International and Local Good Practice in Workplace HIV and AIDS Programme

A Desktop Review

2009

HEAIDS

HIGHER EDUCATION HIV/AIDS PROGRAMME

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Abbreviations and Acronyms

AAU	Association of African Universities
'ABC'	Abstain, Be faithful or Condomise
AIDS	Acquired Immunodeficiency Virus
A-MAG	HIV and AIDS Management Group
ARV	Antiretroviral
CD4	Immune Helper T cells that have CD4 on their membranes
DoHET	Department of Higher Education and Training (formerly part of DoE)
DOTS	Directly Observed Treatment
EABL	East African Breweries Limited
FBO	Faith Based Organisation
FHI	Family Health International
GBC	Global Business Coalition
GIPA	Greater Involvement of People Living with or Affected by HIV and AIDS
GP	General Practitioner
GRI	Global Reporting Initiative
HAART	Highly Active Antiretroviral Therapy
HAMS	HIV and AIDS Management System
HEAIDS	Higher Education HIV and AIDS Programme
HEARD	Health Economics and HIV and AIDS Research Division
HE	Higher Education
HEIs	Higher Education Institutions
HESA	Higher Education South Africa
HIV	Human Immunodeficiency Virus
HMOs	Health Maintenance Organisations
HR	Human Resources
IATT	Inter-agency Task Team

IFC	International Finance Corporation
IEC	Information Education and Communication
ILO	International Labour Organization
ISO	International Standardization Organization
JSE	Johannesburg Stock Exchange
KAPB	Knowledge, Attitudes, Practices and Behaviour
M&E	Monitoring and Evaluation
MTT	Mobile Task Team
NGO	Non-governmental organisation
OHCF	The Organisational Health Consultative Forum
OIs	Opportunistic Infections
PEP	Post-Exposure Prophylaxis
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PLOS	Public Library of Science
SA	South Africa
SABCOHA	South African Business Coalition on HIV and AIDS
SADC	Southern African Development Community
SANS	South African National Standards
SHARP	Sasol HIV and AIDS Response Programme
SIDA	Swedish International Development Cooperation Agency
SOPs	Standard Operating Procedures
SRI	Social Responsibility Index
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UCT	University of Cape Town
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
UJ	University of Johannesburg
US	United States
USA	United States of America
US CDC	United States Centers for Disease Control and Prevention
USAID	United States Agency of International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Executive Summary

This report aims to identify and describe what is considered "good practice" as regards workplace HIV programmes. It is anticipated that the findings will feed into the national-level "Higher Education Workplace HIV and AIDS Programme Framework" and down into the Higher Education Institution (HEI)-specific workplace programmes.

A search of international and local literature was conducted and drew on experiences from the private and public sectors. Whilst HEIs constitute a "workplace" for the academic, administrative and service staff, these institutions also have their own structures and cultures that characterise the higher education sector. For these reasons, special emphasis was placed on identifying good practice that has occurred in this sector. However, it has to be acknowledged that the literature on workplace HIV programmes in tertiary education establishments is sparse.

This review of good practice is particularly focused on issues pertaining to HIV and AIDS but ideally any chronic disease prevention and treatment programme should be situated within a broader Health and Wellness framework. In reality, few HEIs have functioning Health and Wellness programmes and currently, HIV and AIDS programmes will tend to be vertical in design.

Good practice is about what works at grass root level in the real world and appropriately transferring those lessons to other settings or institutions. It is about distilling out what works and what does not. However, it does not imply that there are blue prints available that can simply be applied to an institution in a mechanical manner.

With the accumulation of knowledge and experience over time, consistent themes and common threads emerge and develop into national and international norms and policies. In this regard, UNAIDS and other organisations have subsequently developed policy and programme guides that are useful summaries of good practice.

It is widely agreed that it is useful to approach workplace HIV programmes from a mainstreaming perspective. This approach ensures that such programmes are integrated into the organisation and its policy and budget processes. This reduces the chances of HIV and AIDS issues being viewed as only a health issue to be handled solely by the health services.

Within a mainstreaming approach, this review has dealt with the various components of a typical workplace HIV programme separately. Good practices reviewed in the prevention field include policy development, IEC and behaviour change, condom promotion, VCT, treatment of STIs and implementing Universal Precautions. Good practice in providing treatment for HIV and opportunistic infections was also reviewed.

In addition, good practices within a set of cross-cutting issues that are pertinent to workplace HIV programmes were also considered. Key topics include leadership, gender, involvement of PLWHA, stigma and discrimination, integration of services and M&E.

For each of the above components, a background to the topic and a rationale is provided for why it is an important part of the programme. This is followed by a description of good practice as applied to implementation, monitoring and evaluation.

SECTION 1

Background

The Higher Education HIV and AIDS Programme (HEAIDS) is an initiative of the Department of Higher Education and Training undertaken by Higher Education South Africa (HESA). The Programme is in its second phase of development. It is funded by the European Union under the European Programme for Reconstruction and Development in terms of a partnership agreement with the South African government.

The higher education sector in South Africa has been identified as a key focus area for HIV and AIDS related interventions, as this sector forms the knowledge and skills base of the country and as the students are in the age group most vulnerable to HIV infection.

The overall purpose of the HEAIDS Programme is:

> "to reduce the threat of the spread of HIV and AIDS in the higher education sector, to mitigate its impact through planning and capacity development and to manage the impact of the pandemic in a way that reflects the ethical, social, knowledge transmission and production responsibilities that are the mission of the Higher Education Institutions in society and South Africa."

The purpose of this component of the HEAIDS programme is to reduce the spread of HIV and AIDS in the Higher Education sector and mitigate its impact through support for the design and implementation of comprehensive HIV and AIDS workplace programmes benefiting academic, administrative and support staff at all 23 public HEIs in South Africa.

The focus of this particular report is to present and describe "good practice" within workplace HIV and AIDS programmes and inform the development of workplace programmes for higher education institutions.

SECTION 2

A Health and Wellness Perspective

Whilst this particular review has a focus on HIV and AIDS and the workplace, there is an increasing tendency to situate the prevention and management of chronic diseases like HIV and AIDS within a broader "Health and Wellness" programme.

WHAT IS "WELLNESS"

The word "wellness" first appeared in the 17th century but it was in the late 19th and early 20th centuries that a number of prominent people developed the concept of Wellness and the term Wellness was first used in connection with workplaces by Dr Halbert Dunn in the 1950's. A number of Wellness advocates have shaped the movement in the USA and across the globe since that time.

Beginning in the 1950's in the USA as "Executive Fitness Programs" within organisations such as Johnson and Johnson, Pepsico, Chase Manhattan Bank and many more, Worksite Wellness Programs now exist in large and small workplaces across a diverse range from hospitals to churches

Interestingly, the initial motivator for a wellness approach was the increasing costs associated with ill health in the workplace. Research has shown that it can be a cost-effective approach in terms of reduced health care costs and improved productivity.

Today, "workplace wellness" refers to an organization's ability to promote and maintain the physical and mental health of its employees. It is also about reducing risks to employees' health and wellness through safe work practices, healthy work environments and generally promoting healthy behaviours among employees.

Health promotion means giving employees the tools to improve their own health. This can include offering programmes like Employee and Family Assistance Programmes and Workplace Peer Support.

Common elements of well recognised models include: personal conscious decision to engage in healthy behaviours for optimum living and self responsibility. The most common dimensions included in definitions and models are physical, emotional, social, spiritual, occupational or vocational, intellectual, environmental and recently financial dimensions.

There are direct benefits to the organization and the individual. Healthy employees are more energetic, are less likely to be involved in an accident, are sick less often, and are able to recover from illness faster. Money spent on employee health programmes can result in lower absenteeism, reduced workforce turnover, decreased stress, reduced sick leave, and lower job accident rates.

INTEGRATING HIV AND AIDS PROGRAMMES INTO A WELLNESS PROGRAMME

Wellness programmes in workplaces take many forms and are structured differently depending on the culture of the organisation and on what aspects are covered by the programme. This is because of the broad reach of some programmes, which may cover everything from health care provision to assistance with managing finances, requires a variety of skill inputs. However, wellness programmes are usually housed within the Human Resources department of the organisation.

What is important as regards the workplace HIV and AIDS programme, is that the appropriate linkages are made with other key departments such as the occupational health and safety, training and health care provision.

Universal precautions are an obvious issue to include in a workplace health and safety programme. Several employees in each section should be trained in first aid, the safe handling of blood spills in an emergency and all other components of the universal precautions standard operating procedures.

A common weakness in many corporate HIV and AIDS treatment programmes is that there is a lack of integration or even communication between those providing treatment for HIV and the person providing other health care services to the employee. Of particular importance is the diagnosis and treatment of STIs, tuberculosis and other opportunistic infections. STIs enhance the transmission and acquisition of HIV and need to be prevented and treated in employees with HIV.

Tuberculosis is the most common opportunistic infection and the biggest killer of people living with AIDS.[1] Tuberculosis is also often the first AIDS-defining illness which changes a person's status from HIV-infected to AIDS. It is, therefore, important that TB is actively screened for, diagnosed and treated among those living with HIV. The workplace setting is ideal for following the Directly Observed Treatment (DOTS) regimen as the support person need not be a nurse or doctor. Treating those with dual TB and HIV is best done in the same setting.

If HIV treatment is integrated or at least linked to the general health care of the employee, then it is more likely to be comprehensive and effective.

Another good reason for the workplace HIV and AIDS programme to be situated within a broader wellness approach is that it helps to lessen the stigma around HIV. If employees are attending a workplace clinic rather than an HIV clinic, HIV positive employees may find it easier to access services.

This extends to other components of the workplace HIV and AIDS programme too. For example, if peer educators are "wellness" educators, then there is less chance that their interactions with employees will become stigmatised.

The following case study of Standard Bank reflects the above:

Case Study Integrating HIV and AIDS programme into the Wellness programme

Since 2006 the HIV and AIDS programme at Standard Bank South Africa has been fully integrated into the company's broader health and wellness programme, and its "HIV Champions" (voluntary peer educators) have been rebranded as 'Wellness Champions'. There are two important aspects to the above integration:

- The first is the conscious de-stigmatisation of HIV and AIDS, by approaching its treatment and management strategies in the same manner as those of other life-threatening diseases or conditions. This ensures any employee with a life-threatening disease - whether it's HIV, cardiovascular disease, or cancer - is managed in a consistent and equitable manner.
- The second is the alignment of the bank's general health and wellness goals with those of HIV and AIDS prevention, management and treatment. From identifying potential high-risk behaviours (like drug abuse or sexual assault) to promoting healthy nutrition and exercise guidelines, the bank's existing wellness offerings offer essential support and advice for people who are already immune compromised.

Standard Bank this year won the Global Business Coalition's (GBC) Award for Business Excellence for its HIV/Aids Workplace Programme in 2008. The award effectively recognises the best workplace HIV and AIDS programme in the world.[2]

There are a variety of ways in which organisations establish and maintain Health and Wellness programmes but the reality is that most HEIs, whilst embracing this approach, do not have functioning programmes. As such programmes develop over time, the HIV and AIDS programmes may be subsumed into Health and Wellness. However, in the interim, workplace HIV programmes are more likely to be "free-standing" or "vertical" programmes housed in the Human Resources department. The example below of how the University of Cape Town has integrated their workplace HIV and AIDS programme into broader health care is one approach to how this may be done.

Case study "Organisational Health" at the University of Cape Town

From 2000 to 2005, UCT used the approach they called "organisational health" to provide a mechanism for the institution to view health issues from a strategic perspective and to then provide appropriate health services which was intended to lead to:

- Integration of health-related matters
- Efficient and effective delivery of health care
- UCT being seen as a caring organisation
- UCT having the capacity to deal with complex issues such as AIDS and incapacity.

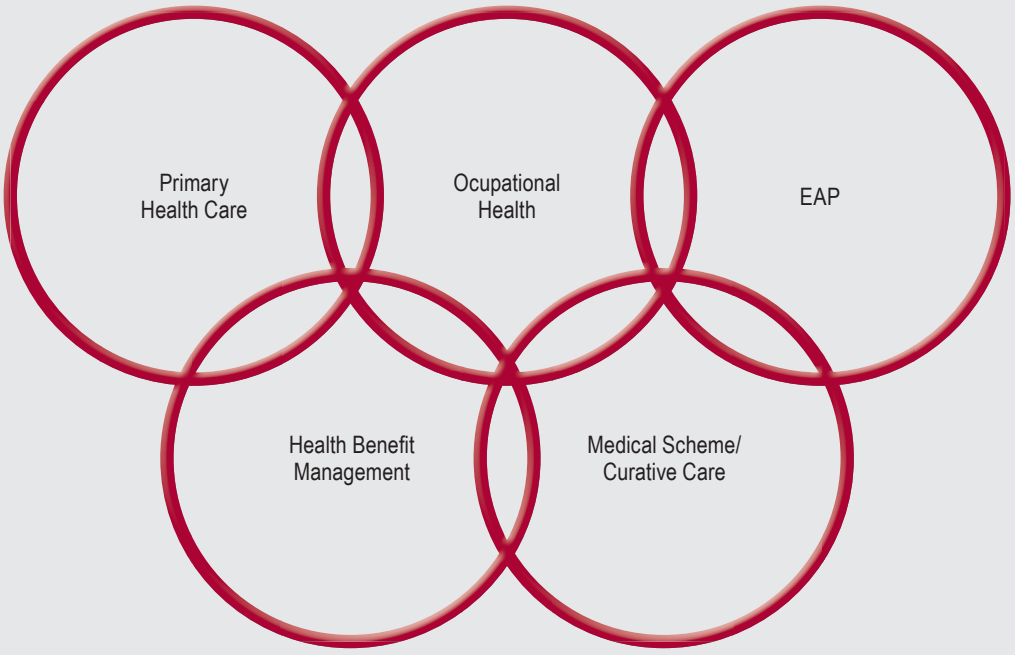
The organisational health section works with people and departments where functions overlap (such as the occupational health section, risk management and campus control). Working with human resource assistants, organisational health influences the manner in which people with health related problems are managed. They also work with union representatives and bodies such as A-MAG (HIV and AIDS Management Group), the HIV and AIDS unit etc.

The organisational health consultative forum (OHCF) is an officially constituted UCT body. It comprises representatives from all areas including health sciences, trade union, finance dept and other key departments.

The key function of the OHCF is to ensure that the organisational health strategy is relevant to UCT's needs. It also has an oversight function and regularly reviews the performance of the service providers of UCT'S health related service providers (including Discovery Health medical scheme, Sanlam disability insurance, Direct AIDS Intervention (HIV services) as well as the activities of the organisational health section.

This model integrates the five key areas of health delivery in the work place and was designed and implemented with success within the Chamber of Mines in the late 1980s. Many industrial and commercial organisations have adapted the model to meet their own health related needs. The integrated delivery of service allows organisations to meet the challenges of complex health issues such as HIV and AIDS, incapacity management and the management of human capital.[3]

Figure 1 Organizational Health Model



SECTION 3

Purpose of this Good Practice document

The overall purpose of the desktop review is to document and learn what workplace HIV policies, practices and programmes have had been most successful with the aim of applying this knowledge to the development of a framework for the HE sector. Examples of good practice were sourced from the international and local literature and there was an emphasis on those good practices which are drawn from the education sector.

SECTION 4

What is Good Practice?

The availability of information on the epidemic and its impacts on companies and institutions has increased immensely in the last decade and there is now a substantial body of literature on this subject. However, there is less information on what organisations are doing to prevent and manage HIV and AIDS, at what cost and to what effect. The lack of information within the public domain restricts the capability of organisations to take innovative, constructive action to manage HIV and AIDS in the workplace and beyond.

In this section the concept of "good practice" is defined, the strengths and limitations of this approach are discussed and how we will go about compiling good practice guidelines for HEIs will be outlined.

'Good 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 organisations, employers and employees can be more effective in responding to issues and acting on agreed principles and standards. By providing clear information on successful experiences, good 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. It is not, however, about absolute statements, definitions of the ideal or 'off the peg' models – good practices need to be adapted to the specifics of each situation and owned by those who use them.

SECTION 5

Identifying Good Practice

Good practice is not about ideas on paper but, instead, good 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 employees 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 practice. Key, too, is that it is made clear how 'established' the practice is and the extent to which it has been applied and evaluated.

Good practice should reflect generally accepted values and principles, such as those set out in the ILO Code of Practice,[4] and are evidence-based with systematic evaluation built in. An intervention that cannot be shown to work or that it is not value for money, is not good practice. It must be ethically sound, and the idea of relevance is central.

An internet literature search was undertaken to identify reports dealing with good practice in workplace HIV and AIDS programmes. Of particular use were the websites of UNAIDS and various business coalitions which have produced a variety of documents on good practice. The reviews are divided into the following sections:

- Policy and legal frameworks
- Workplace policies and programmes: prevention
- Workplace policies and programmes: care, support and treatment
- Links beyond the formal workplace
- Knowledge and evidence: data analysis, monitoring and feedback

The "good practice" section of the report concludes with a set of lessons learnt from reviewing all key good practice documents.

SECTION 6

Limitation of Good Practice as a methodology

Its strengths and its range of uses notwithstanding, good practice has limitations. Good practice follows on from the definition of goals reached through social dialogue - it does not determine these goals. 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.

It is important to remember that good practice is a purported ideology premised on the 'practices' of others and determined and/or deemed 'good' practice based on a subjective set of standards and criteria. It is within this context that organisations, while acknowledging what is deemed good practice, must adapt the principles, policies and programmatic responses only where it is applicable to that organisation. Therefore, good practices can and should only be used as a basis or as a determining guideline for an institutional response to HIV and AIDS which is tailored to suit the conditions and context from which that institution operates.

Further to this, the management of an institutional response must have the capacity and staff to use evidence based planning which seeks to promote lesson learning and good practice. Any attempt at simply copying another institution's programme, while clothed in good intentions, must be done with the utmost caution. As it has been previously alluded to, each institution will have its own unique characteristics of which any response must take cognisance to ensure its optimum success.

Good practice cannot be imposed in all situations without reference to what is specific and different in each nation, region and organization. Good 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 be evaluated again to establish that they work.

Lastly, the notion of validating certain practices is an important one. No institution's programme is flawless and a 'good practice' case study will often dismiss the obstacles, cost and human capacity required to achieve that desired end product. Any institution's response to HIV and AIDS is bound to encounter obstacles and this must be taken into account when developing a programme.

SECTION 7

The Relevance of UNAIDS Global Prevention Policies, Principles and Programmes to Good Practice and the HEI Sector

The essence of good practice is rooted in learning from on-the-ground experiences about what works well and what does not and applying these lessons to similar situations. However, with the accumulation of knowledge around good practice, there emerge common themes and consistent threads that can be distilled out from the wealth of knowledge.

Any identified good practice as regards workplace programmes need to be consistent with what is recognized as good practice at a global level. For example, no matter how good a particular workplace prevention programme is at averting new cases of HIV, if it is done at the expense of human rights, then it cannot be considered good practice.

In this section, the key guiding principles and practices which must underpin any workplace programme framework and programme are described. A full comparison between the UNAIDS documents and the relevance to the HEI sector is provided in appendix 1.

SECTION 8

Essential Policy and Programme Actions

- The promotion and protection of human rights, including gender rights, and the importance of combating and eliminating stigma and discrimination will be a key feature of all workplace policies and programmes.
- Effective leadership at all levels in the sector and institutions is essential if programmes and interventions are going to succeed.
- There needs to be sufficient consultation and involvement of the employees in all aspects of the design and implementation of the workplace policies and programmes.
- The norms and beliefs of the HE sector employees need to be considered and factored into policy and programme design.
- The importance of consulting PLWHA and including them in the design of prevention programmes will be emphasized in the proposed workplace programme.
- Because of the increasing feminisation of the HIV epidemic and the frequent sub-ordinate status of women in society, particular attention needs to be placed on gender rights and equality.
- Men play a key role in perpetuating the vulnerability of women to HIV and so their perceptions, behaviours and needs must be explicitly addressed in the workplace policies and programmes.
- Workplace policies and programmes must be evidence-informed and based on lessons learnt from good practices identified.
- HIV prevention programmes must be comprehensive and sustainable over time and implemented at sufficient coverage, scale and intensity.
- Universal precautions must be implemented throughout the institution.
- Free and easy access to HIV counselling and testing must be a cornerstone of the prevention programme.
- A major focus of the proposed workplace programme for the HEI sector will be on increasing levels of knowledge around HIV and AIDS and modifying behaviour.
- Policies and programmes should promote the integration of HIV prevention and care with sexual and reproductive health services on the campus.
- The HE sector should use the considerable competitive advantage that it has in the fields of education, training, research and information dissemination to the advantage of the sector and society in general.

SECTION 9

Legal and Ethical aspects of Workplace HIV and AIDS Programmes

There are a variety of laws that deal with aspects of workplace HIV and AIDS programmes within the workplace but at the most basic level, adherence should be shown to the South African Constitution Act (Act 108 of 1996), as well as compliance with the related provisions including the Bill of Rights.

Legislation relevant to HIV and AIDS in the workplace includes the application of the following Acts:

- Labour Relations Act, Act 66 of 1995
- Employment Equity Act, Act 55 of 1998
- Occupational Health and Safety Act, 1993
- Compensation for Occupation Injuries and Diseases Act, Act 130, 1993
- Basic Conditions of Employment Act, No. 75 of 1997
- Medical Schemes Act, Act. No. 131 of 1998
- Promotion of Equality and Prevention of Unfair Discrimination Act, No. 4 of 2000
- The Nursing Act, Act 50 of 1978
- The Medicines and Related Substances Control Amendment Act, 1997

The detailed implications these laws hold for HIV and AIDS issues are dealt with in more detail in appendix 2 but the key aspects are summarised below.

Section 6(1) of the Employment Equity Act provides that no person may unfairly discriminate against an employee, or an applicant for employment, in any employment policy or practice, on the basis of his or her HIV status.

No employee, or applicant for employment, may be required by their employer to undergo an HIV test in order to ascertain their HIV status. HIV testing by or on behalf of an employer may only take place where the Labour Court has declared such testing to be justifiable in accordance with Section 7(2) of the Employment Equity Act.

In accordance with Section 187(1) (f) of the Labour Relations Act, No. 66 of 1995, an employee with HIV and AIDS may not be dismissed simply because he or she is HIV positive or has AIDS. However where there are valid reasons related to their capacity to continue working and fair procedures have been followed, their services may be terminated in accordance with Section 188(1)(a)(i).

In terms of Section 8(1) of the Occupational Health and Safety Act, No. 85 of 1993; an employer is obliged to provide, as far as is reasonably practicable, a safe workplace. This may include ensuring that the risk of occupational exposure to HIV is minimised.

An employee, who is infected with HIV as a result of an occupational exposure to infected blood or bodily fluids, may apply for benefits in terms of Section 22(1) of the Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993.

In accordance with the Basic Conditions of Employment Act, No. 75 of 1997, every employer is obliged to ensure that all employees receive certain basic standards of employment, including a minimum number of day's sick leave [Section 22(2)].

In accordance with Section 24(2) (e) of the Medical Schemes Act, No 131 of 1998, a registered medical aid scheme may not unfairly discriminate directly or indirectly against its members on the basis of their "state of health". Further in terms of s 67(1) (9) regulations may be drafted stipulating that all schemes must offer a minimum level of benefits to their members.

In accordance with both the common law and Section 14 of the Constitution of South Africa Act, No. 108 of 1996, all persons with HIV or AIDS have a right to privacy, including privacy concerning their HIV or AIDS status. Accordingly there is no general legal duty on an employee to disclose his or her HIV status to their employer or to other employees.

However, whilst the current laws deal effectively with issues of discrimination, the laws are somewhat silent on the provision of workplace HIV and AIDS programmes and it is the recognition of this that prompted the SA government to promulgate the 'Code of Good Practice on Key Aspects of HIV and AIDS and Employment' in 2000 within the framework of the policy options indicated in the 'Employment Equity Act' of 1998.

The Code's primary objective is to set out guidelines for employers and trade unions to implement so as to ensure individuals with HIV infection are not unfairly discriminated against in the workplace. This includes provisions regarding:

- creating a non-discriminatory work environment;
- dealing with HIV testing, confidentiality and disclosure;
- providing equitable employee benefits;
- dealing with dismissals;
- managing grievance procedures.

The Code's secondary objective is to provide guidelines for employers, employees and trade unions on how to manage HIV and AIDS within the workplace. Since the HIV and AIDS epidemic impacts upon the workplace and individuals at a number of different levels, it requires a holistic response which takes all of these factors into account. The Code therefore includes the following principles:

- creating a safe working environment for all employers and employees;
- developing procedures to manage occupational incidents and claims for compensation;
- introducing measures to prevent the spread of HIV;
- developing strategies to assess and reduce the impact of the epidemic upon the workplace;
- supporting those individuals who are infected or affected by HIV and AIDS so that they may continue to work productively for as long as possible.

Subsequently in 2004, the Department of Labour published their HIV and AIDS Technical Assistance Guidelines (TAG)[5] with the aim of updating the earlier code of good practice. The TAG builds on the Code to set out practical guidelines for employers, employees and trade unions on how to manage HIV and AIDS in the workplace. It also serves as a guide to ensure that individuals affected by HIV and AIDS are not unfairly discriminated against in the workplace. In essence, the TAG is based on the Department of Labour's broad goals in managing HIV and AIDS in the workplace, inter alia, promotion of equality and openness around HIV and AIDS, creation of a balance between rights and responsibilities, and restoration of the dignity of persons affected by HIV and AIDS.

SECTION 10

Good Practice by Programme Components

This section consists of a review of what is deemed to be good practice in the various components of a workplace HIV programme. Whilst examples are drawn from global experience, the focus is on local good practice and, where available, good practice that has been identified within the education sector.

The general principles of good practice for each component are listed and examples of actual practices are provided in boxes. The relevance of the identified good practices to the HE sector are considered and comments made on how these practices may need to be adapted and modified for the sector.

It must be noted that the majority of good practice as regards workplace programmes comes from the private sector with a lesser amount from the governmental and non-governmental sectors. The experience and literature as regards good practice within the education sector is sparse.

SECTION 11

Policy Development and Implementation

BACKGROUND

Initial responses to HIV and AIDS in workplaces, including in HE institutions, tended to be characterised by *ad hoc* responses and to be lacking in coherence.[6] These early responses to HIV and AIDS in the workplace, while important, need to be organised and integrated to ensure a more comprehensive and strategic response to HIV and AIDS. As such, policy development and implementation is a crucial aspect of any HIV and AIDS workplace response whether there is currently no response or where there is a fractured response.

The need for an effective policy framework to guide higher education institutions responses to HIV and AIDS is well recognised. A policy framework provides guidance for action within a workplace ensures consistency with international and national laws and policies and also ensures that the rights of workers are properly supported and protected within any response.[7] [8] As such, a well thought out and implemented policy around HIV and AIDS in the workplace can strengthen the workplace response.

Yet it is imperative that if policies are going to have any meaningful impact on the workplace they also need to be implemented effectively. This means that not only do policies have to be clear in what they are trying to achieve, but that they also need to have the backing of senior management and the resources to ensure their implementation – as such policy development and implementation is closely linked to the cross cutting theme of leadership.[9] Policies need to move from paper and be translated into meaningful programmes, they need to be accessible at all levels of the organisation and not simply remain good intentions. As such good policy development has to be closely linked to an effective implementation strategy.

Some workplaces have chosen to integrate HIV and AIDS into their current policy and programmes around chronic disease, while others have kept HIV and AIDS policy separate. There is no clear answer as which is the better approach for policy. Integrating HIV and AIDS policy as part of a broader and already existing chronic disease policy is thought to reduce the stigma of HIV and AIDS by suggesting it is similar to other chronic diseases; it also suggests a closer integration of services. Yet at the same time integration of HIV into a chronic disease policy can lead to HIV staying hidden and unspoken about, without the necessary resources being transferred, and also ignores that fact that there are additional issues that HIV and AIDS brings up for policy and programmes in the workplace. A separate HIV and AIDS workplace policy allows for specific actions to be taken, a more open approach to talking about HIV and AIDS and for easier monitoring and channelling of resources into an HIV and AIDS policy.

SABCOHA (South African Business Coalition on HIV and AIDS) suggests that every company's HIV and

AIDS workplace programme should be based on four key elements. They suggest that these are:

- Prevention;
- Care and Support;
- Protection of infected or affected employees from stigma and discrimination; and
- Monitoring and evaluation of the programme.[10]

GOOD PRACTICE IN POLICY DEVELOPMENT AND IMPLEMENTATION

In the development and implementation of workplace HIV and AIDS policies, there are clear guidelines of what good practice should be, developed by the ILO[11] and also by the South African Department of Labour.[12]

The ILO Code suggests that workplace policies should be developed in dialogue with key stakeholders, particularly workers and trade unions, either through extensive consultation or through bargaining councils. The policy should be also be rooted in a human-rights framework that supports workers rights.[13] Without developing policy in consultation with key stakeholders it is unlikely that such a policy will be effectively implemented throughout an organisation, as people will not have 'ownership' of that policy.

The ILO Code of Good Practice[14] also suggests that workplace policies cover three key areas:

- Prevention through education, gender-awareness programmes and support for behaviour change;
- Protection of workers' rights; and
- Care and support, including confidentiality and treatment in settings where healthcare is otherwise not available.

The South African Department of Labour[15] additionally emphasises that effective policy development and implementation needs to be underpinned by an assessment of the impact of HIV and AIDS on the workplace, if programmes and policies are going to respond to areas of most need.

Naturally workplace policies should be developed in line with national and international legislation.

Ensuring the implementation of such policy is also an important aspect of policy development. Some higher education institutions, such as the University of KwaZulu-Natal, have chosen to create a separate unit in the workplace, charged with the development and implementation of policy.[16] Other universities have chosen to give the responsibility of ensuring implementation to a senior manager.[17] Central to both of these responses is that who ever is charged with implementation needs to have the resources and commitment to drive the process.

MONITORING GOOD PRACTICE

Monitoring good practice in policy development and implementation can be quite difficult, indicators need to explore whether the policies were constructed in dialogue with key groups or by an individual, whether programmes are well co-ordinated within institutional policies and whether there are enough resources available to translate policies into effective programmes. Obviously, the wider aim of good policy development and implementation is to reduce the number of new HIV and AIDS infections within the workplace and ensure that people living with HIV and AIDS are well supported.

Possible ways of monitoring good practice in this area are:

- Whether the institution has a HIV and AIDS policy in place;
- Whether HIV and AIDS is integrated into key university documentation;
- Whether the policy is in line with international and national frameworks, programmes and laws around HIV and AIDS;
- Whether there is an increase in managers knowledge about policies around HIV and AIDS;
- How inclusive the policy process was;
- An increase in resources – financial and staff – to support the university responses;

- An increase in the number of people who know about the policy; and
- A decrease in stigma relating to HIV and AIDS because of the policy.

The below is a checklist from SABCOHA for what needs to be included in a workplace HIV and AIDS policy. A manager can check whether their particular HEI policy includes the following principles.

Box 1 SABCOHA check list for company HIV and AIDS policies

- People with HIV&AIDS are entitled to the same rights, benefits and opportunities as people with other life threatening illnesses.
- Employee practices related to HIV&AIDS comply with legislation.
- Policy is based on proven scientific knowledge that people with HIV&AIDS do not constitute a risk of transmitting the virus to those around them through ordinary workplace contact.
- The policy makes mention of the need for endorsement by all levels of management, union and other leadership.
- The policy makes mention of the need for the policy to be communicated throughout the business.
- The policy makes provision for confidentiality of employees' medical information and HIV status.
- The policy discusses the need to educate all employees about HIV and AIDS and states that tolerance is then expected from all employees towards anyone being affected by the HI virus.
- The policy mentions that screening for the HI virus will only be done on a voluntary basis or as a legal requirement.
- The policy mentions that necessary training and protective equipment will be specifically provided for those employees exposed to great risk of infection (for example, medical staff).
- It is recommended that this policy be ratified and reformulated if necessary by the HIV&AIDS Steering Committee that you will be appointing. Policy should make mention of the fact that it was developed in consultation with employees at all levels.[18]

Table 1 Workplace policy development and implementation indicators of good practice and sources of data

Indicator	Means of Verification
University has an HIV and AIDS policy in line with international and national guidelines	Check policies
HIV and AIDS policy emerged through social dialogue with stakeholders	Interviews with key stakeholders in institution
Level of resources for implementing HIV and AIDS policy	Review of documents and minutes
Proportion of employees who report that they believe they will not be discriminated against if they disclosed they were HIV positive	KAPB survey
Proportion of employees who know about the workplace HIV and AIDS policy	KAPB survey
Proportion of managers who know about the workplace HIV and AIDS policy	KAPB survey

SECTION 12

Mainstreaming HIV into HEIs

BACKGROUND

Mainstreaming HIV and AIDS into the HE sector helps ensure that HIV and AIDS is integrated into the strategic planning processes of the HEIs and that HIV and AIDS is not simply viewed only as an 'add-on'. Whilst it is true that it is primarily the responsibility of the Ministry of Education to mainstream HIV and AIDS, the institutions themselves need to embrace the concept. In this section we examine what mainstreaming entails and look at some examples of good practice.

The UNAIDS IATT on education "is convinced that HIV and AIDS mainstreaming into existing education sector programmes and projects is the key to addressing

HIV and AIDS effectively through education".[19] In 2008 it produced a document entitled; "Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies".[20] Whilst this document is primarily aimed at development agencies, it does provide useful guidelines for any educational institution that wishes to mainstream HIV and AIDS issues.

GOOD PRACTICE IN MAINSTREAMING

There are several ways of defining "mainstreaming" and 3 of these are provided in box 2 below. A common

Box 2 Definitions of mainstreaming

- **Definition 1:** "Mainstreaming is a process that enables development actors to address the causes and effects of HIV and AIDS as they relate to their mandate in an effective and sustained manner, both through their usual work and through their workplace." UNAIDS, World Bank, UNDP (2005)
- **Definition 2:** "Mainstreaming is the process of analysing how HIV and AIDS impacts on all sectors now and in the future, both internally and externally, to determine how each sector should respond based on its comparative advantage." (SIDA, 2005)
- **Definition 3:** "Mainstreaming HIV and AIDS means all sectors determining:
  - How the spread of HIV is caused or contributed to by their sector;
  - How the epidemic is likely to affect their sector's goals, objectives and programmes; and,
  - Where their sector has comparative advantage to respond to limit the spread of HIV and to mitigate its impact." (University of KwaZulu Natal, HIV and AIDS and Economics Research Division (HEARD), Mobile Task Team on the Impact of HIV and AIDS on Education (MTT), 2005).

WHAT HIV AND AIDS MAINSTREAMING IS NOT

To gain a better understanding of what HIV and AIDS mainstreaming is, it may be helpful to think about what it is not. The following are some examples:

- It is NOT simply providing support for a health ministry's programme.
- It is NOT trying to take over specialist health-related functions.
- It is NOT adding on a few selective, additional functions and responsibilities (instead it is reviewing the core business of a sector from a different perspective and refocusing it).
- It is NOT business as usual – some things must change.21

feature of the definitions is that it involves a thorough investigation of how the institution/sector impacts on the epidemic and, in turn, how the epidemic impacts on the institution/sector. Mainstreaming is a process for integrating these issues throughout the institution or sector.

What are some practical examples of mainstreaming in the education sector?

- Including HIV prevention and sexual and reproductive health rights for students in the curriculum including in pre-service and in-service teacher training;
- Including a component on HIV and AIDS in the induction process for all new staff;
- Introducing practices that improve access to education and reduce vulnerability to HIV infection, for example, by reducing university fees;
- Putting in place policies and practices that promote a safe and inclusive work environment for HEI staff, for example, through prevention education and by adopting a workplace policy that supports all staff, including those who are living with HIV and AIDS, and addresses issues of stigma and discrimination;
- Putting in place policies and systems that ensure access to treatment, services and referral for learners and employees who are affected and infected;
- Ensuring policy and implementation with respect to training and recruitment which takes into consideration future staff depletion rates, and possible disruption caused by increased absenteeism and attrition to other sectors, and in later stages by morbidity and mortality; and
- Ensuring that sector activities do not increase the vulnerability of the communities they work with to HIV and to other sexually transmitted infections (STIs), or undermine their options for coping with the pandemic.

(Certain of the above examples are modified from the IATT report of 2008.)[22]

KEY PRINCIPLES IN MAINSTREAMING

Alignment with the HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011: Policies within HE institutions must aim to reduce new infections and mitigate the impact of HIV on individuals and institutions. To maximise their effectiveness policies and programmes must be aligned with the National Strategic Plan. This is in keeping with the globally accepted practice of the Three Ones Principle – one agreed HIV and AIDS framework, one national AIDS

Table 2 Workplace programme mainstreaming indicators and sources of data.

Indicator	Means of verification
Senior strategic HIV and AIDS team in place with well-defined functions	Minutes of meetings
Baseline impact assessment conducted and used as an advocacy and reference document	Baseline reports available
HIV and AIDS Plan for the HEI linked to routine planning, budgeting and monitoring mechanisms of the HEI and annually reviewed	HIV and AIDS incorporated into latest strategic plan with a budget
HIV and AIDS indicators developed and used to monitor programme activities and outputs	List of indicators and reports available
Human resource policies amended to minimise vulnerability and to take account of staff attrition	Review current HR policies
Conditions of service reviewed to accommodate HIV and AIDS (e.g. reasonable time off for sickness)	Review conditions of service
Guidelines on HIV and AIDS prevention and management developed for managers and lecturers and disseminated	Availability of guidelines
Does the institution support suppliers with developing/running HIV and AIDS workplace programmes?	Evidence of supply chain support

coordinating authority and one country-level M&E framework.[23]

A comprehensive approach: Addressing HIV and AIDS issues in a piecemeal manner is inefficient and largely ineffective. A comprehensive approach requires attention to prevention, care and support (including access to treatment), impact mitigation, workplace issues and management of the response.

A commitment to long-term interventions is essential, as is the involvement of people living with HIV. Promoting a better understanding of factors that put people at risk of HIV (such as unsafe sexual practices and substance abuse), of factors that drive stigma and discrimination, of gender and equity issues, of sexual and reproductive rights, are all part of a comprehensive approach.

Funding and support mechanisms: The Ministry of Education bears primary responsibility for facilitating the mainstreaming of HIV and AIDS in the HE sector and so needs to provide the required access to funding and support structures for HEIs. However, individual HEIs also need to fund and support mainstreaming within their institutions.

INDICATORS OF MAINSTREAMING

Mainstreaming may be viewed as rather "fuzzy" and vague to those unfamiliar with the concept but there are a variety of ways to measure whether it has been successfully implemented or not. Key indicators that relate to the workplace programme aspects of mainstreaming are listed in Table 2.

SECTION 13

Information, Education, Communication and Behaviour Change

BACKGROUND

Information, education and communication strategies for behaviour change are one of the programmatic approaches that workplaces can adopt around HIV and AIDS. As the ILO states "Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV and AIDS."[24] Indeed SADC emphasises that the workplace is a key place for awareness and prevention campaign, emphasising that this should take place during work hours.[25]

The provision of basic and clear information on HIV and AIDS, the routes of transmission and methods of prevention are crucial if people are to change their health behaviours in a positive way. Without such information, people can remain unaware of how their actions may increase their vulnerability to HIV-infection and can also drive HIV-related stigma and discrimination.

There are multiple ways in which people access information around HIV and AIDS in Southern Africa. Much information about HIV and AIDS is gained from the media, whether television, radio or newspapers.[26] Workplace campaigns aiming to increase information around HIV and AIDS can either attempt to work through existing channels of media or else introduce new ones, such as e-mail, the internet, fliers, posters and public rallies. They can also include other means of providing information through specific training for staff and managers, or through media activities used in marketing campaigns.

Behaviour change interventions aim not only to provide information and education about an illness or disease, but also aim to influence people's behaviours through various approaches. Often rooted in psychological models of behaviour they – in general – attempt to get people to reflect on their behaviours, the factors causing them to act in certain ways and give them the confidence and motivation to change their behaviours. Methods include peer education, motivational interviewing and individual psychotherapy.[27]

There is increasing concern that simply providing information about HIV and AIDS is ineffective if it is not backed up with other strategies that support positive changes. This has led to viewing behaviour change programmes as broader than simply the provision of information – with behaviour change programmes beginning to emphasise that people are unlikely to change their behaviours unless they are supported on the one side by reliable, high quality and easily accessible health services, such as VCT, ARV treatment and wellbeing programmes. While on the other side, ensuring that messages are tailored to specific groups and that more broadly there is a supportive environment in which people feel they can change their behaviour. A key aspect of this is creating spaces

in which people can discuss and reflect on information they have gained in a way that allows them to integrate it into their everyday lives. [28]

Within the higher education sector in Southern Africa, three main approaches have been seen to emerge, in an unstructured manner, around the provision of education, information and communication programmes for behaviour change.[29] The first is the provision of information at key moments in the academic year – including student 'orientation week' and World AIDS Day on 1st December. Second, many universities have opted to explore curriculum development as a way of targeting students – either reforming existing courses to take into account HIV and AIDS or else introducing new courses. Third, peer education strategies have been used across Southern African universities as a way of providing information and encouraging behaviour change.[30]

Workplace HIV and AIDS programmes aimed at staff are not widely developed at South African HEIs and, where programmes do exist, they tend to be aimed at the lower echelon employees. There seems to be an attitude among administrative and instructional staff that they do not "need" such programmes primarily because they are not impacted upon by the epidemic.

GOOD PRACTICE IN INFORMATION, EDUCATION, COMMUNICATION AND BEHAVIOUR CHANGE

The ILO provides an overview of what good practice for information, education and communication programmes for behaviour change would look like. They suggest that this would include:

- Being linked to broader HIV and AIDS campaigns in the local community, sector or country;
- Be based on consultation between employers and employees and possibly other relevant stakeholders, such as government departments; and
- Ensuring spaces for reflection about people's own actions, prevention strategies and also a specific focus on gender.[31]

Furthermore information and education campaigns should be specifically targeted to ensure that they are relevant to target groups, and may need to be modified along lines such as gender, age, sexuality and literacy. Information campaigns should also be in a variety of formats, and not simply limited to the written word.[32] For these reasons, good programmes need to be developed in dialogue with those who they are intended for.

SADC also emphasises that information and education campaigns should not only be targeted at employees but also their families, since HIV and AIDS does not only affect one person but whole families and communities.[33]

Given that behaviour change is unlikely to happen through one-off interventions, it is also important that programmes are ongoing so that messages are reinforced and changes in behaviour are sustained.

Information, education and communication campaigns for behaviour change can therefore take a range of different approaches. Some other approaches can include:

- Multi-media approaches, such as radio, leaflets and posters, to encourage behaviour change;
- Development of radio programmes that encourages discussion about HIV and AIDS, gender and access to health services;
- Peer education programmes to encourage behaviour change;
- Compulsory courses for staff that specifically tackle HIV and AIDS;
- Non-compulsory courses that build institutional and research capacity around HIV and AIDS; and
- Regular public talks by key individuals in the university (Vice-Chancellor, student leaders, senior management) and external to the university (expert researchers, religious figures) about HIV and AIDS.

WORKPLACE HIV AND AIDS PEER EDUCATION IN SOUTH AFRICAN COMPANIES[34]

One particular form of IEC and behavioural intervention that has been widely promoted in the private sector has been the implementation of peer education programmes. This approach relies on physical and social proximity between peer educators and their colleagues for effective communication. Peer education has been widely used around the world on a range of issues, particularly in pursuit of health-related behavioural change. However, while main organisations have implemented peer education programmes, the functioning and impact remains under-researched and poorly understood.

The use of workplace peer educators is recommended by a number of good practice guides to company HIV and AIDS programs, such as those developed by the South African Department of Labour and the International Labour Organisation. They are seen as effective channels of communication on HIV and AIDS (and other issues) as well as increasing the effectiveness of all elements of a company's HIV and AIDS program, such as testing, treatment and community outreach.

Theory

A wide range of theories have potential application to peer education – though how these can be directly fed into peer educator activity is not always clear. Perhaps the most useful – and most contentious – involves competing perspectives on the way in which peer educators communicate information.

More traditional programs see peer educators at the bottom of a vertical communication machine in which their job is to translate – linguistically and culturally – information provided by experts. Given the lack of success around HIV and AIDS communication, this conception is increasingly challenged. As an alternative, a model of horizontal communication has been put forward. Here peer educators, using information provided by experts, engage in debate and discussion with peers with the focus on synthesising employees existing lay understanding of HIV and AIDS with current scientific knowledge. Discussion while influenced by peer educators is, in fact, driven by the target audience.

Numbers

The number of workplace peer educators in South Africa is not known. Recommended ratios range from one peer educator to every 50 employees (Department of Labour) to one peer educator for every 20 employers (South African Business Coalition on HIV and AIDS). A survey of five large South African companies in 2005 with over 120,000 employees found a ratio of one peer educator to every 69 employees.[35] It is likely that peer educators are most commonly found within large companies. There are also extensive, usually fragmented and short-term, peer education projects outside of the workplace.

Training

Peer educators are typically provided with a short (two to five-day) initial training. This is often dominated by attempts to convey a huge amount of factual information on HIV and AIDS – often in overly technical format. In the large companies surveyed, follow up or refresher training had been provided to around 70 percent of peer educators who had been active for over two years.

There is strong anecdotal evidence suggesting that there is a high turnover of peer educators. The cause of this is not known, but it is likely that a negative cycle of poor selection, limited training, and difficult tasks. These issues need to be addressed and reversed. The need for ongoing training – raising the possibilities of sequenced and modularised input along with greater communication skill development – is being increasingly recognised, at least by large companies where the experience of managing peer education programs is growing. The need for continuous training, along with other requirements needed to support peer educators means that early claims that peer education provided an inexpensive

way for companies to respond to the epidemic were off the mark.

The Profile of Peer Educators

In comparison to the demographic profile of company workforces there is a marked over-representation of women, particularly African women, as peer educators. Whites, particular men, and particularly more senior management are dramatically underrepresented among peer educators. To some extent this fits the profile of known prevalence in South Africa. However it also represents an additional burden on women who carry out peer education as an essentially voluntary activity. Additionally, the absence of whites in general, and white managers in particular, is noticed by both peer educators and rank and file employees. This feeds into racial theories of the epidemic and undermines peer educators.

Activity

Peer educators conduct extensive activity both in the workplace and in their communities. Of the 600 peer educators who responded to a survey in 2005, 90 percent gave formal talks to co-workers on a regular basis, 67 percent on a weekly or monthly basis. Additionally, this survey found that an average of 25 informal interactions per month conducted at work and in community settings with peers. A more in depth (and probably more accurate) study of a small group of peer educators in a mining company found that peer educators conducted 14 informal interactions per month, on a wide range of issues related to HIV and AIDS and other health issues, though this varied greatly between individuals. In addition to giving formal talks and engaging in informal activity, peer educators are engaged in awareness events, condom distribution, testing programs, community outreach and other aspects of company programs.

The Strengths of Workplace Peer Education

The location of peer education programs within companies, rather than in the community, has a number of advantages. In contrast to community based peer education, workplace programs tend, despite noted shortcomings, to provide better quality and more extensive training. The fact that workplace peer educators are in employment means they are less prone to move on to other activities, either as a result of finding work, or becoming more employable as a result of their peer education activity.

Thus, despite turnover, a cadre of increasingly experiences and informed peer educators is being built within workplace programs. Parallel to this is the emergence of peer educators taking up leadership roles within workplace peer educator structures. Additionally, peer educators operate within company HIV and AIDS programs; there are often close links to other aspects of HIV and AIDS responses – such as awareness events, professional counselling, testing and treatment. While these links often need to be clarified and improved, it is easier for workplace peer education to form part of an integrated response to HIV and AIDS than those based in the community.

Challenges

Many of the challenges faced by workplace peer educators stem from early conceptions of them being a ‘cheap and cheerful’ response to HIV and AIDS. As the complexity of changing behaviour around AIDS becomes apparent, then so too is the need for sustained and extensive inputs into peer education programs. Without this realisation, peer educators are often pushed aside by competing production pressures.

Past practices of minimum training followed by a ‘sink or swim’ approach can no longer be justified. Given this, the first challenge faced by workplace peer education is overwhelmed and under-resourced company HIV and AIDS responses. AIDS managers have to deal with all aspects of HIV and AIDS within a company. Despite their increasing experience, they often have little choice but to neglect their peer education programs.

A focus on peer education requires greater resources put into training. This would mean maintaining the

current training around content as well as increasing training around communication skills and leadership roles. Further, there is a need to shift emphasis from conceptions of vertical to horizontal communication. This would be facilitated by greater investment in peer educator networks and peer-education to peer-educator communication combined with strong lines of communication between company HIV and AIDS programs and peer educator leadership.

Priorities

In maximising the contributions that workplace HIV and AIDS peer educators can make in the response to HIV and AIDS there is a need to improve their effectiveness in existing programs and then ensure the maximum, feasible, take up of peer education within businesses. Strong company-based peer educator programs will need to address questions of the demographic profile of peer educators, the quantity, quality and orientation of training that peer educators receive, their protection from production pressures on the shop/office floor, the development of leadership and a much greater emphasis on peer educator networking.[36]

Case Study Peer Education

The 'I Choose Life' peer education programme at Kenyatta University, Kenya is an example of good practice around peer education. The University has about 14,000 students and 2,500 staff.

The 'I Choose Life' peer education programme was initiated in 2002 in an attempt to increase VCT uptake and increase condom use. Over its first 5 years it is estimated to have trained 2,900 peer educators and through them reached nearly 40,000 students

The impact of the peer educators on the campus has been impressive. Before the programme started, a baseline survey suggested that only 23% of students regularly used a condom. By 2006, when another KAPB survey was undertaken the data suggested that 86% of students were using condoms and there had been an increase of 25% in the number of students testing for HIV. It was also suggested that uptake of VCT was linked to involvement in the programme with 78% of students directly involved in the peer-education programme having undertaken VCT.[37]

Case Study Peer Education and "Healthy Living" Training

NAMDEB, a mining company, is the second largest employer in Botswana and employees nearly 4,000 people. In 1990 it developed and implemented a comprehensive health promotion and HIV and AIDS prevention programme. The programme includes a variety of health promotion activities, including condom distribution, syndromic management of STIs and peer education.

The peer education programme originally focused entirely on HIV and AIDS, but peer educators quickly noticed that people were not engaging in discussions and were becoming bored with the training. As such – and recognising people's needs for education on wider health issues – HIV and AIDS became one issue out of ten health issues discussed every year through monthly meetings by the peer educators.

Peer educators are confident in this approach because employees value the variety of information they get and it allows them to stay interested. As most topics they discuss are affected in some way by HIV and AIDS, most sessions include some discussion around HIV and AIDS.

The programme seems to have been effective – especially in the promotion of condoms. Condom distribution, which was said to be minimal before, rose from 6.7 per 1 000 workers in 1990 to 20.7 per 1 000 workers in 1995.[38] While the number of new HIV diagnoses while initially rising from 6.7 per 1,000 workers in 1990 to 20.7 per 1,000 workers in 1995, it then declined to 16 per 1,000 in 1996.[39]

MONITORING GOOD PRACTICE

It is important to monitor both the processes behind the emergence of information, education and communication campaigns and behaviour change as well as the outcomes. While it is relatively simple to monitor the broad impacts of such campaigns on people's knowledge about HIV and AIDS, it is rather more difficult to attribute people's behaviour change to one programme or policy. However, indicators that explore people's behaviours in relation to HIV and AIDS can be used. Possible measures, depending on what the programme is seeking to achieve include:

- An increase in the number of programmes an HEI is facilitating focussing on education and information for behaviour change;

Table 3 Workplace programme information, education, communication and behaviour change indicators of good practice and sources of data.

Indicator	Means of Verification
Number of information, communication and education campaigns a workplace has	Policy documents
Involvement of key stakeholders in planning and implementation of programmes	Interviews with key stakeholders
Involvement of healthcare providers in information campaigns	Policy documents
Key policies introduced in workplace to support behaviour change e.g. anti-discrimination policy	Policy documents
Percentage of employees who can identify correct means to prevent sexual transmission of HIV	KAPB survey
Percentage of employees who reject major misconceptions about HIV transmission	KAPB survey
Percentage of employees who received an HIV test in the last 12 months and who know their results	KAPB survey
Percentage of employees who used a condom during last sexual intercourse	KAPB survey
Percentage of employees who have been involved in a workplace HIV and AIDS programme	KAPB survey
Proportion of employees who report that they believe they will not be discriminated against if they disclosed that they were HIV+	KAPB survey
Proportion of staff that have engaged with a peer educator in the last 12 months	KAPB survey
Number of peer educators trained per 100 employees	Training records

- Involvement of a range of stakeholders in the development and implementation of information and education campaigns;
- Ensuring information and behaviour change programmes are backed up with supportive health services;
- Ensuring supportive policy and legislation around HIV and AIDS exists in the workplace;
- Increased correct knowledge about how to prevent sexual transmission of HIV;
- A decrease in incorrect knowledge about HIV and AIDS;
- An increased uptake of VCT;
- An increase in people using condoms;
- Reduction in HIV-related stigma; and
- Increased numbers of people reached through programmes.

SECTION 14

Condom Promotion

BACKGROUND

In Southern Africa, the main route of transmission for HIV and AIDS is through sexual intercourse. Amongst sexually active populations, condoms provide a reliable and highly effective means of minimising the risk of transmission. UNAIDS advocates the promotion of condoms as a key approach to preventing HIV and AIDS transmission,[40] as does SADC.[41]

Condom promotion has three interlinked aspects to it. First, ensuring that regular supply of good quality condoms are available. Second, encouraging people to access condoms, and third encouraging consistent and correct use of condoms – as such condom promotion as a policy and activity is closely linked to strategies of education, information, communication and behaviour change.

Choosing not to promote condoms limits the effectiveness of prevention programmes, as populations that are sexually active are likely to remain sexually active. Currently condoms are generally promoted as part of 'ABC' Campaigns, emphasising prevention approaches of Abstinence, Be Faithful or Condomise. Recently US funded approaches have emphasised Abstain approaches alone, although research shows that these are not effective compared to approaches that promote Abstain or Condomise in conjunction with one another.[42]

One of the key issues revolves around translating the demand for condoms into actual consistent use of condoms. Hence condom promotion needs to move beyond generating a demand to broader strategies that encourage consistent condom use as well.

A recently emerging topic in condoms promotion is female condoms or femidoms. These are often seen as easier to promote, partly because there is a 'stigma' surrounding male condoms and also because they are a prevention intervention led by females rather than males, who are generally perceived to be more likely to use prevention technologies.

GOOD PRACTICE IN PROMOTING CONDOMS

Promoting condoms needs to be recognised as a key principal for HIV and AIDS prevention, but also needs to be linked to other forms of HIV and AIDS prevention such as partner reduction, VCT and abstinence, if condom promotion is to be successful. There are multiple aspects that need to be considered surrounding the promotion of condoms, but policies and programmes need to:

- Ensure an adequate and accessible supply of condoms;
- Stimulate greater demand for condoms; and
- Support the greater use of condoms.[43]

The more complicated aspect of condom promotion lies in stimulating greater demand for condoms and

supporting increased use of condoms. Supporting increased use of condoms is tackled in the section 'Information, Education and Communication and Behaviour Change'. Strategies to encourage the greater demand for condoms, rely on a number of different approaches. This can include, making condoms 'cool' through social marketing approaches that apply marketing ideas such as branding and product placement to encourage demand for condoms, challenging misperceptions about condoms, especially various myths that circulate about the efficacy of condoms and also challenging religious and 'cultural' barriers to condom use and often the overly high cost of condoms. Such strategies have included:

- Ensuring that condoms are available at either no cost or extremely low cost;
- Ensuring condoms are always available from key points – such as clinics, toilets, shops;
- Ensuring condoms provided are perceived as good quality;
- Strategies to empower women to be able to negotiate condom use;
- Making sure that messages to promote condoms are tailored to specific groups;
- Peer education strategies that emphasise condom promotion;
- Social marketing techniques to make condoms accessible and 'trendy' for younger audiences;
- The linking of condoms to other prevention strategies, such as abstinence, which aims to delay sexual debut (abstinence) but also ensure that upon sexual debut condoms are used; and
- The promotion of female condoms alongside male condoms, as a way of overcoming some of the social barriers that women face in accessing condoms, and some of the 'stigma' male condoms have.

MONITORING THE IMPACT OF CONDOMS PROMOTION

Monitoring the demand of condoms within a workplace is relatively simple and so exploring the impact of condom promotion campaigns on condom demand is relatively simple. However, because condoms are often accessed outside of the workplace, only monitoring workplace sources of condoms may underestimate the level of demand. Such indicators of demand could include:

- Increases in the demand of condoms (male and female) across the workplace;
- Ensuring supply of condoms from key dispensing areas;
- Perceptions of quality of condoms; and
- Increased levels of knowledge about male and female condoms.

Table 4 Workplace programme condom promotion indicators of good practice and sources of data

Indicator	Means of Verification
Perceptions of condom quality	KAPB survey
Availability of condoms through major distribution points	Manual check of availability
Number of condoms/person distributed through the workplace	Stock records/HR records
Proportion of employees reporting condom use at last sexual intercourse	KAPB survey
Percentage of women who feel confident to negotiate condom use with a sexual partner	KAPB survey
Percentage of women who belief that if their husband had an STI they could refuse sex or negotiate condom use	KAPB survey
Ratio of femidoms distributed compared to male condoms	Stock records
Percentage of employees who can explain how a condom works	KAPB survey
Number of employees receiving peer education or other programmes promoting condoms	HR records/employee records
Percentage of employees who can identify the major routes of transmission	KAPB survey

While demand for condoms might be high, it does not necessarily mean that condoms are used during sexual intercourse. Indeed the demand for condoms is likely to be higher than the actual use of condoms. As such indicators also need to explore whether there is:

- An increase in condom use amongst employees;
- An increase in the number of programmes to encourage condom use;
- An increased ability amongst women to negotiate condom use; and
- An increased number of employees who can explain the major routes of HIV and AIDS transmission and can dispel major myths.

SECTION 15

HIV Counselling and Testing

BACKGROUND

Mandatory testing of employees is prohibited in South Africa [44] so this section only deals with voluntary counselling and testing (VCT). VCT is not only a gateway to treatment, care and support for people living with HIV, but is also an important component of HIV prevention. This is particularly the case in southern and eastern Africa where a large proportion of new infections are occurring among HIV discordant couples. And as such VCT is emerging as a central component to respond to the HIV and AIDS pandemic.[45]

VCT is an important example of the ways in which public health strategies and human rights protection are mutually reinforcing. VCT protects people's rights by ensuring confidentiality, providing information about HIV transmission and personalising discussions of an individual's risk, thus enabling people to make informed decisions about testing and their own risk. In turn, this builds trust between those at risk and the health system, maximising the effectiveness of prevention programmes and ensuring access to treatment, care and support services where necessary.

In many workplace settings, low uptake of VCT has been linked to the fact that people feel confidentiality will not be ensured. In such instances creative thinking – such as providing VCT outside the workplace for free – needs to be implemented.

For VCT to be truly effective in encouraging people to test, it must be linked to a number of other programmes that:

- Promote the use of VCT;
- Have effective post-test healthcare – preferably access to ARVs, but at least treatment of opportunistic infections.

Importantly as the ILO Code of Good Practice makes clear, HIV testing and counselling, should in no way be linked to employment or exclusion from work processes.[46]

GOOD PRACTICE IN HIV COUNSELLING AND TESTING

UNAIDS emphasises that VCT must be underpinned within a human rights based approach. They argue that if VCT is going to be underpinned by rights, it should be based on a '3Cs' model. Which states the testing of individuals must be:

- Confidential;
- Accompanied by **counselling**; and
- Only conducted with informed **consent** – meaning it is informed and voluntary.[47]

They also go on to emphasise that good practice includes ensuring that VCT is developed in conjunction with

other support services, specifically prevention services, for those who test negative and treatment and positive-prevention services for those who test positive.[48]

If workplace VCT is to successfully increase the number of people that choose to test for HIV and AIDS, in conjunction to effective and supportive testing facilities, there need to be campaigns that actively encourage people to test for HIV and reduce the stigma surrounding both the testing and HIV and AIDS.

The South African Department of Labour argues that employees are unlikely to participate in VCT unless:

- They are certain they will not be discriminated against on the basis of their HIV status;
- There is guaranteed confidentiality and medical staff are seen to be independent of management;
- The facilitates for VCT are integrated into other services, so they cannot be identified as using them; and
- There exists a benefit for using VCT, such as a treatment programme.[49]

These underlying good practice principles suggest that a number of programmes and policies may be useful in encouraging VCT, including:

- Integration of VCT services with other health services;
- VCT must be voluntary and enable people to give their informed consent to be tested, based on pre-test information about the purpose of testing. People testing also need to be informed about the treatment, care and support available once the result is known;
- The testing should incorporate post-test support and services that advise those who test HIV-positive on the meaning of their diagnosis, and on referral to the treatment, care and support and prevention programmes and services available to assist them.
- Information and education campaigns around VCT and HIV and AIDS;
- Stigma reduction programmes;
- The introduction of anti-discrimination policies in the workplace;
- Building a relationship with an external health provider outside the workplace to conduct VCT;
- The introduction of a wellness programme following VCT;
- The introduction of an ARV programme;
- Standard operating procedures (SOPs) for all aspects of the process must be developed and followed;
- Testing algorithms and testing kits must all be compatible with government guidelines;
- Delinking VCT testing from Human Resources files; and
- The extension of testing to employees' families.

Case Study Good Practice - VCT

SASOL is a global company, which mines coal, natural gas and crude oil at over 20 sites around the world. In 2002, it implemented the SASOL HIV/AIDS Response Programme (SHARP) in South Africa and Mozambique. Set up with involvement from the business, trade unions, community representatives and independent consultants, the overall aim of SHARP was to reduce the rate of infection amongst its employees and improve the quality of life for employees who are HIV-positive through managed healthcare.

A key component of SHARP is the role VCT plays in facilitating access to appropriate healthcare and in promoting behaviour change. VCT has been encouraged in the company through extensive training of managers and peer education strategies, involvement of trade unions in the programme and the provision of free ARVs to all employees who test HIV-positive.

Uptake of VCT through SHARP has been high at 82% of all employees in South Africa by June 2005. This compares favourably to other workplace VCT programmes, where uptake is between 50% and 60%.[50]

Case Study VCT good practice – Maseno University, Kenya

Maseno University is a small, rural institution with approximately 4,000 students. The Centres for Disease Control helped with the initial establishment of the VCT service but it has since been funded internally. An estimated 12-14 students used the VCT service per day in 2006. As an accredited HIV testing and treatment site since 2003, the university is integrated into the national HIV and AIDS programme. In a catchment area of 80000 people, it received 1,653 clients in 2005 and a further 1,280 clients by October 2006. In a small university context, these are exceptionally high numbers of service users. Integration with the national programme allows for external quality assurance, sharing of data, access to resources and recognition. This example illustrates what is possible within a small institution with modest resources, strong leadership and innovation.[51]

Case Study Good Practice – VCT Uptake

Telkom is Africa's largest communication company, with 31,700 employees in South Africa. It has an effective and comprehensive VCT programme within its workplace HIV and AIDS policy.

The VCT programme that Telkom has introduced has been highly effective at encouraging both employees and their families to test for HIV. Since its inception in 2004, about 65 percent of employees have tested for HIV through the programme and impressively, 65 percent of spouses or partners of Telkom employees have also tested for HIV.

Underlying the high take up of VCT are a number of important strategies. A key aspect of the programme has been to de-stigmatise VCT through encouraging employees living with HIV and AIDS to become ambassadors for testing, through running peer education groups and through an information campaign based on leaflets and posters. Additionally, VCT is available both in workplace clinics and clinics external to the workplace, free of charge. Crucially the VCT programme is also linked into other health services so that the programme is integrated into general healthcare and is also linked to a wellness programme that provides ARV treatment to employees and their families.[52]

Many companies, institutions and HEIs in Africa have noted that uptake of VCT is low amongst employees although this sometimes improves over time. The primary reason for this is probably because of fears over lack of confidentiality when attending "in-house" services. People frequently prefer the anonymity of attending an off-site service such as a government clinic, NGO service or GP.

Our own experience in conducting HIV prevalence studies seems to corroborate this hypothesis because uptake of the VCT services that we offer in parallel to the HIV prevalence study is usually very high. We assume that the employees prefer to use our nurses because they are external to the workplace, know nobody there and are likely to never return once the intervention is over.

For these reasons, many companies use external service providers to provide VCT or to supplement their own VCT services during VCT "drives".

MONITORING GOOD PRACTICE IN VCT

The indicators used to monitor the effectiveness of VCT programmes are fairly simple and standardised. Ideally, the number of employees seeking VCT over time should increase until most have been tested. It is then likely to level off, as most tests will then be repeat tests.

There needs to be caution with some of the indicators of VCT – specifically indicators exploring the total number of people undertaking VCT – this is because it is likely that once someone has tested for HIV and

Table 5 Workplace programme VCT indicators of good practice and sources of data.

Indicator	Means of verification
Total number of employees who received VCT at on-site services per month	Clinic records
Proportion of VCT attendees who are HIV+	Clinic records
Mean CD4 level of HIV+ employees at time of first VCT who tested using on-site services	Clinic records
Proportion of employees who have received an HIV test in the last 12 months and know their results	KAPB survey
Proportion of employees who report non-stigmatising attitudes to PLWHA	KAPB survey
Proportion of employees who have received an HIV test in the last 12 months and report non-stigmatising attitudes of healthcare workers doing the test	KAPB survey
Proportion of employees who would tell another employee that they were going to take an HIV-test	KAPB survey
Proportion of employees who have good knowledge about VCT	KAPB survey

AIDS once they are likely to repeat test and as such the total number of VCTs undertaken in a clinic is unlikely to be the total of number people who have undertaken a VCT test and as such is likely to be an overestimate.

Monitoring the mean CD4 count at diagnosis may be used to monitor the stage of disease that the average employee is at when he/she decides to test. If, over time, VCT becomes more routine and employees start presenting earlier in the course of their illness, then the mean CD4 count will decrease over time.

- Increased uptake of VCT;
- Decreased numbers of complaints of discrimination by people living with HIV and AIDS;
- Increases in CD4 count at time of first testing HIV-positive;
- Increased knowledge about VCT testing amongst employees;
- Decreased complaints about stigmatisation from healthcare workers amongst those undertaking VCT.

SECTION 16

Treatment of STIs

BACKGROUND

Sexually Transmitted Infections (STIs) such as syphilis, gonorrhoea, herpes and Hepatitis B are one of the most common health problems amongst workers.[53] As an illness, without proper and timely treatment these STIs can be a cause of serious morbidity.

UNAIDS, recognises the importance of STI treatment and prevention as a key strategy in HIV-prevention.[54] There are a number of reasons UNAIDS advocates workplace STI treatment. HIV and AIDS is more easily transmitted if STIs are present; one workplace study demonstrated that through an effective STI treatment programme, HIV-transmission could be reduced by up to 40 percent.[55] Fast and effective treatment of STIs ensures that people living with HIV and AIDS remain healthier for longer. Finally, accessing treatment for STIs is one way in which workers can start to become engaged with the health system and access information about HIV and AIDS prevention and treatment.

There are two main strategies for treating STIs, either through looking at STIs in terms of syndromes, or else through testing for specific STIs. The necessary infrastructure and resources required for STI testing and then treatment can often, especially in 'developing' countries, be prohibitive. Syndromatic treatment of STIs, however relies on identifying the presenting symptoms and then, using a flow-chart, come to possible conclusions of the underlying illness and the necessary treatment. Treatment is likely to cover a number of major causes of the presenting symptoms and has been shown to be effective.

GOOD PRACTICE IN TREATMENT OF STIs

UNAIDS provides clear guidance of what policies and programmes to manage STIs should look like. They emphasise that these should be in line with and co-ordinated with National AIDS policies, because many of the issues are very similar. Also they stress that any programme around STIs should be compatible with a human rights approach.[56]

They suggest STI programmes should:

- Include prevention activities;
- Be integrated into maternal, antenatal and family planning services where these exist;
- Target key population groups with acceptable STI care services; and
- Promote early STI treatment together with education around sexual behaviour.[57]

While confidentiality should be at the heart of STI management services, it is likely that in a workplace setting employees do not feel they have adequate privacy. As such workplaces may find that 'in-house' clinics are inappropriate settings for STI treatment and that external service providers are preferable.

Such strategies to prevent, manage and treat STIs might include:

- Campaigns to increase condom use;
- Behaviour change campaigns;
- Programmes to encourage early treatment of STIs;
- Information campaigns to encourage greater knowledge and earlier recognition of STIs;
- Ensuring local populations have access to effective STI treatment services;
- Linking STI treatment into other healthcare services such as ante-natal clinics;
- Syndromatic management of STIs in the workplace; and
- Supporting local clinics in STI treatment.

STI treatment policies and programmes therefore have a strong overlap with other areas of HIV and AIDS treatment and prevention.

MONITORING GOOD PRACTICE

Good practice in STI treatment is centred around the twin aims of speeding up the treatment of STIs (prompt treatment) and reducing the overall incidence of STIs within a given population. The two aims are self-reinforcing and possible indicators could include:

- Decrease in the number of STIs reported amongst employees;[60]
- Increased uptake of STI treatment;
- Decreased levels of stigma towards STIs;
- Increased levels of knowledge about STIs, routes of transmission and symptoms;
- Increased use of condoms.

Case Study STI Management

The Lesedi Project supported by Harmony Gold Mining Company, international funders and the South African Department of Health, began in 1996 in Virginia, a town in Free State Province, South Africa. Virginia has a population of about 80,000 people, which includes a mining workforce of 13,000, 90% of whom were housed in single-sex hostels.

The programme aimed to manage STIs through: 1) syndromic management for mining workers and 2) presumptive treatment of women at high risk of STIs, mainly female sex workers.

In addition the STI management programme was backed up with condom promotion of both male and female condoms and access to sexual health advice and counselling and peer education for women in the local community to promote behaviour change. A key aspect of the project has been ensuring that the wider programme of behaviour change has been participatory.

The initial project was approached with much scepticism by trade union representatives and the community, because of the long history of neglect and confrontation within the mining workplace. However, because of its initial effectiveness it rapidly became recognised as an effective programme and gained support from all stakeholders.

The results from the first stage of the project are impressive. Amongst the mineworkers, gonorrhoea and Chlamydia were reduced by 42%, while there was a 77% decline in genital ulcers. While amongst the women it worked with in the community STI prevalence fell by between 70 percent and 85 percent. It was estimated that this intervention had averted 235 new HIV infections. The intervention was also demonstrated to be cost effective.[58 59]

Table 6 Workplace STI Treatment Programmes, Indicators of good practice and sources of data

Indicator	Means of Verification
Proportion of employees getting treatment for an STI	Medical records
Number of STIs reported per 1,000 in the workplace population	Medical records
Number of STIs reported per 1,000 in the community	Medical records
Proportion of employees who know the routes of transmission of STIs	KAPB survey
Proportion of employees who can recognise major symptoms of STIs	KAPB survey
Proportion of female employees who feel confident to negotiate condom use	KAPB survey
Proportion of employees who report using a condom during their last sexual encounter	KAPB survey

SECTION 17

Universal Precautions

BACKGROUND

Universal precautions are a simple set of standard practices to minimise the risk of transmission of blood-borne pathogens, including HIV in the work setting. Typically these precautions are part of wider health and safety procedures in occupational settings.[61]

Implementing universal precautions allows work environments to be safe and to respond quickly and effectively to any possible incidents that might occur. This requires that workplaces are safe – that they conform to health and safety legislation – and that they have the necessary systems in place to adequately respond to any accidents. It also means that workplaces need to support workers around universal precautions – ensuring that workers feel confident to report accidents and concerns they face and also that workers feel supported when accidents occur.

Universal infection control is a simple standard of infection control practice used in the care of any person to minimise the risk of transmission of blood-borne pathogens.

The central role of Universal Precautions in HIV prevention in the workplace is clearly indicated by the ILO.[62]

GOOD PRACTICE IN UNIVERSAL PRECAUTIONS

There are clear guidelines as to what universal precautions in the workplace would look like. These guidelines are derived from the United States Centers for Disease Control and Prevention (CDC), who published them in 1985 and have subsequently updated them.[63] The key points of Universal Precautions are:

- Applying these universally to all people, no matter what their HIV status;
- Creating protective barriers between blood and other human fluids
- Strategies to prevent injuries from sharp objects, such as knives and needles

A universal precautions programme should:

- Educate employees about occupation risks and methods of HIV transmission and prevention;
- Include the provision of equipment such as gloves and disinfectants as barriers and to clean up after blood spills; and
- Provide post-exposure counselling and follow up care.

More recently there has been a shift in universal precautions around HIV and AIDS, to include discussion of post-exposure prophylaxis as part of universal precautions.

INDICATORS OF UNIVERSAL PRECAUTIONS

Table 7 Workplace programme universal procedures indicators of good practice and sources of data.

Indicator	Means of Verification
The existence of a Universal Precautions policy	Policy exists
Health workers trained in Universal Precautions	Training records
Items needed for Universal Precautions available in health facilities	Review of stocks of gloves and other barrier items
Post exposure care available	Policy exists and PEP kits available

SECTION 18

Post-Exposure Prophylaxis

BACKGROUND

Post-exposure prophylaxis (PEP) is the provision of anti-retroviral therapy following a person's exposure to blood or other fluids containing HIV as a means of stopping the transmission of the virus – currently this needs to occur as quickly as possible after exposure to HIV, with a maximum time limit of 72 hours.[64] It is a relatively new approach to using ARTs that emphasises their role as a preventative tool, rather than as a tool for treating HIV and AIDS.

PEP is closely linked to Universal Precautions, indeed in the workplace Universal Precautions (discussed above) would now typically include PEP.

There are two settings in which the use of PEP is now recommended by the WHO and ILO and endorsed by UNAIDS: [65]

1. The occupational setting – where a person comes into contact with blood which contains the HI Virus – this is typically seen amongst healthcare workers through 'needle-stick' injuries and is considered to be an extension of Universal Precautions; and
2. Non-occupational setting, either through accidents in the workplace that lead to exposure to blood (car accident, falling accident etc.) or because of sexual assault.

The provision of PEP, especially in non-occupational settings, can lead to complex questions about its use.[66]

However in South Africa there is a notional commitment to the provision of PEP through the public health system, which can be supported in workplace programmes and policies.[67]

There is also the additional issue that for PEP to be administered the person requesting it must test for HIV and AIDS and be found to be HIV-negative. This further increases the complexity of the issues surrounding the delivery of HIV-PEP in the workplace setting, where people may be reluctant to discuss or disclose their HIV-status.

GOOD PRACTICE IN PEP

In the occupational setting, the ILO Code of Practice on HIV and AIDS[68] and ILO/WHO[69] recommendations outline what constitutes good practice. Possible actions to promote occupational PEP could include:

- Attempting to reduce the potential for occupational exposure (through implementing Universal Precautions);
- Increasing people's knowledge of Universal Precautions through training and information campaigns;
- Ensuring that confidentiality and informed consent underpin the provision of PEP through ensuring health providers are not linked to management;

- Programmes to inform employees that it is the employer's responsibility to ensure employees are told about PEP, where to access it and it is provided at no cost to employees; and
- Increasing people's knowledge of how to access occupational HIV-PEP and the legal status of this.

As such there is a strong onus on employers to ensure that PEP is available for those people exposed during their work to the HI Virus.

Within non-occupational settings the standards for good practice are a lot less clear. This is linked to the lack of possible ethical trials around this issue. [70] That said there are a number of clear guidelines around the actual provision of PEP in non-occupational setting, including:

- Information campaigns explaining the role of PEP in non-occupational exposure;
- Programmes and policies to ensure that PEP can be accessed quickly;
- Campaigns to decrease the stigmatisation of rape and gender-based violence and to encourage its reporting;
- Ensuring healthcare centres have access to starter kits for HIV-PEP;
- Developing programmes to allow quick and efficient referrals from workplace clinics to hospitals to ensure the delivery of PEP;
- Ensure healthcare facilities are equipped to deal effectively with rape; and
- Encouraging a relationship to develop between healthcare services and police.

Because non-occupational use of PEP is often linked to sexual assault and rape, it is important that alongside the provision of PEP in these cases strong policies and programmes around sexual harassment, gender-based violence and rape are instituted in workplaces as well.[71] These are particularly important if PEP for non-occupational exposure is offered within the workplace, because of the social stigma surrounding rape and gender-based violence, people may be aware of the availability of PEP but refuse to come forward to access it.

The provision of PEP is tightly regulated in terms of medical issues. Workplaces often only hold 'starter packs' of PEP (3 or 4 days supply) before referring people to public or private hospitals for further treatment. However, where access to treatment is highly constrained – because of stigma or supply issues – workplaces should hold a complete regimen of PEP. Good practice principles in the medical provision of PEP include:

- The provision of PEP within as fast time as possible – and under 72 hours – after which HIV-PEP is ineffective;
- Ensuring confidentiality in initial testing and provision of PEP;
- A two-drug rather than three-drug regimen for PEP is recommended because of cost-effectiveness around completion of treatment; and
- The provision of PEP needs to be closely tied to counselling.[72]

As such HIV-PEP is a complicated, but necessary component of a comprehensive workplace response to HIV and AIDS.

Table 8 Workplace programme post-exposure prophylaxis indicators of good practice and sources of data.

Indicators	Means of Verification
Percentage of employees who know about PEP availability	KAPB Survey
Number of times within a year PEP has been given employees	HR/Stock records
Number of employees who have lodged sexual harassment complaints	HR records
Proportion of employees who report that they would access PEP if they were raped	KAPB survey
Number of hours between possible exposure to HIV-infection and starting of PEP	Medical records

MONITORING THE IMPACT OF THE PROVISION OF PEP

The monitoring of good practice around the provision of PEP in the workplace, for occupational and non-occupational situations is relatively easy to monitor if all instances are recorded. Possible indicators may include:

- Increased numbers of employees who say they would use PEP if necessary;
- Increased knowledge amongst employees of PEP;
- Increased implementation of universal precautions;
- Decreased levels of sexual harassment and rape within the workplace; and
- Speed of provision of PEP in the workplace.

SECTION 19

Treatment of HIV

BACKGROUND

The availability of antiretroviral therapy since 1996 has transformed HIV into a chronic, manageable disease rather than an automatic death sentence for most of those that have access to the drugs. In affluent countries there has been a 70% decline in AIDS-related deaths since the advent of antiretroviral therapy.[73]

The major constraint to providing ARV therapy in poorer countries has been the high cost of the drugs although the cost has dropped considerably in recent years and a number of studies suggest that universal coverage of ARV therapy is a cost saving in the long-run.[74] However, costs are not the only barrier to the wide-scale provision of ARV therapy. There are concerns about providing drugs to large numbers of people in settings where health care facilities can barely provide basic primary health care let alone the complex support and monitoring required of ARV therapy.[75]

In spite of these challenges, there are numerous examples of successful ARV programmes being rolled out in resource constrained settings across the developing world[76] including South Africa.[77] One of the settings where treatment is being successfully provided is in private and public sector workplaces.

Employers have a clear business case for offering access to treatment because of the negative impact of HIV and AIDS on productivity and profits. Research in South Africa has shown the significant direct and indirect costs to a company of a case of HIV. In many cases, particularly where employees enjoy high benefit levels, it is highly cost-effective to treat employees[78].

Another benefit to providing treatment to employees is that where people have access to treatment, they are more likely to undergo VCT and there is some evidence that there is a decrease in stigma. Therefore, treatment and prevention should not been seen as competing components of a response but complementary to each other.

GOOD PRACTICE IN THE PROVISION OF HIV TREATMENT

This section consists of a review of the various models as to how employees may access HIV treatment programmes and it concludes with examples of good practice from workplaces in South Africa and from higher education institutions from around Africa.

In the context of the South African workplace, there are four methods of providing treatment to employees and, frequently, a combination of approaches are used within one setting.

Medical aid schemes: Employees that are members of medical aid schemes may access treatment from

their preferred health care provider. In many companies and institutions it is only employees in higher job bands that are members of these schemes and yet it is among those without access that the prevalence of HIV is usually the highest. An advantage of medical aid schemes to the patient is that he/she is able to select a private sector doctor of his/her choice and be treated in privacy. One disadvantage is that quality of care by the private sector is very variable.

Contracted third-party providers: There has been a growth in recent years of so-called third-party providers or health maintenance organisations. Some are NGOs and others are for-profit. These organisations provide services using a variety of models but the common factor is that they interface between the funder (company or medical aid scheme) and the patients. The aim is to provide a high-quality and uniform service whilst also protecting the patients from being identified as HIV positive by the funder. A major advantage of these HMOs is that they are able to provide and supervise the complex treatment and monitoring that is required when treating HIV. A disadvantage to companies and institutions using their services is that the costs are often quite high and they have little control over how the services are run.

In-house schemes: Some of the bigger companies and organisations provide HIV treatment directly to employees through the company health service. This is usually for employees that are not members of medical aid schemes and typically does not cover dependents. An advantage of this approach is that the company has complete control over all aspects of the programme and can provide a uniform standard of care to employees. However, a disadvantage of this approach is that take-up of services is frequently low because employees have concerns about confidentiality, anonymity and victimisation.

Public sector: The "fall-back" position for organisations that are unable or unwilling to provide ARV treatment is to refer their employees to the public sector for care. Whilst South Africa has the largest public-sector ARV programme in the world and coverage is widely spread, the reality is the system is severely overstretched and there are lengthy waiting lists at many sites.

Key components of workplace HIV and AIDS treatment programmes

The decision to provide access to treatment for employees is a major decision to take and can only be done in the context where sustainability is ensured. The key lessons distilled from good practice are listed and discussed here.

1. **Define the extent of the problem and likely risk:** It is important to quantify the prevalence of HIV and how it is distributed within the working population. This permits planning of current and future care requirements and also provides baseline data against which to measure improvements over time.

   In the case of the HE sector, an HIV prevalence, KAPB and risk assessment study is currently being conducted among staff and students at all 23 HEIs. Institutional-level and sector reports will be produced which will provide the information needed.

2. **Workplace policy on HIV and AIDS:** A comprehensive workplace HIV and AIDS policy will provide the framework within which all HIV interventions will be situated. The policy needs to address stigma and discrimination and encourage involvement of PLWHA.

3. **A continuum of prevention, treatment, care and support:** A treatment campaign will be least effective if it is attempted in the absence of a comprehensive prevention and treatment intervention.

4. **Monitoring and evaluation:** The monitoring of individuals on treatment and monitoring of the overall programme is essential to ensure high-quality treatment and efficient functioning of the programme. It is the only way to ensure that goals are being reached and to make necessary modifications to the programme if required.

Case Study Anglo American – Access to Treatment

Anglo American is the largest company in South Africa and has about 140 000 employees in eastern and southern Africa. It was one of the first companies back in the 1980s to recognise the need for HIV policies and programmes and it remains a leader in workplace HIV prevention and treatment interventions. Employees who were members of medical aid schemes had access to antiretrovirals but in July 2002, the company took the decision to provide free antiretrovirals to all employees but not dependents through the company health services.

The aims of the Anglo ARV therapy programme are to:

- Ensure a high-quality, integrated antiretroviral programme using a standardised model of delivery;
- Expand access to antiretroviral drugs;
- Build local capacity;
- Evaluate the clinical and economic feasibility of treatment; and
- Provide a framework for research.

It is estimated that about 33 000 of Anglo employees are HIV+ and that about 5000 require ARVs. However, by the first quarter of 2004, only 1 300 employees were on ARVs.

The provision of drugs, follow-up care, medical staff training and monitoring and evaluation is done through Aurum Health Research which is a wholly owned subsidiary of Anglo Gold. Aurum Health Research has an international standing in the field of HIV research and care and has links with many local and international universities. Aurum also has links with civil society groups such as the Treatment Action Campaign and with business organisations such as SABCOHA (South African Business Council on HIV and AIDS) and the Global Business Coalition on HIV and AIDS.

Monitoring of all patients is done by Aurum with standardised patient files being sent to a central office for data capture. All clinical forms and prescriptions are monitored by doctors at the central office. Clinics and clinic staff are regularly monitored by Aurum staff.[79]

EXPERIENCES OF OTHER AFRICAN UNIVERSITIES WITH TREATMENT PROGRAMMES

In most African countries access to treatment is not widely available through the public sector partly because of costs but also because of weak health care infrastructure. In these countries, universities, the medical schools and their affiliated hospitals comprise the medical elite and so it is perhaps not surprising that these institutions were often at the forefront of providing ARVs to their own staff and others.

Case Study Maseno University, Kenya

This is a small, rural institution with only 4000 students situated 25km outside Kisumu which is on one of the main trucking routes. In the late 1990s the university was losing 8 employees per year to AIDS. The university then implemented a medical levy in 1998 to pay for their anti-malaria programme and to buy ARVs. However, uptake by staff and students was slow with only 10 people on treatment in the first year.

By 2003 the university was designated as an accredited ARV treatment centre and integrated into the national HIV and AIDS Control Programme. Although uptake remained fairly low, by late 2006 78 patients were registered with the treatment programme and 52 were on ART, the death rate had fallen to 1 or 2 per year.

Interestingly, all this developed in the absence of any formalised institutional policy arrangement and it was only in 2007 that such a policy was implemented.

The US CDC gave initial support to the university in VCT provision but the institution has now become self-sufficient.[80]

Case Study University of Dar es Salaam, Tanzania

In May 2000, the government of Tanzania issued a directive that all universities were expected to establish HIV and AIDS committees to structure their response to HIV and AIDS.
The University Health Centre is a large facility which handles up to 200 patients a day and provides services to staff, students and the community that includes treatment of OIs and the provision of HAART. Every employee, their spouse and up to 4 dependents may use the health care facilities.[81]

GOOD PRACTICE IN MONITORING HIV TREATMENT

It is relatively simple to monitor workplace HIV treatment programmes in terms of their effectiveness at reaching key groups, if there has been a baseline survey of the impact and extent of HIV and AIDS in the workplace. Possible indicators therefore need to include:

- Increased uptake of HIV treatment in the workplace;
- Knowledge of the availability of treatment in the workplace;

Table 9 Monitoring Workplace HIV Treatment Programmes, indicators of good practice and sources of data

Indicator	Method of Verification
Number of employees on treatment	Clinic records
Ratio of number of employees on treatment compared to predicted needs of employees	Clinic records – Initial baseline surveys
Perceptions of treatment programme in the workplace	KAPB survey
Levels of adherence to treatment amongst employees on treatment	Clinic records and KAPB survey
Percentage of employees on treatment involved in adherence support programmes	KAPB survey
Proportion of employees who report non-stigmatising attitudes to PLWHA	KAPB survey
Proportion of employees who report that they believe they will not be discriminated against if they disclosed that they were HIV+	KAPB survey

- Positive perceptions of the HIV treatment programme;
- Ensuring that HIV treatment programmes are closely linked to wellness programmes (discussed in Table 9);
- Increased involvement of people on treatment in peer support programmes to increase adherence to treatment; and
- A decrease in stigma for people living with HIV and AIDS.

SECTION 20

Crosscutting Issues

Crosscutting issues are issues that need to be taken into consideration within all the different strategies for workplace HIV and AIDS prevention, during their conceptualisation, design, implementation and review. Often these crosscutting issues require that specific interventions or programmes include the issue as a central component. However, some cross-cutting issues can also specific programmes and policies that need to be introduced to create a stronger context for effective HIV and AIDS prevention and a stronger social environment for protecting the rights of workers and of people living with HIV and AIDS.

SECTION 21

Leadership

BACKGROUND

UNAIDS has consistently emphasised that if HIV and AIDS is to be effectively tackled then there needs to be strong leadership across all sectors.[82] The UNGASS Declaration stated that:

> Strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by governments in combating HIV and AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector. Leadership involves personal commitment and concrete actions.[83]

Leadership for effective HIV and AIDS management is necessary for a number of different reasons, including:

- Creating open discussion about HIV and AIDS leading to a decline in stigma;
- Ensuring that HIV and AIDS is given the priority it deserves in management systems;
- Channelling sufficient resources and finances to adequately respond to HIV and AIDS in the workplace;
- Mobilising other key stakeholders to respond; and
- Creating a supportive context for HIV and AIDS programmes.

Without effective leadership HIV and AIDS can easily remain hidden as a workplace policy, reinforcing stigma, secrecy and shame and undermining workers' rights and the productivity of workplaces.

Strong and effective leadership needs to ensure that other stakeholders are also brought into discussions if individual leaders are to make a significant difference.

GOOD PRACTICE IN LEADERSHIP

Leadership around HIV and AIDS needs to be exerted throughout the different levels of any institution, from those in senior management to those in junior positions. However, leadership from senior management is crucial if HIV and AIDS is to be tackled efficiently and comprehensively across a workplace.

Strong leadership, it is suggested, needs to be reflected in three different areas:

- Internally – strong leadership around HIV and AIDS as a workplace issue;
- Externally – leaders drawing in other key stakeholders, showing leadership within the wider community; and
- Personally – leadership, role-modelling behaviour at an individual level.[84]

Within these three spheres, there are various specific actions that could constitute good practice around

leadership. Internal actions to the workplace are likely to create a supportive environment for HIV and AIDS programmes and policies and hopefully challenge HIV-related stigma and discrimination. Internal workplace activities could include:

- Creation of a high level task teams or committee within the institution to respond to HIV and AIDS;
- Vice-Chancellors chairing HIV and AIDS committees;
- Vice-Chancellors or senior managers speaking at workplace meetings about HIV and AIDS;
- Ensuring institutional and workplace responses are well funded and supported across the workplace;
- Drawing in other stakeholders to ensure social dialogue, including trade unions and healthcare providers.
- Implementing an M&E system that is monitored and reported upon at an executive level and that is based on a few key indicators.

Leadership actions external to the workplace are necessary because workplaces are situated within specific communities and these two interact and also to demonstrate within the workplace leadership commitment to HIV and AIDS management. For HIV and AIDS programmes and policies to be effective in the workplace, they also need to effectively engage local communities. Leadership can involve themselves in ensuring that this occurs. External activities could include:

- Funding local HIV and AIDS initiatives;
- Supporting, through the direct involvement of senior managers, local initiatives around HIV and AIDS;
- Attending sector wide conferences on HIV and AIDS;
- Attending national and international conferences on HIV and AIDS; and
- Ensuring dialogue with key local representatives around HIV and AIDS.

Personal actions of leadership are a way in which individuals can role-model appropriate behaviour in respect to HIV and AIDS. Role-modelling can create contexts in which stigma and discrimination are reduced and HIV and AIDS becomes an issue that is supported rather than hidden in the workplace. Actions of senior managers or Vice-Chancellors at the individual level could include:

- Publicly taking a VCT test;
- Speaking openly about HIV and AIDS within informal settings;
- Supporting the greater involvement of people living with HIV and AIDS in the workplace;
- Encouraging people to undertake a VCT test; and
- Speaking at formal meetings about HIV and AIDS.

Case Study Leadership at the University of Namibia

The University of Namibia is a relatively small institution with about 4,300 students. It's main campus in Windhoek, although it has sub-campuses throughout the country. The Vice-Chancellor has shown strong leadership in the development and implementation of workplace HIV and AIDS policies and more widely. The University's HIV and AIDS policy has been driven by the Vice-Chancellor who has actively ensured buy-in from senior management in the development of HIV and AIDS Policy Guidelines and the Vice-Chancellor has also actively supported programmes developed from the guidelines. The Vice-Chancellor has also demonstrated personal leadership by speaking openly about HIV and AIDS at several public meetings on campus.

As such, the Vice-Chancellor has demonstrated good practice in leadership internally – through ensuring the development of an HIV and AIDS policy that is owned by senior management and at the personal level, by speaking out about HIV and AIDS within the University.[85]

Case Study Leadership at East African Breweries Ltd.

East African Breweries Ltd. (EABL) has approximately 825 employees throughout East Africa. It has implemented a wellness programme, which includes ARV treatment, opportunistic infection treatment and a HIV and AIDS care programme. The programme reaches over 3,200 people as it includes employees' families and on a monthly basis distributes over 6,000 condoms within its workplaces.

A key factor in its success has been ensuring buy-in from leadership across all levels of the company. In this it is supported by the larger company of Diageo, of which East African Breweries is a subsidiary. Diageo provides specialised leadership training in HIV and AIDS for senior management and shop stewards in EABL, ensuring they recognise the importance of the workplace HIV and AIDS programme, know in detail the policies and programmes that are part of it and fully support it.[86]

MONITORING LEADERSHIP

Leadership as a concept is notoriously difficult to monitor and assess. However, it is rather easier to monitor actions of leaders by exploring what is happening in different arenas in regards to HIV and AIDS programmes and policies. A number of possible indicators to assess changing levels of leadership in a workplace setting could include:

- The seniority of person chairing the workplace HIV and AIDS committee;
- An increase in funding towards HIV and AIDS programmes and policy implementation;
- Increased levels of knowledge amongst managers that HIV and AIDS is a workplace issue;
- An increase in the number of times senior managers speak about HIV and AIDS in the workplace; and
- Support for community organisations surrounding the workplace.

Table 10 Leadership of workplace HIV and AIDS programmes and policies, indicators of good practice and sources of data.

Indicator	Means of Verification
Senior manager or V/C chairs HIV and AIDS committee around workplace policies and/or programmes	Minutes of HIV and AIDS committee meetings
Level of funding towards design and implementation of HIV and AIDS programmes and policies	Institutional records of HIV and AIDS committee
Senior management undertake VCT	Review of senior management diaries
Senior management speak publicly about HIV and AIDS in workplace settings	Review of senior management diaries/public records
Senior manager chairs local community organisation around HIV and AIDS	Minutes of local community organisation
Proportion of managers who view HIV and AIDS as a workplace issue	KAPB survey
Proportion of managers that know programmes available to staff members under the HIV and AIDS workplace policy	KAPB survey
Proportion of employees who think that managers would be supportive if they were openly living with HIV and AIDS	KAPB survey

SECTION 22

Gender

BACKGROUND

Within South Africa, the role gender inequalities[87] play in driving HIV and AIDS is well recognised. Gender inequalities mean that women and girls are more vulnerable to being infected with HIV and AIDS – in 2007 UNAIDS estimated 61 percent of adults living with HIV and AIDS in Sub-Saharan Africa are women.[88] Gender inequalities also mean that women are more likely to bear the burden of providing care for people living with HIV and AIDS.

Underlying this statistic is the unequal relationship between men and women, including dominant understandings about the role of men and women in society, women's economic dependence on men, the limited access to education that women face and women's particular vulnerability to gender-based violence.

The impact of gender inequalities on HIV and AIDS prevention, treatment and care policies and programmes is such that they actively undermine prevention programmes, either through stopping women and girls accessing such programmes, or creating situations where women cannot act on their knowledge to prevent HIV and AIDS infections. Programmes can also exacerbate gender inequalities through not considering their impact on the need for care, which is overwhelming provided by women.

Furthermore there is also an increasing focus on the role of gender-based violence and rape in driving the epidemic. This is both through higher levels of vulnerability to HIV and AIDS amongst women because of violence or rape, but also through women choosing not to disclose their HIV-status because of the fear of violence, making it difficult to undertake strategies to prevent HIV-transmission.

There is also a growing focus emphasising that if gender inequalities are to be tackled men need to be included in programmes – especially exploring how their views and behaviours shape their own vulnerability to HIV and AIDS as well as women's vulnerability to HIV and AIDS.

The South African National Strategic Plan on HIV and AIDS and STIs (2007-2011) makes it clear that understanding and responding to gender inequalities needs to be at the heart of any response to HIV and AIDS if they are to be effective.[89] And this is echoed throughout international policies, such as UNGASS.[90] Indeed the importance of making HIV and AIDS policies and programmes gender sensitive and responsive to gender inequalities is highlighted by the ILO as one of its 10 key principles in responding to HIV and AIDS in the workplace.[91]

GOOD PRACTICE IN GENDER

Gender inequalities are deeply entrenched in society, no single programme or policy can eradicate gender inequalities, and indeed there is often much resistance to programmes that do tackle gender inequalities.

As such, the Department of Labour in South Africa, suggests that all programmes and policies that seek to tackle HIV and AIDS effectively need to also seek to challenge gender inequalities.[92]

There are two distinct approaches to tackling gender inequality, both of which are important in relation to HIV and AIDS – they are based on:

- Ensuring current and new responses are 'gender sensitive' – by thinking through how men and women may be differently effected by policies and programmes;
- Introducing special policies and programmes directly aimed at tackling gender inequalities.

Existing programmes and policies need to be made gender sensitive and ensure that through them gender inequalities are discussed and tackled. Such approaches could include ensuring that programmes and policies:

- Recognise men's and women's different vulnerabilities to HIV and AIDS;
- Include an analysis of gender inequalities in planning, implementing and monitoring and evaluation;
- Recognise and respond to women's greater demands around care giving; and
- Actively force people to consider gender inequalities as a driver of HIV and AIDS.

Yet for gender inequalities to be effectively tackled additional programmes and policies need to be introduced that deal specifically with these issues. While there have been a large number of different approaches to tackle this, some possible approaches include:

- Female empowerment programmes, developing women's economic and social skills, allowing women to develop independence from men;
- Increasing women's access to social grants;
- Support discussions in peer education programmes about gender inequalities;
- Introduce programmes to reduce domestic violence;
- Develop prevention programmes that aim to develop communication skills between partners;
- Introduce and promote the female condom;
- Male empowerment programmes, allowing men to reflect on how dominant societal norms may shape their behaviours and place them at risk of contracting HIV and AIDS; and
- Introducing policies around sexual harassment and rape in the workplace.

MONITORING GOOD PRACTICE

Changing gender inequalities through any workplace programmes will be particularly difficult, given that gender inequalities are so entrenched in wider social structures. However, some possible indicators could include:

- Increased perceptions of support for sexual harassment cases within the workplace;
- Increased knowledge amongst employees about the role of gender inequalities in the transmission of HIV and AIDS;
- Increased confidence of women to negotiate condom use;
- Increased numbers of women involved in HIV and AIDS programme and policy design and implementation;
- Decreased reports of sexual harassment in the workplace;[93] and
- Women's subjective feelings around confidence and self-empowerment.

Because of the difficulties of changing gender inequalities, indicators to assess this need to include a specific focus on ensuring policies and programmes are in place and are effective. Some possible indicators from this approach could include:

- Identifying whether sexual harassment policies are in place in the workplace;
- Increase in programmes and policies around HIV and AIDS that specifically include gender as a topic/issue;
- Ensuring workplace policies – such as leave, sick days and family responsibility days, include specific features for women and girls, including areas such as the provision of care;

Table 11 Workplace programmes and crosscutting issues of gender, indicators of good practice and sources of data.

Indicator	Means of Verification
Percentage of women who think sexual harassment is taken seriously in the workplace	KAPB survey
Number of women laying sexual harassment complaints	HR records
Specific sexual harassment policy in the workplace	Policy and document review
HIV and AIDS programmes and policies specifically tackle gender	Policy and document review
Proportion of women involved in programme and policy design and implementation	Document review
Non-HIV and AIDS programmes and policies that consider the impact of HIV and AIDS on women in the workplace	Policy and document review
Proportion of employees who can identify that gender is a key driver of the HIV and AIDS pandemic	KAPB survey
Proportion of female employees who feel they can negotiate condom use with their partner	KAPB survey
Proportion of female employees who, if their partner has an STI feel they could refuse sex or else negotiate use of a condom	KAPB survey

SECTION 23

Involvement of People Living with HIV and AIDS

BACKGROUND

The involvement of People Living With HIV and AIDS (PLWHA) as a cross cutting issue in good practice was recognised at the Paris AIDS Summit in 1994. There, 42 governments declared that the greater involvement of people living with or affected by HIV and AIDS (GIPA) was necessary both for effective responses to HIV and AIDS and for ethical responses. [94] This has been reaffirmed throughout the course of the pandemic, including most recently in the South African National Strategic Plan, which includes meaningful involvement of PLWHA as a guiding principle.[95]

The involvement of PLWHA in programme and policy design and implementation is seen by UNAIDS to have a number of positive outcomes:[96]

- It can help ensure that programmes and policies are responsive to the specific needs to PLWHA; and
- It can challenge stigma and discrimination and personalise HIV and AIDS for people.

There is a need to ensure that PLWHA are involved in real decision-making positions and are not just tokenistic appointments. This has led to various 're-terming' of this issue, from greater involvement of PLWHA (GIPA) to now the meaningful involvement of PLWHA.

There are two possible ways of meaningful involvement of PLWHA in a workplace. First, ensuring the involvement of people already working in the workplace who happen to be living with HIV and AIDS in programmes and policies. The second is through specifically recruiting a person living with HIV and AIDS to take on a particular role or position in an organisation because they are living with HIV and AIDS.

GOOD PRACTICE IN INVOLVING PEOPLE LIVING WITH HIV AND AIDS

As already mentioned there is much emphasis on ensuring that PLWHA who become involved are meaningfully involved and not simply token appointments to positions. In understanding what good practice is for involving PLWHA meaningful in the workplace UNAIDS suggest that it is around:

- Building a supportive environment for PLWHA;
- Building specific skills for PLWHA; and
- And ensuring meaningful involvement of PLWHA in programme and policy design and implementation.

Building a supportive environment for involvement of PLWHA in the workplace can be about many things, but includes:

- Developing and implementing specific policies for workers living with HIV and AIDS;
- Implementing workplace policies around discrimination, disability benefits and HIV and AIDS;

Table 12 Workplace programme involvement of people living with HIV and AIDS indicators of good practice and sources of data.

Indicator	Means of Verification
Number of employees who have disclosed their HIV+ status and are openly living with HIV	HR Records
Percentage of HIV and AIDS committees (at all levels) where employees who have disclosed their HIV+ status are involved	HR records and committee minutes
Programmes and policies are designed in conjunction with PLWHA representatives	Minutes of meetings, interviews with PLWHA
Policies supportive of PLWHA in the workplace	Policy review
Programmes in place to directly support PLWHA	Programme review
Proportion of employees who report non-stigmatising attitudes to PLWHA	KAPB survey
Proportion of employees who report that they believe they will not be discriminated against if they disclosed that they were HIV+	KAPB survey
Number of programmes aiming to build capacity amongst PLWHA in the workplace	Programme review

- Leadership speaking openly about HIV and AIDS to reduce stigma; and
- Implementing concrete programmes to challenge HIV-related stigma.

As well as ensuring that people living with HIV and AIDS work within a supportive environment there is a need to build specific skills, if they are to be more meaningfully involved in the development and implementation of workplace policies and programmes. Possible strategies that could be used to do this, include:

- Training on communication skills, to build PLWHAs engagement in policy dialogue;
- Self-empowerment and confidence building courses;
- Increased training on legal issues relating to PLWHA in the workplace, society and HIV and AIDS;
- The introduction of support groups for PLWHA to build self-confidence;
- Supporting PLWHA going to conferences and external meetings to build knowledge about HIV and AIDS in the workplace; and
- Employing a person living with HIV and AIDS as a 'representative' to set up training, support groups and ensure PLWHA voice in programme and policy decisions.

Finally workplace programmes and policies need to ensure the meaningful involvement of PLWHA in their design and implementation. All the strategies to support PLWHA in the workplace and to encourage their greater participation in programme and policy design and implementation can simply be tokenistic if they are not involved in real decision making processes and their voices are not heard.

Case Study University of the Western Cape: Health Promoters as a way to involve PLWHA

The University of the Western Cape, South Africa in collaboration with Dramaide (a South African NGO) and John Hopkins University, USA, recruited and trained 25 young people openly living with HIV and AIDS as peer educators for the University's residences. Peer educators were to interact both through formal structures and informally with students to provide advice, education and support.

The programme has been a positive way of meaningfully involving PLWHA within the University's structures. It has allowed students to interact directly with people who are comfortable with their HIV-status and has allowed key issues to be raised and openly debated.[97]

MONITORING GOOD PRACTICE

Monitoring the impact of meaningful involvement of PLWHA is once again difficult to achieve. However a number of possible indicators could be:

- Emergence of specific policies relating to PLWHA – especially around discrimination;

- Increased disclosure of HIV status by employees living with HIV, and their increased involvement in, and leadership of, prevention, care and advocacy efforts;
- Increased numbers of training programmes specifically for PLWHA;
- Reduced numbers of complaints about discrimination by people living with HIV;
- Emergence of specific training for PLWHA; and
- Decreased levels of stigma and discrimination for PLWHA.

SECTION 24

Stigma and Discrimination Reduction

BACKGROUND

Since the first cases of AIDS were identified, the stigma and discrimination associated with this disease has promoted the transmission of HIV and negatively impacted on treatment and mitigation. South Africa is no exception to this and stigma and discrimination stalks all walks of life, including the HE sector.

Stigma restricts the open and frank discussion of HIV and AIDS, hampers mobilization and encourages concealment, denial and appropriate treatment seeking behaviour. It also leads directly to discrimination at a variety of levels against PLWHA.

Global consensus on the importance of tackling AIDS-related stigma and discrimination is highlighted by the Declaration of Commitment adopted by the United Nations General Assembly Special Session on HIV and AIDS in June 2001.[98] The Declaration states that confronting stigma and discrimination is a prerequisite for effective prevention and care, and reaffirms that discrimination on the grounds of one's HIV status is a violation of human rights.

However, the promulgation of appropriate policies at global and national levels has limited impact on reducing stigma and discrimination "on the ground". Such policies need to be backed up by policies and programmes at the sector and institutional level.

GOOD PRACTICE IN REDUCING STIGMA AND DISCRIMINATION

Because stigma and discrimination is pervasive in our communities and is expressed in a multitude of ways, it requires a multi-pronged approach that is consistent and sustained over time. It will not be eliminated by any "quick fix" solutions. An appropriate approach includes the following:

- All policies at sector and institutional level must protect against discrimination and protect the rights of people living with HIV.
- All HIV programmes should pro-actively address stigma and discrimination reduction measures.

A variety of methods have been used by projects, programmes and activities to challenge HIV-related stigma, discrimination and human rights violations. Some of this work has been designed to tackle stigma and discrimination directly whilst other approaches have been more wide ranging and attempted to create supportive and enabling environments.

Many of these initiatives have aimed to reduce stigma through the use of multiple strategies. These have included:

- Creating a supportive and confidential space for the discussion of sensitive topics;

- Providing comprehensive HIV treatment and AIDS care, including access to antiretroviral therapy; and
- Empowering people living with HIV to take the lead in diverse support and advocacy activities.

Anti-discrimination measures

Anti-discrimination measures that have been employed in workplace and institutional settings aim to de-institutionalize stigma and discrimination through a variety of strategies including.

- Implementing non-discriminatory policies;
- Promoting understanding about AIDS through the education of managers and employees;
- Improving the quality of life of employees living with HIV through access to integrated care;
- Ensuring redress where cases of discrimination occur; and
- Improving the quality of care in health services for patients living with HIV.

MONITORING THE IMPACT OF ANTI-STIGMA AND DISCRIMINATION INTERVENTIONS

It is not easy to make direct, causative associations between stigma reduction efforts and impact. Nevertheless, there are a number of indicators in an institutional setting, which may be used to track a reduction in stigma and discrimination including the following:

- Increased willingness of employees to volunteer in HIV prevention and AIDS care programmes;
- Increased disclosure of HIV status by employees living with HIV, and their increased involvement in, and leadership of, prevention, care and advocacy efforts;
- Increased uptake of HIV counselling and testing;
- Increased uptake of treatment;
- Reduced numbers of complaints of discrimination by people living with HIV; and
- Reduction in self-stigma and increased confidence among people living with HIV.

Table 13 Workplace programme VCT indicators of good practice and sources of data.

Indicator	Means of verification
Proportion of employees who participate in workplace HIV prevention and treatment programmes	KAPB survey
Number of employees who have disclosed their HIV+ status and are living openly with HIV	HR records
Percentage of employees who received an HIV test in the last 12 months and who know their results	KAPB survey
Proportion of employees who report non-stigmatising attitudes to PLWHA	KAPB survey
Proportion of employees who report that they believe they will not be discriminated against if they disclosed that they were HIV+	KAPB survey

SECTION 25

Integration of Services

BACKGROUND

There is an emerging consensus that HIV and AIDS programmes and policies need to be integrated as part of broader sexual and reproductive health services and wellness programmes.[99] There are two key main reasons for this. First, it reduces the stigma of accessing HIV and AIDS services. Second, it provides for closer co-ordination and reduced duplication of services, and ensures that access to one programme can be supported by access to many other services.

In the South African National Strategic Plan on HIV and AIDS and STIs[100] one of the objectives is to integrate sexual and reproductive health and HIV-prevention services. A similar approach is offered by 'wellness' programmes. Wellness programmes aim to keep people living with HIV and AIDS healthy, engaged in the health system and delay their need to start ART. Again, the National Strategic Plan places wellness as one of its objectives.[101]

The integration of sexual and reproductive health services, such as ante-natal, post-natal and family planning, with HIV and AIDS prevention and management strategies, is seen to have four key linkages, which their integration can improve:

- Learning about HIV-status and access to services;
- Promoting safer and healthier sex;
- Optimising the connection between HIV and AIDS and STD services; and
- Integration of HIV and AIDS with maternal and infant health.[102]

Wellness programmes, are typically focused much more on people already living with HIV and AIDS. They focus on the fact that typically people living with HIV and AIDS are likely to experience frequent illness, and a key aim of healthcare should be to treat these at the primary health care level. Such care can include treatment of opportunistic infections, treatment of STDs, information on positive prevention, living positively with HIV and AIDS and nutrition. And once a person has progressed onto needing ARV treatment, a wellness programme can support adherence through counselling and effective management of treatment side effects.

Many HEIs may not offer such wide healthcare programmes. Integration in such situations then means ensuring that HIV and AIDS workplace programmes are able to refer people onwards to specific services – whether they be based in the public, private or NGO sector.

GOOD PRACTICE IN INTEGRATION OF SERVICES

UNAIDS suggests that good practice within the integration of services, should be built on a number of core principles, including:

- Addressing the structural determinants of HIV and AIDS and ill-health – including tackling poverty and increasing access to health services;
- A focus on human rights and gender;
- Promoting a co-ordinated and coherent response;
- Meaningful involvement of PLWHA;
- Fostering community participation; and
- Reducing stigma and discrimination.

Such an approach calls for a wide range of different strategies that aim to provide information, education, alongside comprehensive primary healthcare. Various approaches can be used to achieve these within the workplace setting – generally through a clinic. The Department of Labour suggest that wellness programmes and the integration of services could include:

- The provision of CD4 counts within healthcare clinics;
- Treatment of opportunistic infections in workplace settings;
- Counselling around living positively with HIV and AIDS;
- Peer education groups or support groups;
- Referral systems onto higher levels of healthcare;
- Syndromic management of STDs;
- Information and behaviour change campaigns on condom use; and
- Positive prevention.[103]

Case Study Supporting Wellbeing

De Beers the diamond mining company introduced a well-being programme for its employees. Part of the wellbeing programme included comprehensive treatment for TB and STI management within the workplace, and access to information on healthy living. The wellbeing programme also offered free counselling to employees and their families.

Through this programme, the incidence of TB in their mines in South Africa decreased by 13.95% from 387 per 100 000 in 2005 to 333 per 100 000 in 2006. Because of the close relationship between HIV-infection and TB, cutting TB is likely to boost immune systems of people living with HIV and AIDS and ensure they remain healthy for longer.[104]

Case Study Integrating Services

Maseno University in Kenya, a small rural university with approximately 4,000 students, has its AIDS Control Unit directly integrated into the university's Department of Public Health and works closely with a 23 bed University Health Centre in the delivery of a range of public health services. The Health Centre sees around 100-120 people per day, and approximately 10-12 of these of students undertaking VCT. The health clinic is also linked into the wider National AIDS programme and is also used by local communities for VCT testing. It also offers a limited ARV service to those people most in need.

Through integrating VCT, ARV provision and broader healthcare, the stigma of accessing services has been reduced. Also because it is linked into the national AIDS programme, the sustainability of the project is also secure.[105]

Table 14 Workplace programme integration of services indicators of good practice and sources of data.

Indicator	Means of Verification
Proportion of employees who participate in workplace HIV prevention and treatment programmes	KAPB survey
Percentage of employees who received an HIV test in the last 12 months and who know their results	KAPB survey
Proportion of employees who have told another employee that they have undertaken a VCT test	KAPB survey
Number of services accessible through one clinic or health centre	Review of clinic services
HIV services are linked to ante-natal and family planning services	Review of clinic services

MONITORING GOOD PRACTICE

As integrating services for HIV and AIDS prevention and care is so diverse, the possible areas that need to be monitored are quite diverse. However, through integration of services it hoped that access to VCT, treatment and other issues are made easier to access. As such possible indicators could include:

- Decreased perceptions of stigma for going to undertake a VCT test;
- Increased levels of VCT testing;
- Increased access to information around HIV and AIDS prevention;
- Increased numbers of employees willing to access HIV prevention programmes; and
- VCT and other HIV services are bundled with other healthcare services.

SECTION 26

Monitoring and Evaluation

BACKGROUND

All programmes and policies need to be monitored and evaluated to assess their effectiveness and to account for their use of resources. Monitoring and evaluation allows managers to identify whether interventions are having their intended effects and also creates the opportunity to reflect on possible changes that may be made to programmes and policies.[106]

Monitoring and evaluation typically perform different functions. Monitoring tends to aggregate information across sites and time. As such, monitoring provides an overview picture of what all programmes and policies are achieving and allows the identification of what issues/topics are being effectively tackled through a multitude of routes and where further work still needs to be done.[107]

In contrast evaluation attempts to make a more direct assessment between specific programmes, policies and outcomes – essentially assessing how effective a programme has been in achieving its specific aims and/or targets.[108]

As such, monitoring and evaluation programmes are complementary allowing both a broad analysis, as well as more specific analyses of what is working and where challenges still remain.

For monitoring and evaluation programmes to be effective, it is necessary that they explore change over time. They can focus on individual behaviours or institutional frameworks and activities, and preferably both.

A key aspect of monitoring and evaluation programmes is that they allow evidence based decisions about programmes and policies to be made. They allow calculations as to whether programmes are cost-effective, are having their intended effect and also highlight where there are still gaps in programmes. This allows learning and reflection to occur internally, within an organisation, and it requires that such information be translated into action through reviewing workplace HIV and AIDS programmes and policies.

GOOD PRACTICE IN MONITORING AND EVALUATION

Good practice in the monitoring and evaluation of workplace HIV and AIDS programmes relies on a number of factors:

- A baseline assessment;
- Construction of appropriate indicators and data collection tools;
- Strong analysis of collected data; and
- Feedback, reflection and learning from the analysed data, leading to programme and policy review and change.

The Department of Health emphasises that an initial baseline assessment of both the impact HIV and AIDS is having in the workplace and also basic information around HIV and AIDS, such as number of condoms distributed and people's knowledge about HIV and

AIDS is critical. The baseline information of the impact HIV and AIDS is having in the workplace allows programmes and policies to be tailored to where there is greatest need. While the basic information allows for later assessment of the impact programmes and policies have had in changing this information.[109]

The second key aspect of good practice is creating indicators that allow either a direct or indirect measure of change. Indicators can either be process indicators – exploring how a programme has engaged with certain issues or else be outcome indicators – exploring the overall impact of programmes and policies in key areas. Indicators can take the form of:

- Quantitative indicators – that seek to provide evidence in the form of numbers;
- Qualitative indicators – which provide evidence through narrative; and
- Proxy indicators – which are used when the actual change cannot be directly measured and are a way of generating data that cannot otherwise be accessed.

The Department of Health in South Africa argues that the ultimate question with regards the effectiveness of workplace HIV and AIDS programmes is "Has the programme changed behaviour and reduced the prevalence of HIV and AIDS and STDs?"[110] And as such the indicators must be able to answer this question if nothing else.

Once indicators have been established a method for data collection needs to be created. Data can be collected in a variety of ways, from knowledge, attitudes, behaviour and practice surveys, through anonymous HIV-testing, to focus group discussions, or reviewing workplace programme and policy documents. For data collection to be good practice, it is necessary that data collection tools create data, which is reliable and valid, allowing for accurate data that can be compared across time.

Where possible the creation of indicators and systems of data collection should be in line with international or national programmes and policies, which have good practice indicators. International and national frameworks and documents provide a key resource for indicators. The National Strategic Plan in South Africa is one source of possible indicators that can be used to monitor the impacts of policies and programmes.[111] Indicators and methods of data collection obviously need to be changed to make them viable for workplace settings.

Finally, good practice in monitoring and evaluation requires that the data is analysed and then used. Without use of the data the monitoring and evaluation of programmes and policies is effectively pointless. The outcomes of the process of monitoring and evaluation should lead to reflection about the impact of programmes and policies on HIV and AIDS and assessments of the programmes cost effectiveness. This then needs to lead to change in programmes and policies to respond to what has been learnt.

The process of reflection on monitoring and evaluation data also needs to be carried out in conjunction with reflections on changes about what is known about HIV and AIDS – whether this is what constitutes good practice in the workplace, or changes in the pandemic.[112] The South African Department of Labour also emphasizes that changes in laws need to be taken into account as part of the monitoring and evaluation process.[113] Monitoring and evaluation of programmes needs to take these broader changes into account.

MONITORING GOOD PRACTICE IN MONITORING AND EVALUATION

Ensuring that good practice is included in the monitoring and evaluation strategy for workplace programmes and policies requires ensuring that workplace HIV and AIDS programmes and policies collect data and actively use this data in assessing the impact of the programmes and policies. Possible indicators could include:

- Increased levels of data collection on programmes;
- Regular review and analysis of data;
- Increased levels of discussion between stakeholders about the data;
- Monitoring and evaluation workshops that lead to programme and policy reform.

Table 15 Workplace programme monitoring and evaluation indicators of good practice and sources of data.

Indicators	Means of Verification
Is there a monitoring and evaluation programme in place	Workplace documents
Regularity of review and analysis of data collected through workplace programme	Workplace documents, minutes of meetings
Number of meetings per year during which workplace HIV and AIDS programmes and policies are reviewed	Minutes of meetings, workplace documents
Perceptions of programme reviews by stakeholders	Interviews with key stakeholders

SECTION 27

Reporting

BACKGROUND

Reporting is the formal documentation of processes, programmes and events – which may be required by law. Reporting is important internally and externally on workplace programmes around HIV and AIDS. Internally there are a number of reasons that reporting is important, it:

- Ensures oversight by senior managers;
- Allows managers to understand the impact of HIV and AIDS in the workplace;
- Allows stakeholders to appraise what is happening in the workplace; and
- Demonstrate the use of funds.

Externally, depending on the workplace, there may be legal provisions for reporting but there are other reasons as well:

- JSE listed companies are required to demonstrate in reports how they are responding to HIV and AIDS in the workplace;
- Builds confidence on the part of stakeholders that the company (or HEI) is responding;
- To build a body of knowledge about responses to HIV and AIDS in the workplace; and
- To report good practice on responses to HIV and AIDS in the workplace.

There is a need to develop effective reporting procedures so that all stakeholders can see what workplaces are doing locally to respond to HIV and AIDS, and so that they can use this as a way to engage with workplace policies. It also stops companies from waiting to see what will happen, to being forced to respond because they have to report openly about what they are doing.

GOOD PRACTICE IN REPORTING

Good practice around reporting is very much subject to what the aims of the reports are. Within South Africa, there has been an attempt to produce a standardised framework for reporting on HIV and AIDS programmes in the workplace through the development of the Global Reporting Initiative (GRI). More widely the GRI is concerned with developing fixed standards of reporting on companies – in particular the sustainability of companies. As part of its programme it has included reporting of workplace HIV and AIDS policy and programmes.[114] The GRI argues that a standardised reporting procedure allows:

- Increased credibility of corporate organisations' HIV and AIDS reports;
- Streamlined HIV and AIDS reporting processes;
- A quick and reliable benchmarking on HIV and AIDS performance; and
- The reinforcement of local, national and international management standards and codes of good practice. [115]

The GRI reporting framework covers four main areas: 1) Governance, exploring company policy and overall strategy and planning for HIV and AIDS; 2) Workplace conditions and HIV and AIDS management, emphasizing programmes that are in place, the scale of budget etc.; 3) Depth and quality of programmes, aiming to get direct information on the effectiveness and quality of the programmes that are implemented; and 4) Monitoring and evaluation procedures, including specific targets that the company hopes to achieve.[116]

Another source with regards to organisations reporting on HIV may be found in the King II Report. The overall aim of this report is to provide indicative, aspirational guidelines to South African organizations who are seeking to improve on their disclosure practices and recognise the importance of the relationship between an organization and the community in which it exists.

Whilst the King II Report covers a variety of topics which should be reported on, it proposes that organizations should disclose "the HIV and AIDS strategy plan and policies the company has in place to address and manage the potential impact of HIV and AIDS on the company". However, it does not require companies to report on the outcomes of their HIV and AIDS Programmes.

The South African Bureau of Standards has released a new HIV and AIDS Standard that uses established international techniques of quality management and environmental management to assist, encourage and support organizations in both the public and private sectors to implement an HIV and AIDS Management System (HAMS). It is based on the SANS 9001/ISO 9001(for quality management) and SANS 14000/ISO 14000 (for environmental management) series of standards. It falls short of addressing clinical requirements or specific treatments for employees affected by HIV and AIDS. It also does not include, while based on the ISO 9001 and ISO 14001 standards, requirements specific to these and other management systems, such as those for occupational health and safety, and financial or risk management.

The JSE launched the Social Responsibility Index (SRI) in South Africa in May 2004 (see Table 16). The SRI index has a number of criteria related to environment, society and governance and related sustainability concerns. Criteria identify the issues that companies must meet in order to show that they have integrated triple bottom line practices across their activities. Within each of the areas of measurement, a number of themes are covered. To meet the indicator requirement companies must have included at least one HIV and AIDS indicator. Once again this reporting format does not include any reporting on the outcome of the HIV and AIDS Workplace Programmes.

Table 16 JSE SRI Index in South Africa on HIV and AIDS

Companies operating in high risk countries are required to meet at least the core indicators for HIV and AIDS		
	Core indicators	**Desirable indicators**
Policy	■ Existence of HIV and AIDS Policy (covering a minimum of confidentiality, non-discrimination, commitment to develop and implement programmes for treatment / prevention)	■ Global applicability
Management and Performance	■ Evidence of risk assessment in relation to HIV and AIDS ■ Prevention, education and awareness programmes for employees ■ Access to voluntary counselling and testing for employees	■ Doc objectives and targets for addressing direct HIV and AIDS ■ Strategies for addressing the indirect business risk of HIV and AIDS effect on customers base and supply chain ■ Occupational health and safety procedure to prevent transmission ■ Provision of treatment care and support for employees ■ Sponsorship of community based education and awareness programmes
Reporting	■ Existence of a policy ■ Evidence of a risk assessment	■ Global application ■ Objective and targeting in relation direct impacts ■ Employee involvement in prevention and treatment programmes ■ Community programmes

Source JSE reporting requirements

Table 17: Workplace programme reporting indicators of good practice and sources of data.

Indicator	Means of Verification
Regularity with which information is reported back to key stakeholders	Interview stakeholders
Creation of good practice case studies within the workplace setting	Programme and policy review

A key aspect of good practice in reporting is ensuring that reports are distributed widely to key stakeholders, including workers, trade unions, local communities and health authorities and that the report can be commented on and discussed with the company to develop company policy and programmes further.

MONITORING GOOD PRACTICE IN REPORTING

Monitoring good practice in reporting requires ensuring that reporting around HIV and AIDS programmes and policies is done internally and externally. Possible indicators could include:

- Increased information available about HIV and AIDS in the workplace for external stakeholders;
- Increased information on good practices within the workplace;
- Consistent reporting of information internally and externally around HIV and AIDS in the workplace.

Notes

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APPENDIX 1

A listing of the UNAIDS Global Prevention Policies, Principles and Programmes and the Relevance to the HEI Sector

A listing of the UNAIDS Global Prevention Policies, Principles and Programmes and the Relevance to the HEI Sector

Table 18 A comparison of essential policy actions with what is relevant for the HEI sector.

Essential Policy Actions	Relevance to the HEI sector
Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate discrimination and combat stigma. All over the world, AIDS has thrived on stigma, shame and discrimination and has given rise to the abuse of human rights. Protecting and promoting human rights are therefore an essential part of any comprehensive AIDS prevention strategy, as is promoting the dignity of people living with HIV and AIDS.	The promotion and protection of human rights, including gender rights, and the importance of combating and eliminating stigma and discrimination will be a key feature of all workplace policies
Build and maintain leadership from all sections of society, including governments, affected communities, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions. National governments have the mandate to direct policy, provide resources, and offer leadership at a scale that will arrest and turn back the HIV epidemic. Numerous opportunities exist for the display of leadership and a significant scaling up of the national response. Politicians and leaders in all sectors including religious, business and community must use every opportunity available to speak out openly about AIDS and its growing impact on individuals, families, communities and societies.	Within South Africa it is recognized that a lack of leadership has undermined prevention efforts at a national level as well as at institutional level. Previous reviews have highlighted this problem within the sector. For these reasons, the workplace programme framework that will be proposed will have a heavy and explicit emphasis on the key role that leadership plays and must be seen to play
Involve people living with HIV, in the design, implementation and evaluation of prevention strategies, addressing the distinct prevention needs. Since the beginning of the epidemic prevention strategies have been more effective when they have meaningfully involved people living with HIV in their design, implementation and evaluation. HIV prevention strategies have, however, often failed to address the distinct prevention needs of people diagnosed with HIV and/or to build capacity for their meaningful participation. The aim of prevention for people living with HIV is to empower them to avoid acquiring new sexually transmitted infections, delay HIV disease progression and avoid passing their infection to others.	The importance of consulting PLWHA and including them in the design of prevention programmes will be emphasized in the proposed workplace programme. In addition, it is recognized that in South Africa the particular prevention needs of PLWHA have often been ignored and so will be made explicit in our proposed programme.
Address cultural norms and beliefs, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission. HIV transmission is fuelled by a variety of factors, including most importantly, the local context created by local norms, myths, practices, and beliefs, as well as social, economic and human security realities. HIV prevention efforts must be tailored to respond to those norms, practices and beliefs that hamper HIV prevention. Simultaneously, those norms, practices and beliefs that potentially can support HIV prevention need to be fully harnessed.	A review of the literature as regards the norms and beliefs of the various HEI employee sub-populations will be undertaken and taken into consideration during programme design. In addition, as information comes in from the KAPB study, this will be used in programme design.

Essential Policy Actions	Relevance to the HEI sector
Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls, involving men and boys in this effort. Gender inequalities as well as gender norms and relations, including practices around sexuality, marriage and reproduction; harmful traditional practices; barriers to women's and girls' education; lack of access for women to health information and care; and inadequate access to economic, social, legal and political empowerment are major contextual barriers to effective HIV prevention. Worldwide, women and girls have been rendered vulnerable to infection by widespread inequalities and economic, political, social, cultural and human security factors. Action in each of these areas and towards the broader goal of gender equality is necessary to turn back the increasing feminization of the epidemic globally. In addition, it is important to engage men and boys in these efforts for a long-standing impact on gender inequalities. Involving men is important not only because they often control women and girl's vulnerability to HIV. Societal norms about masculinity and gender also heighten men's vulnerability to HIV since they encourage men to engage in behaviours that put their health at risk and deny them needed protective information and services.	It is recognized that there are particular problems in South Africa as regards the status of women and women's rights. Whilst women's rights are enshrined in national policies, the practice on the ground is often very different. HEIs are not immune to these contradictions. It is also recognized that women, and young women in particular, are especially vulnerable. Bearing this situation in mind Gender rights and equality will be a cornerstone of all policies and programmes. It is also recognized that men play a key role in perpetuating the vulnerability of women to HIV and so their perceptions, behaviours and needs must be explicitly addressed in the workplace programme.
Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted. AIDS is an epidemic of the information age. Yet it is precisely those tools of the information age that are our strongest weapons to fight the AIDS epidemic to fight denial, inaction, ignorance, stigma and discrimination: the key forces that allow this epidemic to spread. Since there are many variations in the contexts that determine behaviour; communication approaches to promoting HIV prevention need to be specific to be relevant to local situations. Government policy and an understanding of social and economic context, culture, and gender relations must inform the development of communication strategies for HIV prevention.	A major focus of the proposed workplace programme for the HEI sector will be on increasing levels of knowledge around HIV and AIDS and modifying behaviour. Customised approaches are required for the various categories of employees in the sector.
Promote the links between HIV prevention and sexual and reproductive health. The overwhelming majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Sexual and reproductive health initiatives and HIV prevention initiatives should be mutually reinforcing. Both HIV and sexual and reproductive health are driven by many common root causes and stronger linkages between them will result in more relevant and cost effective programmes with greater impact. Integrating HIV prevention in existing reproductive and sexual health programmes can rapidly scale up coverage of HIV prevention programmes.	There will be an emphasis in the framework on integrating HIV prevention and care with sexual and reproductive health services on the campus.
Support the mobilization of community based responses throughout the continuum of prevention, care and treatment. Communities have been at the forefront of the response to AIDS since the emergence of the epidemic. Mobilizing communities to act collectively ensures that the AIDS epidemic is owned and responded to by all levels of society. Not only is this in keeping with the rights of communities but it also ensures that the response is sustainable, reaches the necessary populations, and achieves impact. Community mobilization is therefore central to effective HIV prevention and the AIDS response as a whole. It requires investment and support and cannot be taken for granted.	A focus of the workplace programme will be on consultation and involvement of the employees in all aspects of the design and implementation.
Promote programmes targeted at HIV prevention needs of key affected groups and populations. Although comprehensive prevention programmes must be made available to the general population, actions must be taken to identify key populations based particularly on epidemiological data both those most at risk of HIV infection and those living with HIV and to address their specific c prevention needs and that of their sexual partners, where applicable.	Within the employee population at a particular HEI it is probably not appropriate to identify particular sub-groups for targeting because of the risk of stigmatising such groups.
Mobilizing and strengthening financial, and human and institutional capacity across all sectors, particularly in health and education. There are a range of resources needed to mount and sustain an effective HIV prevention response as part of a comprehensive AIDS programme. These include expanding and making more effective use of existing finances, and strengthening institutional and human capacity. Strengthening the capacity of key institutions in several sectors is critical to ensuring adequate HIV prevention. There has to be some breakthrough in ensuring that health systems are strengthened to ensure rapid and adequate HIV prevention (particularly in a context where access to treatment is increasing), that the education sector fully play its role especially in the area of comprehensive and appropriate sexual education, and that social services (particularly those concerned with the care of orphans and vulnerable children, including girls) and the private sector and civil society organizations are fully engaged in this intersectoral effort. Strengthening civil society capacity (and especially the capacity of organizations of people living with HIV) to raise resources, build institutions and undertake HIV prevention is crucial.	The HE sector should use the considerable competitive advantage that it has when it comes to HIV prevention. In particular, the skills within the sector in the fields of education, training, research and information dissemination should be harnessed. The sector is the ideal environment for monitoring and evaluating the impact of a prevention programme and for disseminating the findings and lessons learnt.

Essential Policy Actions	Relevance to the HEI sector
Review and reform legal frameworks to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV. Effective HIV prevention programming takes place within the existing legal framework of a country. However, review, and if necessary, reform of the existing legal frameworks is essential to ensure that people's ability to control their risk of infection through comprehensive programmes is protected. This would include the elimination of the gender-based inequalities that fuel the epidemic through sexual exploitation and gender-based violence; access to health care and other services free from discrimination; the provision of opportunities for work and a safe work environment; removing barriers to effective evidence-based HIV prevention, including among sex workers, injecting and other drug users, and men who have sex with men; and access to education. In particular, existing national legislation should be reviewed, and reformed if necessary, to ensure that it is consistent with international human rights obligations.	This particular issue is a national concern rather than the direct responsibility of the HEI sector with the caveat that progressive elements within the sector can advocate for national policy reform.
Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies. New technologies, such as HIV preventive vaccines and microbicides, offer hope for sustained control of the HIV epidemic, particularly in the worlds most vulnerable and marginalized populations, of which women constitute such large proportions. Policy makers and donors need to generate sufficient support for research and development in ways that promote efficiency and coordination and are based on ethical principles, as well as contributions of intellectual and financial capital by the private sector. Developing countries, in collaboration with those who can provide support where it is required, need to build capacity for clinical trials, social research, licensing and access.	The HEI sector is already the key player nationally as regards research into the development and evaluation of new prevention technologies.

Table 19 A comparison of essential HIV prevention programmes and the relevance to the HEI sector.

HIV Prevention Programmes	Relevance to the HEI sector
All HIV prevention efforts/ programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality	All workplace policies proposed in this project will recognize the importance of human and gender rights
HIV prevention programmes must be differentiated and locally-adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented	It is recognized that the HEI sector is unique and that existing workplace programmes cannot simply be transposed onto the sector but instead need to be carefully customised
HIV prevention actions must be evidence-informed, based on what is known and proven to be effective and investment to expand the evidence base should be strengthened.	We are using global and local good practice to inform our workplace programmes. As information comes through from the HIV prevalence and KAPB research project, this will be filtered into the framework and individual HEI programmes
HIV prevention programmes must be comprehensive in scope, using the full range of policy and programmatic interventions known to be effective.	The framework that will be proposed will be comprehensive. However, it will be "modularized" so that HEIs will be able to phase in components over time depending on their capacities
HIV prevention is for life; therefore, both delivery of existing interventions as well as research and development of new technologies require a long-term and sustained effort, recognizing that results will only be seen over the longer-term and need to be maintained.	Sustainability considerations will be foremost in the development of the workplace programme framework. This project will also link with the "Funding" project so that funding initiatives are based on real costs and long term visions.
HIV prevention programming must be at a coverage, scale and intensity that is enough to make a critical difference	Prevention programmes that are known to work will be designed to be implemented at sufficient coverage, scale and intensity. Only prevention interventions that are novel or of unproven efficacy will be piloted on a small scale
Community participation of those for whom HIV prevention programmes are planned is critical for their impact.	For the purposes of the workplace programmes in the sector, the community is defined as the employed population in each HEI. There will be substantial consultation with employees on all aspects of the programme. Information on employee perspectives on current programmes will be filtered into programme design

Table 20 A comparison of essential programmatic actions for HIV prevention and the relevance for the HEI sector.

Essential Programmatic Actions for HIV Prevention	Relevance to the HEI sector
Prevent the sexual transmission of HIV - prevention of sexual transmission of HIV must have as its basis the promotion and protection of human rights, including the right to control one's own sexuality, free of coercion, discrimination and violence. Programmes should be comprehensive, high quality and evidence-based, and should include accurate and explicit information on safer sex, including correct and consistent male and female condom use, as well as abstinence, delay in onset of sexual debut, mutual fidelity, reduction of the number of sexual partners, comprehensive and appropriate sexual education, and early and effective treatment for sexually transmitted infections	All these points will be embedded in the policies and programmes that will be developed. Ideological influences that may choose to emphasise particular components (such as abstinence only) will play no role in programme development. Instead, all interventions will be evidence informed
Prevent mother-to child transmission of HIV - involves a comprehensive package of services including preventing primary HIV infection in women, preventing unintended pregnancies in women with HIV infection, preventing transmission from HIV-infected pregnant women to their infants, and providing care, treatment and support for HIV infected women and their families.	Information provision and awareness raising on PMTCT issues will be integral to the prevention programme. The actual provision of PMTCT interventions will be a component of the HIV treatment interventions and will depend on the mode of treatment delivery
Prevent the transmission of HIV through injecting drug use, including harm reduction measures - by developing a comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy.	Injecting drug use remains relatively uncommon in SA and is not considered a driver of the HIV epidemic on the region, particularly in this population. However, there is some evidence that injecting drug use is on the increase and this issue will not be ignored in the workplace programme. At this stage, with so few people injecting drugs, the emphasis is likely to be on prevention rather than mitigation.
Ensure the safety of the blood supply - includes mandatory and rigorous HIV screening of donated blood, respecting the confidentiality of blood donors, and promoting appropriate clinical use of donated blood.	This is of no significance to the sector as HEIs have no role in ensuring a safe blood supply.
Prevent HIV transmission in healthcare settings including both formal and informal settings - through the consistent use of universal precautions and post-exposure prophylaxis for HIV infection. It is also recommended that all countries should use only auto-disposable syringes and safe disposal for immunization.	Prevention of transmission within the campus health care facilities is unlikely to be a source of new infections but, nevertheless, universal precautions and state-of-the-art technologies to minimize risk of transmission will be part of the proposed workplace programmes. Free and easy access to post-exposure prophylaxis will be a feature of the framework and institutional programmes
Promote greater access to voluntary HIV counselling and testing - while promoting imperative in any HIV prevention strategy. Efforts should be made to encourage people to know their HIV status through access to client-initiated voluntary and confidential counselling and testing, and routine offer of testing in the health sector, respecting the principles of confidentiality.	Providing access to VCT and promoting its use will be a cornerstone of the proposed workplace programme. VCT will be routinely offered to employees using the campus health services
Integrate HIV prevention into AIDS treatment services - to exploit the synergy between the two by training health sector personnel and community care providers in the provision of both HIV prevention and care, offering HIV preventive counselling in treatment settings, and ensuring the availability of HIV prevention commodities and services in all health care settings.	Integration of prevention and treatment services will be emphasized in the workplace programme
Focus on HIV prevention among young people - there is a need to provide young people with a full complement of tools to prevent HIV transmission including comprehensive, appropriate, evidence and skills-based sexual education in schools; youth friendly health services offering core interventions for the prevention, diagnosis and treatment of sexually transmitted infections and HIV; interventions to prevent transmission through unsafe drug injecting practices; services targeted to other vulnerable groups at high risk; mass media interventions; and consistent access to male and female condoms, readily available to all who need them. Programming, planning, implementation and monitoring of HIV prevention activities should include the meaningful involvement of youth.	The workplace programme focuses on employees and not students. However, the particular risks that young employees are exposed to and the needs and vulnerabilities of this group will be considered in the development of the workplace programme.
Provide HIV-related information and education to enable individuals to protect themselves from infection - knowing the facts about how HIV is spread and can be prevented and learning skills for HIV prevention form an essential part of all HIV programmes.	The provision of IEC materials, communication programmes and peer-education programmes along with other approaches that are appropriate for HEI employee populations, will form a core component of the proposed workplace programme

Essential Programmatic Actions for HIV Prevention	Relevance to the HEI sector
Confront and mitigate HIV-related stigma and discrimination - a supportive environment for HIV prevention should be created through legal and policy action to reduce HIV-related stigma and discrimination, by promoting public awareness and openness about AIDS, and by ensuring the greater involvement of people living with HIV in all aspects of HIV prevention.	It is recognized that stigma and discrimination are obstacles to the effective implementation of prevention and treatment programmes. Stigma and discrimination will be dealt with at the policy level as well as being a common thread running throughout prevention and treatment programmes
Prepare for access and use of vaccines and microbicides - it is crucial to ensure that men and women will have access to new prevention technologies once they have been tested, proven safe and effective, and approved for use.	Given the recent failures of all microbicide and vaccine clinical trials and the distant time horizon for these technologies, there will not be substantial emphasis on these issues. Instead, emphasis will be placed on inculcating a critical awareness of new developments so that, if and when promising technologies do become available, employees will not be resistant to such interventions

APPENDIX 2

The Law and HIV and AIDS

INTRODUCTION

This section of the report deals with the legal and ethical aspects of HIV and AIDS in the workplace. A brief review of the legislation is outlined, including its relevance to the disease. Following the legal perspective, the ethical background is explored. The outputs of the legislative framework analysis are envisaged to contribute to the development of a monitoring and evaluation planning process. A summary of each act, with a short description of how it relates to HIV and AIDS in general, and HIV and AIDS in the workplace in particular.

THE LEGAL PERSPECTIVE

On an institutional level of social control, any societal response to HIV and AIDS is driven greatly by the legal framework that exists in the society. Therefore, any response to the management of AIDS should be in compliance with existing legislation. At the most basic level, this means that adherence should be shown to the South African Constitution Act (Act 108 of 1996), as well as compliance with the related provisions including the Bill of Rights.

Legislative aspects of HIV and AIDS relate to how relevant laws are applied in the workplace, and why both employers and employees should foster an awareness of their rights and obligations. Unfair discrimination as a result of HIV and AIDS related issues is common in the workplace, however, legislation and judgments delivered by the courts, have evolved in recent years to a level of sophistication that demonstrates circumspection and fairness in the highest degree to both employers and employees.

Owing to social stigmatization and the attention the condition attracts, specifically in the media, as well as the varied settings in which discrimination against individuals suffering from HIV and AIDS takes place, it becomes a matter of necessity to explore relevant legislation and the role legislation plays in the societal management of the condition. Significant progress is observed regarding perceptions of HIV and AIDS on societal level in terms of alleviation and destigmatization, and this trend has advanced to legislative processes and the deliverance of judgments.

This trend is most noticeable in judgments regarding HIV and AIDS in the workplace, as illustrated in the matter between Irvin & Johnson Limited and Trawler & Line Fishing Union (other respondents included), where the aforementioned expressed a need for voluntary and anonymous testing for HIV and AIDS in order to perform realistic manpower planning in order to minimize the impact of HIV and AIDS, mortalities due to the condition, and to enable sufficient support structures to cater for the needs of employees suffering from the condition, and to implement proactive steps in stemming the spread of HIV and AIDS. Negotiations with unions proved positive, and the labour court ruling

allowed for anonymous HIV and AIDS testing under certain conditions.

Legislation relevant to HIV and AIDS in the workplace includes the application of the following acts:

- Labour Relations Act, Act 66 of 1995
- Employment Equity Act, Act 55 of 1998
- Occupational Health and Safety Act, 1993
- Compensation for Occupation Injuries and Diseases Act, Act 130, 1993
- Basic Conditions of Employment Act, No. 75 of 1997
- Medical Schemes Act, Act. No. 131 of 1998
- Promotion of Equality and Prevention of Unfair Discrimination Act, No. 4 of 2000
- The Nursing Act, Act 50 of 1978
- The Medicines and Related Substances Control Amendment Act, 1997

This desktop review of legislation will look at the contents of these acts in greater detail, and discuss their implications for the management of HIV and AIDS in the workplace. A review will also be undertaken of how the provisions of these pieces of legislation have been applied in practice.

In addition to legislation, there have been other responses to the epidemic in terms of its legal and ethical dimensions. The Department of Labour has set out a Code of Good Practice on Key Aspects of AIDS and Employment, linked to the Employment Equity and Labour Relations Acts. The University of the Witwatersrand has set up the AIDS Law project at their Centre for Applied Legal Studies, which provides legal support to people and organisations affected by HIV and AIDS.

Since, as already mentioned, societal responses to HIV and AIDS are driven, in part by the legal framework, this exists in a particular society. Therefore, any response to the management of AIDS should be compatible with existing legislation. This means that adherence should be shown to the **South African Constitution Act (Act 108 of 1996)**, as well as compliance with the Constitutional provisions including the Bill of Rights. Unfair discrimination is explicitly outlawed in the "Equality Clause". Section 9 of the Constitution provides that every person is entitled to equality before the law and equal protection by the law, and prohibits both the State and any person from unfairly discriminating directly or indirectly against another person on various grounds, such as race, gender and disability. (HIV and AIDS Technical Assistance Guidelines, Department of Labour).

The following section briefly summarises the implications that each Act has as regards HIV and AIDS in the workplace:

- **Labour Relations Act, Act 66 of 1995.** Despite the fact that its perspective, scope, and application is wider than HIV and AIDS, this act creates a framework for the management of HIV and AIDS in the workplace. The application of this act in the workplace facilitates, for example, voluntary and anonymous testing for the condition in view of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job (Section 7(2), Section 50(4). Other conditions that the Act may specify include the provision of counselling, confidentiality, and, amongst others, vulnerability of sufferers.
- **Employment Equity Act, Act 55 of 1998**. The philosophy and application that this act considers is equality. This implies (and specifies) the prohibition of unfair discrimination and harassment against an employee or job applicant suffering from HIV and AIDS. This means that an employee suffering from the condition, should be, for example, eligible for promotion, that absenteeism from the workplace due to the condition, should not be held against the employee, and that employers should put realistic and fair support structures in place to compensate for employee absenteeism and turnover due to HIV and AIDS deaths. It also guards against stereotyping.
- **Occupational Health and Safety Act, 1993.** This act provides for the health and safety of persons at work and for the health and safety of persons in connection with the use of plant and machinery; the protection of persons other than persons at work against hazards to health and safety arising out of or in connection with the activities of persons at work; to establish an advisory council for occupational health and safety; and to provide for matters connected therewith, including

HIV and AIDS in the workplace, with regards to health and safety issues. The Act also forbids victimization (by implication against employees suffering from HIV and AIDS). The Act also covers the matter of "*biological monitoring*" which means a planned programme of periodic collection and analysis of body fluid, tissues, and excreta or exhaled air in order to detect and quantify the exposure to or absorption of any substance or *organism* by persons, including HIV and AIDS. In the ambit of this act, the emphasis falls on the protection of the health of the employee. However, the employee also has an obligation to inform the employer should he suffer from any illness or condition that poses a threat to his health or the health of other people in the workplace.

- **Compensation for Occupation Injuries and Diseases Act, Act 130, 1993.** This Act provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases; and to provide for matters connected therewith. Disablement, which can be caused, by HIV and AIDS, as well as compensation is dealt with in this act.
- **Basic Conditions of Employment Act, 1997.** This act advances economic development and social justice by regulating the right to fair labour practices conferred by section 23(1) of the Constitution by establishing and enforcing basic conditions of employment; and by regulating the variation of basic conditions of employment. With regard to HIV and AIDS, this act prohibits discrimination against job applicants who have HIV and AIDS, including hiring and termination of employment. The purpose of this Act is to advance economic development and social justice by regulating the right to fair labour practices as referred to in the Constitution (in other words, apply fair labour practices to HIV and AIDS sufferers), and regulate variations of basic conditions of employment (therefore prohibiting changing conditions, for example, to terminate an employee's employment should the employee suffer a terminal illness, such as HIV and AIDS).
- **Medical Schemes Act, Act 131 (1998).** This act forbids any unfair discrimination, either directly or indirectly, against any person based on their age and health status, including HIV and AIDS. The Department has firmly closed the door on products where the only form of innovation [and/or research] involves discrimination against people who need health care the most. In the application of this Act, the debate about utilizing generic medicines is addressed, and medical schemes "ruthlessly" refuse to pay for original medicines, only for the generic equivalents. This places HIV and AIDS medication, its cost and availability for the poor and sick in the limelight. This debate is still raging in South African society. Only recently Government has made generic HIV and AIDS drugs available to sufferers.
- **The Nursing Act, Act 50 (1978)**. This act governs nursing practise in South Africa. In terms of this act, a professional nurse must register with the South African Nursing Council in order to practise within the scope as laid down. The Act also states that the knowledge and skills required to practise must be kept up to date. Clinical skills are those of observation and treatment. Many occupational health practitioners work alone and as the sole provider of healthcare at the workplace need to evaluate their own clinical performance objectively and arrange for continuous up-dating of knowledge and skills.
  - **The scope of practise for registered nurses (Regulation 2490 dated 24/10/90).** The scope of practise of a registered nurse entails acts or procedures which may be performed by scientifically based physical, chemical, psychological, social, educational and technological means applicable to health care practise.
- **The Medicines and Related Control Amendment Act (1997).** This act makes provision for manufacturing, keeping, sale of medicines and their compounds, prescribing and registration of medicines. It also prescribes the forms to be used for any application for the registration of any medicine and the particulars of the medicine, which includes the packaging of scheduled substances, labels, sealing, advertising and selling if drugs.
- The Department of Labour has set out a **Code of Good Practice on Key Aspects of AIDS and Employment**, which is linked to the Employment Equity and Labour Relations Acts, and provides a

standard setting out the content and scope of an appropriate response to HIV and AIDS in the workplace. It further deals with the provision of creating a non-discriminatory work environment, HIV testing, confidentiality and disclosure, providing equitable employee benefits, dealing with dismissals, and management of grievance procedures.

- Currently, the University of the Witwatersrand (WITS) is conducting an **AIDS Law project** under the leadership of Mark Heywood. This project provides comprehensive information for both the uninformed that seek help, as well as those involved in specialized research on the Law and HIV and AIDS. It also provides information for those who know virtually nothing about the disease and support structures, to information for those who perform specialized and intensive research.

Generally speaking, Labour legislation demarcates the disease, thereby "legitimizing" its existence to enable society to deal with it in a structured manner. It enables transparency, which results in better coping mechanisms, a well as improved research and the provision of formal support.

HIV and AIDS is currently treated as a chronic disease, similar to cancer, since new, more effective drugs are produced which enables palliative treatment and provides the patient with the ability to live longer and enjoy a higher quality of life.

The legal perspective, however, is not the only perspective that will be explored in this study. A thorough investigation will be performed in order to outline and emphasize the ethical aspects related to HIV and AIDS. Ethical aspects related to HIV and AIDS include testing, treatment, and research. Key issues analysed include confidentiality, informed consent, and ending of life, research design, conflict of interest, vulnerable populations, and vaccine research. Ethical principles will be discussed (e.g. beneficiality, confidentiality, [disclosure], informed consent for HIV testing, including special procedures for HIV testing, exceptions to informed consent, and pre-natal HIV testing. Additionally, end-of-life issues, research ethics, vulnerable participants, and ethical issues in vaccine research will be discussed briefly...

When a legal-ethical benchmarking instrument for HIV and AIDS in the workplace is developed, it has to be viewed from a macro point of view (institutionally). Then the relevant legislation can be distilled into "checkpoints" for the employer to enable him to determine his status on the grid of compliancy.

The governance accountability structure of the legal framework that has to be complied to is outlined below:

Table 21 Legislative Compliance Grid

Legislation	Principles	Legal issue	Practical Purpose	Workplace Implementation checkpoints
Constitution Act, (Act 108 of 1996),	Bill of Rights – Equality Clause	Unfair Discrimination	Protection of the individual citizen by the law	■ **Formal over-arching HIV and AIDS Strategy and Policy** in place, stating the organisation's position on HIV and AIDS ■ **Workplace Policy and implementation** structures regarding employees as equal by law, e.g. statement in **employment contract** with employee ■ **Education and training strategy and plans** about unfair discrimination in the workplace. ■ **Provision of legal services** for employees re unfair discrimination or grievances related to HIV and AIDS
			Prohibition by both the State and any person from unfairly discriminating directly or indirectly against another person on any grounds, such as race, gender and disability [*including a debilitating disease such as HIV and AIDS, TB, Cancer etc.*].	■ **Workplace Policy** implementation structures regarding employees as equal by law, e.g. statement in **employment contract** with employee

Legislation	Principles	Legal issue	Practical Purpose	Workplace Implementation checkpoints
Labour Relations Act, Act 66 of 1995	Management of HIV/Aids in the Workplace	Voluntary & anonymous testing Provision of counselling, confidentiality, protection of vulnerability of sufferers	Creates opportunity for employer to put in place support structures for employees suffering from HIV and AIDS and other debilitating diseases	■ Include, in Workplace Policy, the **implementation of support structures** where employees can volunteer for testing (or outsource it). ■ Provide, if not present already, a **counselling clinic** and labour-related **medical/nursing facilities. Including medication**
Employment Equity Act, Act 55 of 1998	Equality	Unfair discrimination and harassment	An employee suffering from HIV/AODS must benefit from all rights, privileges and obligations that other employees benefit from. Stereotyping	■ All day-to-day workplace issues, such as **absenteeism** (due to opportunistic illnesses), should be treated with objectivity and singular procedures, e.g. the requirement of sick leave certificates. ■ Employers must ensure that sufficient broader **support mechanisms** exist in the workplace to sustain the employee in the organisation. ■ Employers must ensure, in the employment contract, that all employees understand the **practical application of the phenomenon of stereotyping** and its consequences for employees in the workplace.
Occupational Health and Safety Act, 1993	Health & Safety of employees at the workplace	Creating a physically and mentally safe work environment protecting employees against health and safety hazards	Establish **Advisory Council for Occupational Health and Safety**, and the provision for matters such as HIV and AIDS in the workplace regarding health and safety issues. The Act forbids **victimization** against employees suffering from HIV and AIDS. The Act also covers the process of **"biological monitoring"** (planned programme of periodic collection and analysis of bodily fluid, tissues, excreta or inhaled air to detect and quantify the exposure to or absorption of any substance or organism by persons, including HIV and AIDS The emphasis in this Act falls **on protection** of the health and safety of the employee.	■ Employer must have an **Occupational Health and Safety Policy** in place. ■ **Procedures** should exist that operationalise this policy. ■ Produce monthly Safety, Health, & Quality **Reports about the workplace** ■ **Proactively identify** hazards and **implement interventions** to minimize risks and enhance awareness through **Safety, Health Environmental & Quality Audits, Investigations**, and **inspections** of the workplace ■ **Induct** and **coach** employees through an induction and training programme and curriculum for all new employees and contractors about OCHA ■ Hold regular **safety meetings** with management and other stakeholders ■ **Distribute correspondence** with external parties, Health and safety agreements, policy, safety packs and minutes to all employees ■ Provide/supply **Personal Protective Equipment** to employees to ensure safety
Compensation for Occupation Injuries and Diseases Act, Act 130, 1993	Compensation	Compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees, or for death resulting from such injuries.	The Act provides for compensation due to occupational injuries, diseases, or death due to these events resulting from the workplace, and matters connected therewith, as well as disablement (which can/cannot be caused by the aforementioned.)	■ Check relevant **NOSA/ISO Certification** and compliance ■ Ensure compliance to all industry & occupational **health and safety standards** ■ **Implement Hazard Identification Risk Assessment** through workforce training ■ Implement an, e.g. **"Safety Through Empowerment of People (STEP)"** programme and **ensure training** of workforce on this matter. ■ Ensure HIV and AIDS **Awareness Training** ■ **Lease** with HR Functionaries

Legislation	Principles	Legal issue	Practical Purpose	Workplace Implementation checkpoints
Basic Conditions of Employment Act (1997)	Advancement of economic development & social justice	The regulation of the right to fair labour practices conferred by Section 23(1) of the Constitution by establishing and enforcing basic conditions of employment.	This Act prohibits the discrimination against the employment of job applicants suffering from HIV and AIDS, including the hiring and termination of employment. This Act advances economic development and social justice by regulating the right to fair labour practices as referred to in the Constitution. It also regulates variations of basic conditions of employment (thereby prohibiting changing conditions of employment, should the employee suffers from a terminal illness, such as HIV and AIDS, Cancer, etc.	■ Ensure a clear, legally compliant **policy** for basic conditions of employment **inclusive of HIV and AIDS** ■ Ensure that the policy is translated into clear **work processes** and **procedures inclusive of HIV and AIDS** ■ Ensure that policies, processes, and procedures include **indemnity** on the part of the employer regarding HIV and AIDS ■ Ensure, through thorough record holding, that employment practices reflect all basically disadvantaged demographic categories of employees, such as the blind, the deaf, etc.
Medical Schemes Act, Act 131 (1998).	Fairness in the distribution of any form of health care	Prohibition of discrimination in the distribution of health cares, as well as research and other processes where the usage of persons who represent the poorest of society and need health care the most.	The usage of generic medicines against the original (upon years of research has been performed), is addressed in this Act. Medical schemes "ruthlessly" refuse to pay of for medicinal claims of the original medicine, but pay out willingly for generics, which are sometimes substandard, and much cheaper and economical to afford, especially chronic medicines for patients suffering, amongst others, of HIV and AIDS. The cost and availability of these medicines is currently in the spotlight. The government is obliged to improve access to health care services, including essential medicines. The Treatment Action Campaign (TAC) has been lobbying and taking legal action to have cheaper HIV and AIDS drugs imported into South Africa	■ Ensure proper processing of medical claims ■ Inform employees of their rights regarding medication for HIV and AIDS and the consequences of using alternative and generic medicines ■ Include such information in HIV and AIDS **Training and Awareness** programmes in the workplace.

Legislation	Principles	Legal issue	Practical Purpose	Workplace Implementation checkpoints
Department of Labour: Code of Good Practices on Key Aspects of AIDS and Employment	The Code is based on principles and legal provisions contained within international law, the Constitution, labour legislation, other relevant acts and the common law. Equality and non-discrimination between individuals with HIV infection and those without and between HIV and AIDS and other comparable illnesses; The creation of a supportive environment so that employees with HIV or AIDS can continue working for as long as possible; Protection of human rights; Ensuring the rights and needs of women are addressed in all policies and programmes; and Consultation, inclusively and participation of all stakeholders in all policies and programmes.	The Code has two legally-related objectives: Firstly to **provide guidelines** on how to eliminate unfair discrimination based on HIV status in the workplace; and Secondly, to provide guidance on the **management** of HIV and AIDS in the workplace. The principles embodied in the Code have been drawn from **national** and **international** law as well as **best practices** in the management of HIV and AIDS in the workplace. The most important of the international codes that have been used to inform and develop the Code are: The SADC Code of Good Practice on HIV and AIDS and Employment (1997) HIV and AIDS and Human Rights: International Guidelines (United Nations: 1998) The ILO Code of Practice on HIV and AIDS and the World of Work (2001) South African law	To set the scene in the broadest sense about the HIV and AIDS pandemic and how it affects morbidity, mortality, absenteeism, staff morale, the cost of benefits, products and services and investment. To minimize the impact of HIV and AIDS, it is imperative that every workplace in South Africa responds to the challenge of HIV and AIDS through prevention of further infections and implementation of management strategies.	**Employment policies and practices:** ■ Recruitment procedures, advertising and selection criteria: Recruitment and selection procedures and policies cannot exclude, directly or indirectly, people on the basis of HIV status, for instance, by insisting that only applicants who are HIV negative may apply. ■ Appointments and the appointment process: The appointment process cannot unfairly discriminate, directly or indirectly, against applicants living with HIV and AIDS, for instance by denying appointments to those who test HIV positive as was done in the Hoffmann v SAA case. ■ Job classification and grading: The policies relating to job classification and grading of employees should not unfairly discriminate against employees living with HIV and AIDS by for instance, denying them, directly or indirectly, certain types of employment for this reason. ■ Remuneration, employment benefits and terms and conditions of employment: Employees with HIV and AIDS may not be unfairly discriminated against, directly or indirectly, for instance by offering them lower rates of pay or denying them employee benefits, on the basis of their HIV and AIDS status. ■ Job assignments: HIV and AIDS should not be a factor used to unfairly discriminate, directly or indirectly against employees in assigning jobs. For instance, an employee living with HIV and AIDS should not be unfairly denied the opportunity to take job assignments abroad. ■ The working environment and facilities: Policies relating to the working environment and work facilities should not unfairly discriminate, directly or indirectly, against employees living with HIV and AIDS. For instance, employees living with HIV and AIDS should enjoy equality of access to workplace facilities such as toilets and canteens. ■ Training and development: Training and development policies may not unfairly discriminate, directly or indirectly, for instance by denying training opportunities to employees living with HIV and AIDS. ■ Performance evaluation systems: Systems and policies regarding performance evaluation should not unfairly discriminate, directly or indirectly, on the basis of HIV status, so that employees living with HIV and AIDS are evaluated on a fair and non-discriminatory basis. ■ Promotion: HIV status should not be used as a factor to unfairly discriminate, directly or indirectly, against an employee in determining promotion opportunities.

Legislation	Principles	Legal issue	Practical Purpose	Workplace Implementation checkpoints
		The Code is based on principles and provisions contained in: The Constitution; Labour legislation; The common law; and Related legislation.		■ **Transfer:** Policies may not unfairly discriminate, directly or indirectly against an employee with HIV and AIDS. ■ **Demotion:** HIV and AIDS should not be used to unfairly discriminate, directly or indirectly, against an employee by for instance, demoting someone who is known to be living with HIV and AIDS. ■ **Disciplinary measures other than dismissal:** Policies and procedures regarding disciplinary measures should ensure that HIV status is not used to unfairly discriminate, directly or indirectly against employees in the application of such measures. ■ **Dismissal:** Dismissal procedures may not unfairly discriminate, directly or indirectly based on HIV and AIDS, for instance by dismissing employees who are known to be living with HIV and AIDS.
Nursing Act, Act 50 of 1987	Protection of a patient from misconduct and discrimination	To provide guidance to a registered nurse regarding the conduct of her professional duties To provide rules for acts and omissions resulting in misconduct by the registered nurse To protect the patients right to confidentiality and privacy	This Act protects the patient from unprofessional acts and behaviour which poses a threat to their life or could result in the deterioration of their health or condition It is very descriptive regarding the way in which professional information should be dealt with and the punishment for misconduct	■ Ensure that professional paid-up membership with the South African Nursing Council is in place when registered nurses are employed for the private sector during recruitment. ■ Training and education on adherence to ethical principles pertaining HIV positive patients in the workplace should be provided
The Medicines and related Substances Control Amendment Act, 1997	Provision for manufacturing, keeping, sale of medicines and their compounds, prescribing and registration of medicines	To protect the public by regulating the keeping, sale, prescribing and dispensing of medicines	Supply of safe and affordable medicines Protection of the public by unlawful practises	■ Occupational Health Nursing Practitioner should have a dispensing licence and adhere to all permit requirements as stipulated in the legislation

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