political leaders from the USA and the Russian Federation, under the auspices of TPAA (Transatlantic Partners Against AIDS), discussed common issues and explored ways in which business and labour in both countries can respond to the crisis. They resolved to intensify cooperation in areas of joint scientific and behavioural research, including vaccine development, USAID support for the development of behaviour change strategies and strengthening capacity more generally, and increased support for collaboration between business and labour, including the establishment of a Task Force with the general objective of "supporting collaborative initiatives on HIV in the world of work".

Expanding workplace programmes: the tasks ahead

Many of the elements that are necessary for an expansion of workplace programmes are already in place, but there remain significant obstacles. Not the least of the problems is how to support through technical cooperation an extension of workplace prgrammes given the continuing weakness of existing structures for supporting capacity development in this area. On the positive side there is now general agreement as to the core principles that should guide workplace programmes, and these are well articulated in the ILO Code.

It is evident, however, from this review of best practice that effective workplace programmes should be the outcome of a continuous process of review of what is relevant and what works, and what does not. A process that necessarily involves all of the stakeholders, including management, unions, government, civil society organizations, donors and communities, and one moreover that takes account of specific local conditions, opportunities and constraints. In effect there is no blueprint as to what to do and how to do it, although there does now exist an increasing body of evidence as a guide to going forward with effective workplace activities.

The constraints in moving forward can be stated briefly, although how to address these is more problematic.

- It is clear that many governments have still to put in place comprehensive workplace programmes, in part because they do not understand why these are essential in terms of protecting human and organizational capacity. This is true even in countries experiencing severe losses of human resources in the worst affected countries. In part, therefore, the issue is one of transforming the policy environment so that there is a greater understanding of the threat that HIV/AIDS poses for development, and the role of workplace programmes in the national response.

- The private sector in some countries and regions has developed effective workplace programmes, and much of the experience of what can be achieved is derived from their activities. But this is not at all the general state of affairs even in countries with severe losses of labour, such as South Africa, where most enterprises continue not to understand why workplace programmes are essential and make good economic sense. So part of the task in moving forward is to support an extension of workplace programmes within the private sector in all countries and regions, and this is again a policy question initially - how to ensure that private enterprises, large as well as small and medium entities, understand the issues that HIV/AIDS raises for them as producers and employers.

- Nevertheless the private sector has developed models of what to do and how best to do it, and the ILO Code has been an important guide. The core principles have played an essential role in the progress that has been made, although most enterprises have developed activities that reflect their particular needs and location. What is now needed is to transfer this understanding of what is effective to other enterprises through processes of technical cooperation. Furthermore, there is need to draw on existing knowledge of how to establish and implement workplace programmes and apply this experience to the public sector. Since conditions vary between the private and public sectors, and within the sectors, the transfer of learning will require processes of mediation to ensure relevance and effectiveness.

How will the above tasks be undertaken, and where is the capacity globally, regionally and at country level to undertake these complex tasks? While there are organizations with expertise such as the ILO and its UNAIDS partners, global and national business coalitions, NGOs, and many individual enterprises and unions, there is a real gap in respect of capacity globally given the size of the task to be undertaken.

The steps that seem to be required are as follows:

- Undertake a capacity assessment in each of the main regions so as to establish what capacity exists and how to strengthen it so as to align capacity with needs. It should be noted that capacity development also includes effective use of existing capacity.

- Undertake a needs assessment region by region which should establish a baseline from which to plan subsequent activities.

- Establish a data base on who is doing what and where, including information relating to ongoing workplace activities at country and regional level, based on the best practice approach. Funding should be sought to maintain the data base, and to provide technical support to those who access it. This could usefully be a function undertaken by the ILO with the assistance of UNAIDS and other stakeholders.

- Develop with stakeholders in government, employers and unions a programme for strengthening capacity through training, workshops, staff exchanges and study visits. It is important that activities be undertaken that ensure that learning is transferred between organizations and countries so that learning processes are accelerated, and time is not spent relearning what is already known.

- As a result of the capacity assessment to develop activities in each of the main regions and sub regions, to provide technical support to public and private sector organizations and to governments in moving forward effective comprehensive workplace programmes. This will include support to Ministries of Labour and other key ministries, where existing capacity is presently largely missing.

- To support workplace programme development with an initial concentration on those countries where the epidemic is most mature and is presently causing the greatest social and economic impact. In many of these countries the focus should be on sustaining human and organizational capacity in the public sector, and in key private sector activities such as mining, transport, tourism, commercial agriculture, where livelihoods are directly threatened by HIV/AIDS.

The ILO should in collaboration with its tripartite partners play a leading role, as envisaged within UNAIDS, in taking forward an ambitious plan to expand workplace programmes globally. For this to be feasible it is essential that the capacity of the ILO itself be strengthened and that financial resources be provided to ensure the required expansion. It is clear that the ILO at present does not have the requisite capacity at either global or regional level and this capacity will itself need to be created as a matter of urgency.

It is desirable for the ILO in collaboration with other organizations such as GTZ, the US Department of Labor, Family Health International, the Global Business Coalition and others, to actively support workplace programme development, including the provision through regional mechanisms of ongoing technical support to workplace activities – proposed and operational. Such technical support is at the present time largely absent, and is undoubtedly a factor in the slow pace of expansion of workplace activities in all regions, including those most affected by the epidemic in Africa, the Caribbean, and increasingly in the countries of Eastern Europe and the former Soviet Union.

The ILO Code is a very valuable starting point in moving forward with an expanded response to the epidemic with a focus on the world of work. But it is only a starting point, and the critical and urgent need now is to strengthen capacities in partner organizations so as to rapidly expand access to workplace programmes in all regions. For this to happen the ILO and other donors will have to mobilize substantial additional resources as an initial step towards globalizing the workplace response to HIV/AIDS.

The way forward will necessarily have to be one based on partnerships – between social partners and civil society organization, and one which increasingly depends on regional and international collaboration. As resources become more plentiful, especially from the Global Fund and the World Bank through its MAP lending, but also from other donor sources, so also are the opportunities widened for joint activities. These opportunities for partnerships should be encouraged, given that they are mechanisms for mobilizing resources and building on the experience of programmes that can demonstrate effectiveness in responding to HIV/AIDS in the world of work.

Annex 1. **A selection of best practices**

The examples of best practice shown in sections 1 to 3 correspond to the three working groups.
Sections 4 and 5 raise issues that are relevant to all three working groups.

Section 1. Policy and legal frameworks

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Example of specific law on HIV/AIDS	**Cambodia, Law on the prevention and control of HIV/AIDS, 2002**	23
Example of adapted labour legislation	**Bahamas, Employment Act No. 27, 2001**	24
The use of disability legislation	**China, Hong Kong Disability Discrimination Ordinance, 1995**	24
Sectoral agreement between multinational and trade unions	**Anglo Gold South Africa, and the NUM, MWU-S, NETU, SAEWA, UASA**	25
Employer and worker organizations at national level	**National Confederation of Eritrean Workers and the Employer's Federation of Employers**	26
Tackling stigma and discrimination – building trust between the partners	**Illovo Sugar, South Africa**	26

Section 2. Workplace policies and programmes: prevention

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Education and information – peer educators and the community	**Geita Gold Mine Ltd. (GGML), Tanzania**	29
Behaviour change – personal risk assessment and change strategies	**BMW South Africa**	29
Behaviour change – self-help groups and partnerships for change	**South African Clothing and Textile Workers Union**	30
Behaviour change – condom use	**Migrant female factory workers, Thailand**	31
Behaviour change – safe use of needles at work	**The Democratic Nursing Organisation South Africa (DNO-SA)**	31
The gender dimension – making space for men and women	**Stepping Stones, Uganda**	32
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Section 3: Workplace policies and programmes: care, support and treatment

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Treatment – responding to opportunistic infections through partnership	**Pfizer – South Africa Alliance**	36
Treatment – a comprehensive approach to care	**Volkswagen do Brazil**	36
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Section 4: Links beyond the formal workplace

Subject	Example	Page
Managing the transition from formal to informal	**Placer Dome Western Areas Joint Venture**	39
Informal structures – extending social protection	**ILO Programme on Strategies and Tools against Social Exclusion and Poverty**	39
The community – encouraging local entrepreneurship	**Kahama Mining Corporation, Tanzania**	40
The community – treatment for STDs and social outreach	**The Lesedi project**	40
Vulnerable groups – sex workers	**Sonagachi project, India**	41
Isolated and vulnerable groups – people living with HIV/AIDS	**Federation of Kenya Employers and Association of People Living with AIDS (TAPWAK)**	42
Vulnerable groups – young people	**The Youth Employment Network (YEN) of the UN, World Bank and ILO**	42
Vulnerable groups – mobile workers	**The Shell Company of Thailand**	43

Section 5: Knowledge and evidence: data-analysis, monitoring, and feedback

Subject	Example	Page
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Financial data – balancing financial incentives and 'doing the right thing'	**American International Insurance, Thailand**	45
Monitoring and feedback	**The Ministry for Public Service and Administration, South Africa**	45

Workplace action on HIV/AIDS: identifying and sharing best practice

Annex 2. **The ILO Code of Practice: key principles**

The ***ILO Code of Practice on HIV/AIDS and the world of work*** is a set of internationally recognized guidelines to promote and support action in the world of work. Developed through extensive consultation with member States and approved by representatives of government, employers and workers from all regions, the Code contains fundamental principles for policies at national and enterprise levels, and practical guidance for workplace programmes. It is complemented by an education and training manual.

The 10 key principles (*text from the Code is in italics*):

1. Recognition of HIV/AIDS as a workplace issue: *HIV/AIDS is a workplace issue* because it affects workers, enterprises and the vital skills base of countries. *It should be treated like any other serious illness/condition in the workplace* – this statement aims to counter discrimination and also the fears and myths that surround HIV/AIDS. *The workplace has a role to play in the wider struggle to limit the spread and effects of the epidemic* – later sections of the Code, especially those on prevention, training, and care, clearly explain this role.

2. Non-discrimination: *There should be no discrimination against workers on the basis of real or perceived HIV status.* The ILO's response to the epidemic is rights-based. The principle of non-discrimination extends to employment status, and access to health insurance, pension funds and other entitlements of staff. *Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention*: if people are frightened of the possibility of discrimination, they will try to conceal their status and are more likely to pass on the infection to others. Moreover they will not seek treatment and counselling. All successful prevention initiatives have been part of a wider approach that included establishing an atmosphere of openness, trust and a firm stand against discrimination.

3. Gender equality: *The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons.* It is therefore important that HIV/AIDS programmes respond to the circumstances and needs of men and women separately as well as together – both in terms of prevention and social protection to mitigate the impact of the epidemic.

4. Healthy work environment: *The work environment should be healthy and safe, so far as is practicable, for all concerned parties*. This includes the responsibility for employers to provide information and education on HIV transmission, and appropriate first aid provisions in the event of an accident. It doesn't, however, give employers the right to test employees in the interest of public health, because casual contact at the workplace presents no risk of HIV transmission. *A healthy work environment facilitates … adaptation of work to the capabilities of workers in light of their physical and mental health* - so mitigating the impact of AIDS on workers and enterprise alike.

5. Social dialogue: *The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate* – this is not only fundamental to the way the ILO works, but is very practical in that any policy is more likely to be implemented effectively if it has been developed with the full participation of all concerned parties. The active involvement of those living with HIV/AIDS should also be sought.

6. No screening for purposes of exclusion from employment or work processes: *HIV/AIDS screening should not be required of job applicants or persons in employment*. HIV testing not only violates the right to confidentiality but is impractical and unnecessary. At best, an HIV test result is a "snapshot" of someone's infection status today. It's no guarantee that he or she will not become infected tomorrow, or next month. It should also be remembered that people with HIV may remain perfectly fit and healthy for many years, and are not a risk to co-workers in terms of casual workplace contact.

7. Confidentiality: *There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers.* (See above). The right to confidentiality doesn't, of course, only apply to HIV/AIDS – rules of confidentiality have been established in the <u>ILO Code of Practice on the protection of workers' personal data</u>, 1997.

8. Continuation of employment relationship: *HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be encouraged to work for as long as medically fit in available, appropriate work.* This principle is based on the fact that being HIV-positive is not the same as having AIDS and a number of possible opportunistic infections. Reasonable accommodation to help workers continue in employment can include rearrangement of working time, special equipment, extra rest breaks/sick leave, time off for medical appointments, part-time work and return-to work arrangements.

9. ***Prevention***: *HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies* - guidelines and examples are given in succeeding sections of the Code, especially section 6. Prevention can be furthered through a combination of information, participatory education including personal risk assessment and life skills, practical support for behaviour change such as condom distribution, and treatment for sexually transmitted infections (STIs).

10. Care and support: *Solidarity, care and support should guide the response to HIV/AIDS in the world of work.* Prevention and care should be seen as a continuum and – together with the protection of rights - as a comprehensive workplace 'package'. The availability of treatment encourages confidential voluntary testing, which promotes prevention. Care and support includes the provision of voluntary testing and counselling, treatment for opportunistic infections – especially TB - and antiretroviral therapy where affordable, workplace accommodation, employee and family assistance programmes, healthy living information, and access to benefits from health insurance and occupational schemes (more details in part 9 of Code).

ILO standards and HIV/AIDS

While there is no ILO Convention that specifically addresses HIV/AIDS at the workplace, many instruments exist which cover both protection against discrimination and prevention of infection. The Conventions that are particularly relevant include:

- Discrimination (Employment and Occupation) Convention, 1958 (No.111). This is one of the eight fundamental conventions of the ILO
- Occupational Safety and Health Convention 1981 (No. 155)
- Occupational Health Services Convention 1985 (No. 161)
- Termination of Employment Convention, 1982 (No.158)
- Vocational Rehabilitation and Employment (Disabled persons) Convention, 1983 (No. 159)
- Social Security (Minimum Standards) Convention, 1952 (No. 102)
- Labour Inspection Convention, 1947 (No. 81) and Labour Inspection (Agriculture)

Annex 3. Overview of ILO/AIDS activities, 2002-2003

Technical cooperation projects	**International HIV/AIDS Workplace Education Program** funded by the USDOL in 10 countries and 2 subregions
	HIV/AIDS prevention in the transport sector and the informal sector of selected African countries funded by SIDA-Sweden in 11 countries
	HIV/AIDS and the world of work: consequences for labour and socio-economic development, funded by Italy in 10 countries
	Implementing HIV/AIDS workplace policies and programmes, funded by GTZ-Germany in 7 countries
	Labour Market and Employment Implications of HIV/AIDS, funded by SIDA-Sweden in 3 countries
	Projects funded by **UNAIDS Programme Acceleration Fund (PAF)** in 13 countries
Meetings, training workshops, other support activities	ILO/AIDS participation in 9 global meetings, 13 regional events, 27 national and technical meetings, training workshops, 4 fact-finding missions. Support to elaborate funding bids, workplace policies and programmes, project documents: 6 countries
Publications	▪ *Education and training and manual: Implementing the ILO Code of Practice on HIV/AIDS and the world of work* (English - French and Spanish versions forthcoming) ▪ *Contributing to the fight against HIV/AIDS within the informal economy: the existing and potential role of decentralized systems of social protection*, ILO/STEP and ILO/AIDS, 2002 (English) ▪ Working Paper 1: *Labour market and employment implications of HIV/AIDS,* Franklyn Lisk, 2002 (English) ▪ Working Paper 2: *Human capital and the HIV epidemic in sub-Saharan Africa*, Desmond Cohen, 2002 (English) ▪ Working Paper 3: *Le Recueil de directives pratiques du BIT sur le VIH/SIDA: un instrument au service de la promotion des droits fondamentaux*, Marie-Claude Chartier, 2002 (Français, English) ▪ Working Paper 4: *Technical cooperation and the HIV epidemic,* Desmond Cohen, 2003 (English) ▪ ILO handbook: "HIV/AIDS no Mundo do Trabalho: as Ações e a Legislação Brasileira". ▪ 'Toolkit' for the social partners in the Asia-Pacific and Africa Regions as part of the UNAIDS Partnership Menus: Action against AIDS in the workplace (also translated into Chinese, Khmer and Vietnamese)
Activities with ILO's constituents: selected examples	**Training for government officials** Following successful meetings of labour inspectors in Central and Eastern Europe, and training courses in Senegal, further training on HIV/AIDS and labour inspection is planned with the African Regional Labour Administration Centre, Harare, March 2004. *Asia Pacific Regional Seminar on International Labour Standards and Equality Issues for Judges, Manila, 16-19 September 2003*: High-level judges and workers' and employers' representatives from eleven Asia-Pacific countries convene to address the relevance and use of international labour standards on equality, and the ILO supervisory system. The seminar will include sessions on HIV/AIDS and is

complemented by ILO training materials on discrimination that guide labour judges/industrial tribunals in rulings related to HIV status.

Employers and their organizations
As well as employer-specific activities in every TC project, ILO/AIDS has offered technical support for the development of policies, training materials and events at global level and in Africa, Asia, Latin America and the Caribbean, the CIS, and the Arab States. The Programme has provided advisory services to employers' organizations and supported the development of Business Coalitions on AIDS in, for example, Ethiopia, Singapore, and Zambia. It has contributed to a range of meetings at all levels, including sub-regional meetings for employers in West/Central and in East/Southern Africa, the Caribbean and the CIS, for employers in Syria, and for the hotel and tourism sector in Egypt. Sectoral meetings have also been held for the social partners in the transport sectors of 8 southern African countries. Most recently, ILO/AIDS supported the ECOWAS Conference in Ghana, 'Scaling up the response of the private sector in the fight against HIV/AIDS', September 2003.

Workers and their organizations
As well as worker-specific activities in every TC project, ILO/AIDS has offered technical support for the development of trade union policies, training materials and campaigns at global level and in Africa, Asia, Latin America and the Caribbean, the CIS. The Programme has contributed to a range of meetings including ICFTU and OATUU regional meetings in Africa (and ICFTU in Asia), consultation with global union federations, seminar for the Arab states on AIDS and the role of trade unions, participation in regional (Africa) and global meetings of the International Transport Workers' Federation and Public Services International, national workshops on health and safety and HIV/AIDS in Barbados, Belize, Jamaica, Trinidad and Tobago (among others). Sectoral meetings have also been held for the social partners in the transport sectors of 8 southern African countries.