A Decade of German Support for Workplace Health

Concepts – Results – Lessons Learned

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<th>Description</th>
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<tbody>
<tr>
<td>ACCA</td>
<td>AIDS Control in Companies in Africa</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>AMICAALL</td>
<td>Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral Drugs</td>
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<td>AWISA</td>
<td>AIDS Prevention &amp; Health Promotion Workplace Programmes in Southern Africa</td>
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<td>BOHS</td>
<td>Basic Occupational Health Service</td>
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<td>BMZ</td>
<td>Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism of the Global Fund</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CSR</td>
<td>Corporate Social Responsibility</td>
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<tr>
<td>DED</td>
<td>Deutscher Entwicklungsdienst (German Development Service, now GIZ)</td>
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<td>DEG</td>
<td>Deutsche Investitions- und Entwicklungsgesellschaft mbH</td>
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<tr>
<td>EABC</td>
<td>East African Business Council</td>
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<td>EAC</td>
<td>East African Community</td>
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<td>EWP</td>
<td>Employee Wellbeing Programme</td>
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<td>FP</td>
<td>Focal Point</td>
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<td>GBC</td>
<td>Global Business Coalition on Health</td>
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<td>GDC</td>
<td>German Development Cooperation</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFTAM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<td>GIZ</td>
<td>Gesellschaft für Internationale Zusammenarbeit GmbH</td>
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<tr>
<td>GTZ</td>
<td>Gesellschaft für Technische Zusammenarbeit GmbH, now GIZ</td>
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<tr>
<td>HCT</td>
<td>HIV counselling and testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IAS</td>
<td>International AIDS Society</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>InWEnt</td>
<td>Internationale Weiterbildung und Entwicklung GmbH (Capacity Building International), now GIZ</td>
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<tr>
<td>KAPB</td>
<td>Knowledge, Attitude, Practice and Behaviour survey</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NCD</td>
<td>Non-communicable diseases</td>
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<td>OSH</td>
<td>Occupational Safety and Health</td>
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<tr>
<td>PABC</td>
<td>Pan-African Business Coalition on HIV and AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Preventing Mother-to-Child Transmission [of HIV]</td>
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<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
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<tr>
<td>REC</td>
<td>Regional Economic Community</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SME</td>
<td>Small and medium-sized company</td>
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<tr>
<td>SPAA</td>
<td>Support of the Private Sector in Africa to fight AIDS</td>
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<tr>
<td>STD or STI</td>
<td>Sexually Transmitted Disease or Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WPP</td>
<td>Workplace Programme</td>
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Executive Summary

Since the end of the 1990s, German Development Cooperation (GDC), with funding from the German Federal Ministry of Economic Cooperation and Development (BMZ), has been contributing both considerable resources and technical know-how to programme development and implementation around workplace health improvement. Starting out with company collaborations in the framework of public private partnerships (PPP), GDC developed an approach for workplace HIV management that was exemplary to many other initiatives to come. In the last decade, 49 projects and programmes with a workplace focus were conducted, 46 of them direct partnership contracts with companies reaching more than 1.9 million employees of both large and small enterprises. These projects proved very cost-effective, costing about 5.5 Euros of German public funding per capita on prevention, treatment and care. There was an almost fifty-fifty division of support between large enterprises and small and medium-sized companies combined. The 30 completed projects included in this evaluation reported considerable improvement around the following core indicators:

- **Company HIV management**: 95% of the programmes measuring this management indicator reported that their partner companies introduced an HIV workplace policy as a basic precondition of HIV management.
- **Risk management**: Of those programmes measuring HIV counselling and testing (HCT) as an instrument to manage personal risk, 79% reported an increased uptake of HCT among employees.
- **Stigma and discrimination management**: 77% of those programmes following up on knowledge level and misbeliefs reported decreases in misbeliefs and increases in knowledge.

Most PPPs went beyond the companies’ own workforces to benefit communities and supply chain companies. And equally important – they served as learning incubators for generating new ideas and approaches, which could then be adapted to other company and country contexts. Due to the short duration of PPPs, long-term impact monitoring remains under the auspices of the partnering companies. A kind of “Alumni” PPP network and a harmonized indicator framework could contribute to improved, long-term follow-up of achievements, successes and challenges. The AWISA Network, which functions as an online interactive information exchange platform on workplace interventions, could serve this purpose.

GDC continued to re-design its approach to fit companies’ needs. The earlier HIV-only programmes were extended, first, to malaria and TB, and later, to other diseases and mentally distressing factors, such as over-indebtedness of employees. These further efforts eventually lead to the promotion of comprehensive Employee Wellbeing Programmes (EWP). In order to respond to the important factor of sustainability, first steps were made towards integrating health into traditional structures of occupational safety and health (OSH). Guidelines on integrated health management were developed jointly with the transport industry in Southern Africa and the hotel industry in the region of the East African Community (EAC).

In addition to working with companies directly, GDC also supported national and regional support structures of the private sector. The regional programme ACCA (AIDS Control in Companies in Africa) partnered with national business coalitions in six countries. Its successor programme SPAA (Support of the Private Sector in Africa to Fight AIDS) worked with a continental umbrella body of national business coalitions called Pan-African Business Coalition on HIV and AIDS (PABC) as well as the East African Business Council (EABC) and the AIDS Unit of the Southern African Development Community (SADC) Secretariat.

This more system-related approach operated at a meso level of society and used business associations to multiply investments in capacity development. Advocacy, training and information thus reached a greater number of companies and access of business to funding sources for HIV programmes was improved; however, calculating the impact of these meso-level efforts on employees and workers remains challenging, due to the indirect contact of business coalitions and associations with the intended target group, namely a company’s workforce. Regional-level experiences revealed that the best results are achieved if dynamic and mutually beneficial partnerships between

regional and national level stakeholders are established and maintained. Activities benefitting the envisioned target group of workplace programmes, namely employees, ultimately have to take place at country level.

Industry approaches have the potential of combining the benefits of direct partnerships with companies and support of business associations. In such an approach, the sector’s associations as well as company champions have to be involved in order to mobilize the rest of the sector and even to reach out to contractor companies or small and medium-sized businesses. Very promising is the combination of health with general quality initiatives of the industry which go beyond health to include other technical topics relevant to the respective industry. By capitalizing on such opportunities, workforce health can be promoted as a worthwhile investment critical to improving overall standards in production, operation and service.

The workplace health concepts and tools of GDC are flexible enough to respond to new challenges while continuing to innovatively address still-perplexing problems. One such new challenge is the consolidation of parallel structures that have been set up for HIV management, which have side-lined existing efforts to bolster occupational health and safety provisions. Other topics needing to be addressed include non-communicable diseases (NCDs), environment and health or pandemic control. The workplace offers access to a variety of target groups, such as young and older workers or women, who have particular health-related needs, including maternal health. Vocational training can be used to supplement industries’ efforts to improve health among the youth. With specific knowledge on comprehensive and integrated health management of an industry, such an approach would combine the general health risks that adolescents and young adults are facing in societies with elevated occupational health and safety risks of young employees in specific work settings. Private sector collaboration can also be more intensively used for strengthening health systems, i.e. by reducing the burden of workplace-originating diseases or by extending business contributions to health financing.
Section 1: Introduction

The Private Sector as a Development Partner

The HIV pandemic is still one of the most significant challenges to health, development, economic and social progress in many regions of the world, especially in Africa south of the Sahara. HIV is expected to continue to be a leading cause of mortality and morbidity in many countries and populations; the UNAIDS estimates that over 34 million people around the world are infected with HIV. According to the International Labour Organization (ILO) more than two thirds are persons of working age (15 – 49 years old), in the prime of their working lives. In the context of the above, HIV has not only become an international and national issue, but also a workplace issue.

Although the overall growth of the global HIV epidemic appears to have stabilised, levels of new infections are still high in various countries, particularly in East and Southern Africa. Due to the significant scaling up of antiretroviral treatment programmes, the character of the HIV pandemic has changed. Initially, the HIV pandemic was treated by high prevalence countries and international development partners as a national disaster which required emergency responses. Today, the decline in HIV-related deaths and the increasing number of people living with HIV as a chronic disease has shifted both attention and resources to addressing the long-term consequences of the pandemic and the sustainability of HIV prevention, treatment and care structures. An increase in the number of people having to cope and live with HIV will have a corresponding impact on the world of work. The effects of antiretroviral therapy (ART) are especially evident in Sub-Saharan Africa, where an estimated 21% fewer people died of HIV related causes in 2010 than in 2005, and it is estimated that approximately 25.5 million persons of working age are currently living with HIV in Sub-Saharan Africa.

Over the past fifteen years, recognition of the detrimental effects of the HIV pandemic has grown among the business community. In 1999, the United Nations’ former Secretary-General Kofi Annan motivated the international business community to form a Global Compact for sustainable development and, in 2001, he encouraged the private sector to actively combat HIV as a threat to economic progress. His ‘Call to Action’ proposed the creation of a Global Fund to mobilize financial resources predominantly from government and also addressed the private sector to invest in the response to HIV. In the same year the United Nations General Assembly adopted a ‘Declaration of Commitment’ which included a commitment by African governments to promote and support workplace programmes as part of their overall strategies to prevent and control HIV. The International Labour Organisation (ILO) provided employers, employees and governments with the ‘ILO Code of Practice on HIV/AIDS and the World of Work’, laying out principles on which workplace programmes should be based. For the German government, the HIV response at the workplace became a major orientation and a first testing ground for a new concept of public-private partnerships (PPP) promoting collaboration between companies and German development agencies. Starting from the end of the 1990s, both – the PPP as an instrument and HIV programmes as a joint social objective between private and public sector – were developed in step.

Increasing attention is now given to additional health issues challenging the private sector. Globally, an estimated 2.3 million employees die annually from work-related accidents and diseases. According to ILO, this death toll creates costs of as much as 4% of the gross domestic product (GDP) worldwide. The World Health Organisation (WHO) reports that selected work-related risk factors account for 40% of all occupational injuries and diseases responsible for 1.5% of the total global burden of disease. Additionally, non-communicable diseases, costing an estimated 4% of the global gross domestic product, are of increasing importance, especially to low and middle income countries.

The successful advocacy for global investment in vertical, multi-sectoral HIV programmes led to the creation of pol-
icy, logistics and service structures which often by-passed existing health management provisions of a country. This was also the case at the workplace. Traditional institutions concerned with promotion and safe-guarding of occupational safety and health (OSH) were side-lined in the attempt to motivate companies around HIV-centred action. Companies’ contributions ranged from HIV workplace programmes as part of their social responsibility activities to business-oriented systemic interventions that make use of companies’ core competences and leadership influence.

The public sector, which is the biggest employer in countries with high HIV prevalence rates, responded as well. As a consequence of the AMICAALL Declaration on HIV and AIDS (1997) and the World Bank Local Government and HIV/AIDS Initiative (2003), the public sector intensified its efforts to implement HIV workplace programmes in governmental institutions at all levels. Since 2003, it is also a policy of the German Federal Ministry for Economic Cooperation and Development (BMZ) that all German Development Cooperation (GDC) programmes and projects mainstream HIV9 in countries with generalized epidemics 10.

Additionally, the WHO has long-promoted the well-established fact that a healthy workforce in a healthy workplace also means a healthy business12. Accordingly, business efforts towards comprehensive health promotion and safety at work are directly relevant to competitive factors, such as the management of direct costs and the pursuit of new business opportunities. Contributing to the wellbeing of employees is more than corporate social responsibility in action; it is a strategy for risk management, value creation, and generating competitive advantage.

A decade of involvement in the implementation of HIV workplace programmes (WPPs) in development cooperation has provided ample time and opportunities to test new ideas, to understand HIV in the context of workplace health more generally and to assess the capacities and capabilities of companies to manage workplace health. It has been a dynamic decade which has necessitated periodical adjustments in approaches, concepts and even objectives, including the broadening of our scope from managing HIV in the workplace to a more comprehensive management of workforce health. In section one, an overview is given of German support in the form of public private

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9 Mainstreaming HIV/AIDS is “a process that enables organisations to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace” (Definition provided by UNAIDS 2005).
10 In a generalized epidemic, HIV is firmly established in the general population e.g. in Kenya with an HIV prevalence rate of 7.4% (2008: Kenya AIDS Indicator Survey)
11 WHO 1086: Ottawa Charter for Health Promotion (21 November 1986)
partnerships and programmes for workplace interventions. In section two, the text takes a deeper look into the concept of workplace programmes, summarizing the experiences acquired and the conceptual adaptations that were derived from the lessons learned. Section three analyses the results that were reported from the various public private partnerships and programmes conducted at company level. Section five draws attention to the work conducted jointly with business associations, looking at achievements of partnerships with national business coalitions, regional private sector bodies and industry associations. Based on the findings of the preceding sections, section five highlights the major milestones and provides an initial picture of the potential for expanding interventions to promote health at the workplace.

**German Support of Business Health Engagement**

The involvement of the formal economy in combatting HIV, especially in sub-Saharan African countries facing major epidemic challenges, is seen as a key strategy in the fight against the epidemic\(^\text{13}\). The German Federal Government initially supported WPPs on HIV initiated by international companies in South Africa in the late nineties of the last century. German Development Cooperation, in general, and GTZ\(^\text{14}\), DED\(^\text{15}\) and InWEnt\(^\text{16}\) (now all merged into GIZ\(^\text{17}\)) and DEG,\(^\text{18}\) in particular, got involved in these efforts early on through development partnerships, such as the Public Private Partnership (PPP) initiative of the BMZ.\(^\text{19}\) The GDC supported selected companies in most of the Sub-Saharan countries but also in Brazil, China and Ukraine within the PPP framework. A total of 46 PPPs focusing on workplace programmes were established between 1999 and 2011. Forty of those partnerships were funded out of the PPP funds established by the German government; the remaining six PPPs were conducted with funds from programmes such as AWISA and ACCA. The overall German contribution for these PPPs sums up to about 10.5 million Euros (36%); the private sector contributed a corresponding sum of 18.7 million Euros (64%). A number of smaller PPPs were integrated in health programmes of GDC in various countries, especially in Africa. These PPPs were not included in this analysis.

In 2002, the BMZ commissioned GTZ to set up the regional project “AIDS Control in Companies in Africa (ACCA)” (2002 – 2007) with the purpose of further promoting the private sector response to HIV on the continent. The workplace experiences gained with multinational companies in South Africa were used as a blueprint for the roll-out of HIV WPPs, especially among smaller national enterprises in other African countries. Besides advising individual companies on the design and implementation of HIV WPPs, ACCA soon expanded its support to national business coalitions against HIV, which first emerged in 2002 as service providers and advocates for companies willing to address the challenges of HIV. This process was supported by the World Bank and other national and international organizations such as UNAIDS, and the World Economic Forum. The BMZ invested 5.2 million Euros in the two phases of the ACCA project lasting from early 2002 to end of 2008.

A second GDC programme called “AIDS Prevention and Health Promotion Workplace Programmes in Southern Africa (AWISA)\(^\text{20}\)” started around the same time as ACCA and is still on-going. The former DED and InWEnt jointly developed trainings and an advisory concept to

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\(^\text{13}\) The private sector response as described in this document focus on initiatives of the formal sector that have the economic potential to tackle HIV and AIDS at the workplace. The informal economy, with approximately 70% of the potential working population in developing countries (World Bank 2010: Shadow economies all over the world), needs to be addressed through other approaches.

\(^\text{14}\) Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

\(^\text{15}\) Deutsche Entwicklungsdienst (DED)

\(^\text{16}\) Internationale Weiterbildung und Entwicklung (InWEnt)

\(^\text{17}\) On 01.01.2011, Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ) was established through a merger of Deutscher Entwicklungsdienst (DED), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) and Internationale Weiterbildung und Entwicklung (InWEnt).

\(^\text{18}\) Deutsche Entwicklungsgesellschaft (DEG); http://www.deginvest.de/

\(^\text{19}\) More information on the PPP initiative and its guidelines can be found under www.giz.de or www.developpp.de

\(^\text{20}\) AWISA started in 2003 as a strategic partnership project of the DED and InWEnt and is now part of GIZ supporting projects in South Africa, Malawi, Mozambique, Namibia, Zambia and Tanzania.
assist small companies as well as non-governmental and governmental organisations in implementing workplace interventions and activities to mitigate the impact of HIV. AWiSA’s current project phase will end in 2012. The various phases of AWiSA between 2003 and 2012 were financed with 4.3 million Euros.

Starting in 2008, the regional programme “Support of the Private Sector in Africa to fight AIDS (SPAA)” followed the ACCA project. It aimed at strengthening the regional support of private sector responses to HIV by engaging regional economic communities (RECs), business associations, industries and business coalitions as advocates and service providers. Specifically, the programme worked with industries to develop standards and guidelines on employee health management that integrated HIV and TB measures. The programme collaborated with the East African Business Council (EABC), the Southern African Development Community (SADC) and the Pan-African Business Coalition on HIV/AIDS (PABC). It was funded with 3.0 million Euros over a time period beginning in 2008 to the end of 2011.
Understanding, Learning - and Adapting the Approach

Since more than a decade, GDC has continually adapted its comprehensive WPP approaches with the aim of optimizing and tailoring their design for the private and public sectors.

Initially, it was GDC’s main objective to support private sector organizations, raise awareness, mitigate the impact of HIV and, thereby, create an economic and social climate more conducive to business and industry. Over the course of the decade, the WPP approach was broadened from HIV-only workplace initiatives to employee wellbeing and an integration of HIV and TB management into the framework of traditional OSH. A wealth of data from private sector organizations demonstrates that, in the long term, companies that promote and protect workers’ health are among the most successful and competitive, and also enjoy better retention rates for their employees.

The results of the continuing development process of the GIZ workplace programme approach is captured in Figure 1.

Figure 1: Continuing development of the workplace programme approach

Section 2: A Healthy Workforce as a Development Objective

Goetz et al., 2008, Workplace Health Promotion. Policy Recommendations that Encourage Employers to Support Health Improvement Programs for their Workers. Washington, Partnership for Prevention
All comprehensive WPPs supported by the BMZ have in common that they target employees in the private and public sectors, their dependents and other persons in the locality. The programmes are flexible and can be tailored to the individual needs of large, medium-sized and smaller companies, as well as to public employees. By integrating HIV and TB management in classic OSH, legal frameworks and supervisory institutions at national level become important factors and partners in the development of effective public–private sector collaborations on health. These institutions have the power to make specified health action mandatory and to enforce legal obligations. GDC programmes aim to guide companies in initiating and implementing WPPs within existing legal frameworks.

In order to ensure long-term successful and sustainable workplace programme initiatives, guiding principles of all approaches are to

- Involve the management in the process and demand competent leadership;
- Build capacity and establish committed management structures;
- Demand participatory involvement of employees to promote ownership;
- Link workplaces with the existing health system to provide relevant services.

Cooperation between the business community including trade unions, governmental institutions, private health service providers and the public healthcare sector is a key element of these measures. The German technical support organizations offer the following advisory services which enable organizations to implement their individually designed workplace programme:

- Research in form of needs assessments, operational research and impact analyses;
- Support of state-of-the art programme design and planning processes;
- Training of human resource and programme management structures;
- Design and provision of educational materials;
- Development and implementation of monitoring, evaluation and quality assessment measures;
- Development of guidelines for workplace health management.

In addition to the services described above, the GIZ WPP approach offers extended advisory services which focus on specific components such as social protection, financial wellness, workers’ living environments, pandemic preparedness or outreach to supplier companies.

### The Basics of HIV Workplace Programmes

More than a decade of experiences in HIV workplace interventions has revealed that companies welcome guidance in addressing health issues of their workforce. The recommendations published by various international and bilateral organisations such as UNAIDS, ILO and GIZ encourage companies to seek opportunities for prevention, to improve medical care and treatment and to establish a non-discriminatory and supportive environment for HIV-positive employees. As mentioned in section one, GIZ programmes stress quality control, sustainability and a long-term outlook as main features of development projects, in general, and HIV programmes, in particular.

### Prevention

Preventing new HIV infections is one of the main objectives of HIV workplace programmes. Prevention involves changing behaviour and perceptions. Educational, awareness-raising materials are developed for specific target groups, utilizing existing communication channels and, where appropriate, modern means of communication. Education offered by trained peers, from colleague to colleague, has proven to be a successful method. The peer education approach can be extended and strengthened in presentations by singers, storytellers or drama groups.

Other key messages of HIV prevention, which vary by target group, include the promotion of correct and consistent male and female condom use and the encouragement of employees to use HIV counselling and testing (HCT) services. Knowing one’s own HIV status increases people’s willingness to behave responsibly, which can help to reduce or prevent the spread of HIV. HIV testing services are accompanied by intensive pre-test and post-test counselling. It is vital that the confidentiality of HCT services is ensured and that HIV tests meet the quality standards of the WHO.
Medical care and treatment
Combating HIV starts with supplying medical services at an early stage. There is a wide variety of corporate medical services. Some workplaces have set up in-house treatment services with a doctor, while others offer only first aid in their health facility. Some enterprises cooperate with nearby private or public health facilities.

The focal area of effective HIV care is the provision of anti-retroviral therapy (ART) as a treatment option to restore the health of HIV infected people. ART can also reduce stigma around HIV. HIV-positive pregnant women and their babies receive special ARV treatment to inhibit the transmission of the virus during labour, delivery and breastfeeding (PMTCT – Preventing Mother to Child Transmission). Other focal areas in health care are risk reduction through treatment of sexually transmitted diseases (STDs), as there is a strong link between STDs and HIV, and treatment of opportunistic infections and diseases such as TB.

Human resource management
In most cases, a company’s or public institution’s human resources department is closely involved in planning, implementing and monitoring the HIV workplace programme. It usually hosts the HIV coordinator or focal person and is the interface between workforce and management in the form of a multi-sectoral HIV team. The team drafts an HIV workplace policy that clarifies the rights and duties of employees and management concerning HIV. In general, the policy affirms non-discrimination and confidentiality to HIV-positive employees and defines the components of the workplace programme. To ensure the successful implementation of the policy it is of utmost importance that the document is widely communicated and accepted by all stakeholders including managers, employees and employee representatives. The policy should be regularly reviewed and modified to accommodate changing circumstances.

Outreach to contractor companies and neighbouring communities
Since companies are involved in the communities where they operate in a number of ways, activities within the community and partnerships with other stakeholders and institutions are a natural option for comprehensive corporate social responsibility (CSR) strategies. Such involvement can also target HIV prevention or other health promotion. It contributes to equity in societies where being formally employed is a privilege and an advantage, considering the huge size of the informal sector in developing economies. Various organisations such as the World Bank, the International Labour Organisation (ILO) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) offer funds to support company outreach activities. Most PPPs supported by GDC also targeted population groups beyond the company workforce.

A special form of community outreach is undertaken by larger and often multinational companies. They support small and medium sized enterprises (SME) in their supply chain to tackle HIV. SMEs employ 50 – 70% of Africa’s formally employed workforce and are the economic backbone of Africa. Outreach activities effectively scale up a company’s response to HIV. Through the “Supply Chain” approach men and women working in SMEs gain access to the services they need to protect themselves from HIV. Small and medium enterprises face the same effects of the epidemic, but do not have the adequate resources to implement comprehensive WPPs.

Targeting Small and Medium-Sized Enterprises: AWiSA
Small and medium-sized enterprises play a key role in reducing poverty and achieving the Millennium Development Goals (MDGs) in African countries22. Most of the SMEs face several difficulties regarding workplace HIV management, such as lack of funds and dedicated human resources. Moreover, the struggle to stay in business affects SMEs more than their larger counterparts and can make HIV-related services for employees a low priority23.

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With a focus on small and medium sized businesses, the AIDS Prevention and Health Promotion Workplace Programmes in Southern Africa ( AWiSA) started out as a cooperation between the former DED and InWEnt (now GIZ). The aim of the programme is to reduce the socio-economic impact of the HIV epidemic in the most affected areas in the SADC region. AWiSA provides HIV training in order to mitigate the negative impacts of the epidemic. Through their activities AWiSA creates awareness for the problem of HIV in workplaces. Furthermore the programme supports the implementation of workplace programmes and policies in small and medium enterprises.

AWiSA is a regional project with advisors currently working in Malawi, Mozambique, South Africa and Zambia. To further promote regional exchange of information and experience, an internet-based platform functioning as a Community of Practice in sub-Saharan Africa has been established called AWiSA-network24.

**AIDS Prevention and Health Promotion Workplace Programmes in Southern Africa (AWiSA)**

- Sensitise managers and stakeholders to the implementation of HIV workplace programmes and policies
- Train facilitators to carry out workshops and seminars
- Train focal persons in carrying out workplace programmes in their organisations
- Support the implementation of the initialised workplace programmes
- Apply monitoring and evaluation instruments.

**From HIV to Comprehensive Employee Wellbeing**

Experience has shown that a workforce may lose interest in a programme solely focussing on HIV. The repetition of messages leads to fatigue, especially given that a vast majority of formal sector employees are HIV negative. In order to react to changing workforce trends and also to tackle other diseases influencing the wellbeing of employees, partnership companies of GDC such as Ohlthaver & List in Namibia, or multinationals such as Daimler, VW and Unilever started to broaden the content of their messages, moving away from solely addressing HIV, tuberculosis and sexually transmitted diseases. The most advanced companies now provide information and services on wellbeing in general, including such elements as nutrition, alcohol and drug abuse, exercise, financial wellness and benefit schemes.

**Benefit schemes**

Low income countries such as most sub-Saharan countries face an acute shortage of funds to cope with the multiple burden of HIV, other communicable diseases (e.g. Malaria), maternal and child health issues, and the rise of non-communicable diseases (e.g. diabetes and hypertension). This is combined with heavy reliance on direct, out-of-pocket payments (e.g. user fees) to raise domestic funds for health. In many cases, these direct payments prevent access to treatment services or impose severe financial stress on households. Out-of-pocket payments lead to inefficiency and inequity in health care provision - people who can pay are being served, while people who cannot pay are being under-served25. Through PPPs companies are encouraged to contribute to sustainable health financing. In some PPP projects (e.g. Kenya, Tanzania and Ghana) companies enabled the enrolment of HIV infected people in national care and treatment programmes, or financed the payment of insurance premiums for employees in national and private health insurance schemes.

**Financial wellness**

Fighting excessive indebtedness and introducing comprehensive debt counselling are the main focus areas of financial wellness components of workplace programmes (e.g. projects in South Africa, Kenya and Ghana). A survey has shown that excessive indebtedness is a major challenge for sustained wellbeing of South African families26. Families supplement their income by loans to meet the daily survival needs resulting in a viscous cycle of debt, as they are not able to repay the loans. Excessive debts have a detrimental effect on the mental wellbeing of individuals leading to diseases like depression or substance abuse. The

24 www.awisa-network.net
risk of over-indebtedness and inadequate retirement or pension fund building is higher among employees facing increasing health expenditures due to HIV.

**Employee wellbeing programme (EWP)**

Taking into consideration the experiences of recent years, the employee wellbeing programme (EWP) was developed to cover all workplace programme components and features described above. The EWP approach tackles the employee’s entire wellbeing. It aims at improving health, social protection and financial wellness of the employees and their core families. The EWP consists of the following key features as presented in Figure 2: a health component with preventive, curative and psycho/social support; a financial wellness component with financial education and counselling measures; and a social protection component targeting general welfare, health, life and accident insurances and retirement schemes. The EWP approach was developed by GIZ in cooperation with companies and organisations in Ghana and is currently implemented in various African countries such as Ghana, Kenya and Namibia.

**Using Established Structures - Integrated Health Management**

Occupational safety and health (OSH) interventions advise the employer, as well as workers and their representatives, on the requirements for establishing and maintaining a safe and healthy working environment. They are preventive in nature but also regulate situations when occupa-

tional disease or injury has occurred. OSH is increasingly being viewed as a key component of primary health care since a great share of diseases and injuries addressed by the health care system originate from the workplace. Especially in societies which are in the process of becoming industrialized, the safeguarding of workers’ health is a growing concern. The ILO has promoted OSH with various conventions since the 1960s.
The parallel funding of HIV prevention and mitigation has created parallel structures in the workplace. Existing structures governing OSH were side-lined in the development of HIV policies and instruments. Integrated health management is now correcting this error by linking all health issues in the workplace and by integrating HIV and TB management into the wider and already established context of OSH. This view is shared by various multinational companies such as Volkswagen, Unilever and Daimler.

Classic OSH structures which are mandatory for companies of a certain size in many countries provide a variety of options for integrating HIV and TB management. The policy and management structures like the OSH representative and the committee of workers and management can be expanded to cover HIV issues. The traditional risk assessment done in OSH can be used to detect risks of HIV transmission inherent in a companies’ production or operation processes. A growing concern is how chronically sick workers, including people living with HIV on anti-retroviral treatment, can cope with health hazards like dust or stress, etc. Regular health check-ups are an opportunity to promote HIV counselling and testing and to screen for TB risk factors or symptoms. Opt-in HIV testing means that a worker has to actively demand a test; opt-out HIV testing refers to active rejection of a routine HIV test. Education and training can easily be expanded to cover various health issues. The inclusion of equipment and information on HIV transmission via blood is generally a requirement of an HIV workplace programme. Figure 3 shows the options at a glance:

Figure 3: Options for integrating HIV and TB management into existing OSH structures

The SPAA programme developed industry-specific approaches to integrate employee health as part of overall quality improvement. In transport, this approach takes into account the risks long distance truck drivers face in terms of accidents, chronic disease and transmission of HIV and other infections. In the hotel industry, integrated health management covers the occupational safety hazards of various workplaces, risks for chronic disease development and also infectious disease transmission. Special attention is given to sexual harassment as one specific factor, which puts female employees in hotels particularly at risk.

Section 3: Working with Companies - Results of a Decade of HIV Workplace Programmes

Measuring Progress and Impact

Measuring impact or performance is part and parcel of any programme and project in development cooperation. Progress monitoring is also a concept familiar to the private sector. Usually managers, in particular in the business sector, calculate return on investment, year-on-year growth and product sales to make informed decisions; however, a survey conducted in 2006 indicates that only approximately 30% of business organisations implemented recognized measures for monitoring and evaluation (M&E) of their workplace programmes. In another survey from 2010 on donor agencies’ responses to HIV at their workplaces, it was stated that the agencies were generally positive about the impact of their workplace programmes on risky behaviour. They believed that the benefits outweighed the costs. But only a few development organisations such as GIZ were identified as organisations having a systematic monitoring and evaluation approach in place to measure the impact of their workplace programme.

Monitoring and evaluation are essential parts of workplace programmes, particularly in the provision of qualified feedback about effectiveness. Within the M&E framework the workplace programme managers responsible are tasked with regularly assessing progress on set project outputs and goals and objectives. They also periodically check the quality of interventions to ensure that best practice standards are maintained.

ACCA and SPAA developed guidelines and tools for results-based monitoring of HIV workplace programmes, which allow monitoring of achievements in the areas of risk assessment, behaviour change and health status. This was also included in an interactive course called “Monitoring & Evaluation of HIV/AIDS Workplace Programs” designed in partnership with the Global Business Coalition (2006). In 2008 this tool was amended to monitor workplace activities to prevent malaria and TB transmission. Additionally, various GDC programmes developed specific M&E tools, including the “Health Economic Model for Employee Wellbeing Programmes (2011)” developed on behalf of the GIZ Wellbeing Programme in Ghana, the Cost-Benefit-Analysis (CBA) developed by ACCA in 2004 and the AWiSA Toolbox for small and medium enterprises.

Definition of Monitoring and Evaluation (M&E)

Monitoring:
What are we doing and what is the progress towards achieving goals and objectives?

Evaluation:
What have we achieved? What impact have we had?

M&E helps programme implementers to:
- Determine the extent to which the programme/project is on track
- Make needed corrections
- Make informed decisions regarding operations management and service delivery
- Ensure the most effective and efficient use of resources
- Evaluate the extent to which the programme/project is having the desired impact.

28 GBC 2006: The State of Business and HIV/AIDS, a baseline report
29 The International NGO Training and Research Centre (INTRAC) 2010: Responding to HIV and AIDS in the Workplace. Policy Brief for International Agencies, July 2010
30 GTZ 2004: Results-based Monitoring: Guidelines for Technical Cooperation Projects and Programmes
32 The AWiSA toolbox is being constantly updated and adapted to specific target groups.
In an effort to gain a better understanding on the impact achieved by the various PPPs, the following chapter first briefly outlines the profile of all PPPs supported by GDC on health at the workplace. It then looks more closely at key indicators and results reported by those PPPs that were finalized until mid-2011.

**Portfolio of Workplace Programmes Supported by GDC**

Since 2002, GIZ and DEG have conducted 49 programmes and projects targeting workplace health on behalf of the BMZ. Forty-six of those were direct public private partnerships with companies and three were regional programmes. The PPPs were implemented in 15 countries most of which located in sub-Saharan Africa. Of the 46 PPPs, 30 were completed, 14 of them are still in implementation and two were terminated ahead of time. The two premature terminations of partnerships were, in both cases, due to financial difficulties on the part of the private sector partner. In the case of the Kenyan company, the financial pressure led to retrenchments and the eventual decision not to invest further in the PPP. In the case of the Chinese partnership, the company went bankrupt and could therefore not fulfil the financial obligations of the PPP agreement. The information on impact of HIV workplace programmes documented in this report is based on the final evaluation reports of 30 completed projects.

The following graphs compare the thematic and geographic focal areas of the various implementing organisations of GDC. Most of the PPPs were implemented in sub-Saharan African countries since HIV prevalence is highest in these countries. Furthermore, Sub-Saharan Africa is a focal region for German development cooperation.

### Table 1: Participation in the labor force for male and female adults and youths

<table>
<thead>
<tr>
<th>PPPs managed by</th>
<th>Now GIZ</th>
<th>DEG</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GTZ</td>
<td>DED</td>
<td>DED / InWEnt</td>
<td></td>
</tr>
<tr>
<td>Projects completed</td>
<td>24</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Projects terminated ahead of time</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Projects in implementation</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Projects/programmes*</td>
<td>35</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

* Status GIZ, DEG September 2011

As described in section two, HIV is a core element of all initiatives and integrated into further reaching concepts such as health management and employee wellbeing programmes. To date, other topics such as general health promotion, occupational safety and health, social protection and financial wellness make up 10% to 20% of all PPPs.
Data shows further that GDC supported projects in a large variety of WPP settings, for example, among small grower businesses and in various industries. The workplace programme approach was adapted to various settings such as multi-national enterprises or small and medium-sized companies, urban transport companies and manufacturing industry or agricultural holdings. Almost half of the PPPs expanded beyond the scope of the partnering company to include communities or smaller businesses that make up a larger company’s supply chain.

Graph 1: Regions covered by PPP projects focussing on workplace programmes*

Graph 2: Distribution of small, medium-sized and large companies in PPPs*

Companies representing various industries were partners of the PPPs. Agricultural companies employing permanent and casual as well as skilled and unskilled workers made up the greatest share with about one third, reflecting the importance of agriculture for most developing countries, on the one hand, and the impact of this industry on employees’ health, on the other. Service providers made up the second largest group, followed by the manufacturing industry, transport and food and beverage companies. Tourism held a smaller share of the overall industrial distribution. Around 17% of the projects covered more than one industry.

* These ratios are approximate values since some PPPs operated in overlapping regions

33 The definition of small, medium and large companies is very different in each country according to national economic capacity. Therefore no attention could paid to differences in outcome due to lack of comparability.
Nearly half of the participating companies invested in communities in the form of outreach initiatives; 33% supported their contractor companies and enabled them to mitigate the impact of HIV through their corporate social investment and responsibility programmes.

The data presented in Table 2 (page 20) highlight how many people were reached through workplace programmes. The efficacy of workplace programmes becomes even clearer when the high number of beneficiaries is viewed relative to the low public expenditures invested in workplace programmes. This result speaks in favour of the public private partnership concept and further supports the relevance of the strategy to involve the private sector in the fight against HIV as mentioned in section one.
Key Indicators of HIV Workplace Programmes

Clear and measurable indicators are at the heart of a workplace programme’s monitoring and evaluation system. A programme is deemed effective if the indicators show that targets are being achieved; it is efficient if the proposed results are being achieved with the smallest amount of resources.

As mentioned previously, ACCA and SPAA developed guidelines and tools for result-based monitoring of HIV workplace programmes that allow monitoring of achievements in the areas of employee health (corporate health management), risk reduction (risk management), behaviour change (stigma management) and health improvement (health status management) referring to HIV. Other monitoring indicators that can assist businesses in assessing the impact of HIV on productivity and profitability include ‘worker absenteeism’, ‘employee turnover’ and ‘medical costs’. These indicators were also introduced to companies. Experiences with most companies indicated that it was difficult to get reliable data for these indicators; the companies simply do not collect this information.

The proposed impact indicators of ACCA and SPAA are standardized indicators developed by UNGASS[^34] in order to closely monitor the development of the epidemic. The indicators were then adapted to the specific context at workplace programme level.

The following key impact indicators were proposed and implemented in most of the GDC workplace programmes:

**Corporate health management**
- *Number of companies with HIV workplace policies*
  This indicator was developed by UNGASS to measure the national commitments and concerted actions of a country. In the context of workplace programme activities it is an indicator to measure commitment of a company’s management and its systematic approach to implementation.

**Risk management**
- *Number of counselled and tested persons*
  This indicator is related to individual risk assessment and behaviour change. Being counselled and tested is very important for individuals because they get to know their HIV status, can reflect on their behavioural risks and will hopefully be empowered to manage their status. Thus, they will be able to protect themselves and avoid infecting others. Knowledge of one’s HIV status is also a critical factor in the decision to seek treatment. Data from survey respondents must remain confidential.

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[^34]: In 2001, 189 countries adopted a Declaration of Commitment about HIV/AIDS, agreed upon during the 26th Special Session of the General Assembly of the United Nations (UNGASS). This declaration reflects the global consensus regarding the slowing down of the AIDS epidemic by 2015. In an effort to monitor the progress of the Declaration, UNAIDS proposed a group of indicators for countries to enable them to analyse the effectiveness of their HIV and AIDS strategies.
HIV-related knowledge and stigma management

- **Occurrence of misbeliefs, stigma and level of knowledge with regard to HIV and AIDS**
  Dispelling misconceptions around possible modes of HIV transmission is as important as providing correct information about actual modes of HIV transmission. The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. The belief that HIV can be transmitted through sharing food only reinforces the stigma faced by people living with HIV. In the context of a workplace programme, this indicator is particularly useful for measuring knowledge. Knowledge is seen as one factor influencing behaviour change. In addition, investigating knowledge levels helps to define the content of health education.

Health status management

- **Incidence of sexually transmitted infections (STI) and/or tuberculosis infections**
  This indicator specifies the rate of new infections (incidence) of STIs and/or TB and, therefore, measures changes in the health status of the target group.

There is a strong link between STIs and HIV. The presence of an untreated STI – such as herpes or gonorrhoea – increases the risk of HIV transmission. Unprotected sexual practices that expose a partner to the risk of STI transmission also put that partner at risk of contracting HIV.

Tuberculosis is a leading cause of morbidity and mortality in people living with HIV, including those on ART. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international and national guidelines is essential for improving the quality and longevity of people living with HIV. Ideally, the indicator also measures what percentage of HIV-positive TB cases access appropriate treatment.

- **Number of employees with medical aid cover**
  This indicator is useful in assessing the extent of equal access of employees and their core families to health services. It is based on the assumption that the necessity of direct out-of-pocket payment of health system user fees can constitute a barrier to equal access for poor and vulnerable groups and can impose severe financial stress on people seeking treatment. Employees with medical aid cover generally have better access to health system support, which, again, is assumed to have a positive impact on health status.

The primary measurement tools and data sources of recommended impact indicators are described in Table 3.

Table 3: Overview of data sources for monitoring and evaluation of workplace programmes

<table>
<thead>
<tr>
<th>M &amp; E Tools and Instruments at the Workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Behavioural surveys on knowledge, attitude, practices and behaviour (KAPB);</td>
</tr>
<tr>
<td>- Confidential client and patient tracking systems to obtain information on HCT uptake and numbers of TB and STD cases;</td>
</tr>
<tr>
<td>- Programme monitoring reports to obtain information on the policy status;</td>
</tr>
<tr>
<td>- Tailored surveys that identify the medical aid coverage of employees and their families.</td>
</tr>
</tbody>
</table>
Impact of GDC HIV Workplace Programmes

In the context of GDC, public private partnerships target innovative approaches and, therefore, provide seed funding for testing of concepts and implementation of new initiatives that go beyond a company’s core business. The objective of the PPP is to provide initial support for activities of broader societal value which can then be sustained by the company alone. To understand the informative value of the data presented on the following pages and tables, it is important to remember that companies that collaborate with GDC within the PPP framework benefit from technical and financial assistance only for a short period of time, generally lasting between two and three years. On account of this, the most important impact the PPP concept can have is to establish long-term oriented workplace programmes with well-adapted and implemented policies tackling HIV. The short duration of the PPPs does not allow for the evaluation of the long-term effectiveness or efficiency of implemented workplace programme initiatives on the part of GDC – the onus lies with the company to ensure future monitoring and evaluation of WPPs.

Using the key indicators to assess short-term impacts of the 30 completed and documented projects, interesting insights and noteworthy developments were revealed. The general overview on the frequency of use of the key impact indicators (Table 3) is helpful, as it informs which activities of the companies concerning HIV were seen as most productive with regard to leveraging resources and achieving workplace programme objectives. Most companies focused on human resource management and behaviour change initiatives in the form of risk and stigma management. Monitoring of indicator performance was focused, accordingly.

Table 3: Overview on frequency of used key indicators

<table>
<thead>
<tr>
<th>No</th>
<th>Core indicators of impact</th>
<th>Indicator used by completed projects</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Misbeliefs reduced and knowledge increased</td>
<td>13</td>
<td>43%</td>
</tr>
<tr>
<td>2</td>
<td>Number of counselled and tested persons increased</td>
<td>24</td>
<td>80%</td>
</tr>
<tr>
<td>3</td>
<td>Number of workplace programmes with HIV policies increased</td>
<td>21</td>
<td>70%</td>
</tr>
<tr>
<td>4</td>
<td>Number of employees with medical aid cover increased</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>5</td>
<td>Incidence of STI infections on company level reduced</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>6</td>
<td>Incidence of TB infections on company level reduced</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>7</td>
<td>Indebtedness of employees reduced</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

Table 4 outlines how many of the 30 companies in the PPP chose to monitor a specific indicator. Most companies chose the numbers of employees counselled and tested for HIV (24 companies) and the development of a workplace policy (21 companies) as core indicators. Another well-favoured indicator was the occurrence of misbeliefs and the level of knowledge (13 companies). Only those companies running own health services for employees could report on incidence data on STIs and TB. The same holds true for the few companies providing medical aid to employees. Indebtedness as an indicator was only chosen by one partnership because activities in this area are the result of a more recent expansion of the workplace programme concept.

The indicator “Number of workplace programmes with HIV/AIDS policies increased” is often used by larger, multinational companies in order to monitor the status of a newly implemented workplace programmes or specific programme components in other branches. It indicates the commitment or performance of the company’s employee health management (corporate management). The French multinational cement producer Lafarge is a good example. The former GTZ supported Lafarge’s develop-
ment of a well-monitored workplace programme in various African countries. After the initial conceptualization of workplace activities for employees, the PPPs focused on community outreach and supply chain involvement. The Lafarge “road map” monitoring system, as well as the company’s strict reporting enforcement, can be seen as exemplary. More information is provided in the case study below.

CASE STUDY: Africa-Wide Health Management of the Lafarge Group

LAFARGE: Development of comprehensive workplace programme policies and road maps as M&E instruments

Lafarge is one of the world’s leading producers of cement, aggregates, concrete, and gypsum. In 2011, the Group employed 90,000 people in 76 countries. Lafarge made the commitment to fighting HIV in Sub-Saharan Africa in 2001. According to their approach, which treats HIV as a management issue, Lafarge involved local managers, employees and local service organizations. Lafarge started partnerships with the Global Business Coalition on Health and former GTZ in order to develop comprehensive workplace programme policies. Mbeya Cement in Tanzania was among the first Lafarge companies to start a workplace programme in 2002 supported by ACCA on behalf of the BMZ (2002 – 2007).

Design and Implementation
In 2003, Lafarge published its HIV guidelines for management teams and employees to support the implementation of non-discrimination and confidentiality policies. The policies were adapted to the national context of each company. Furthermore, Lafarge created a road map based on local practices and experiences. The road map monitors and evaluates all of Lafarge group members’ HIV programmes.

Components of Lafarge’s HIV programme:
- Education: educational literature and peer educators who build awareness and encourage their colleagues to act responsibly
- Prevention: distribution of free condoms
- Free, anonymous, HIV counselling and testing
- Care and treatment: free anti-retroviral (ARV) medication and opportunistic disease treatment

Reported outcome
As a result of these measures, in 2007:
- 100% of employees in sub-Saharan Africa received regular information about HIV
- 75% participated in HCT campaigns,
- Over 2000 people (employees, dependants and community members) benefited from ARV treatment.

Way forward
The success of Lafarge’s HIV programme is largely due to partnerships with various stakeholders such as employees, families, trade unions, governmental and non-governmental organisations and international and bilateral organisations. The Group has partnered with
- GIZ in Kenya (Bamburi Cement), Malawi (Portland Cement) and Nigeria (Ashaka Cement)
- The Global Fund to Fight AIDS, TB and Malaria in Cameroon, Uganda and Malawi
- USAID in Uganda and Nigeria
Table 4 indicates the reported improvements for each indicator. Of the 21 companies that chose the development of a workplace policy as an indicator, 20 (95%) designed a workplace programme policy during the PPP and implemented it upon termination of the PPP project contract.

<table>
<thead>
<tr>
<th>No</th>
<th>Core indicators of impact (n= number of projects with this indicator)</th>
<th>Improvement reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Misbeliefs reduced and knowledge increased (n=13)</td>
<td>10 (77%)</td>
</tr>
<tr>
<td>2</td>
<td>Number of counselled and tested persons increased (n=24)</td>
<td>19 (79%)</td>
</tr>
<tr>
<td>3</td>
<td>WPPs with HIV policies increased (n=21)</td>
<td>20 (95%)</td>
</tr>
<tr>
<td>4</td>
<td>Number of employees with medical aid cover increased (n=3)</td>
<td>2 (67%)</td>
</tr>
<tr>
<td>5</td>
<td>Incidence of STI infections on company level reduced (n=2)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>6</td>
<td>Incidence of TB infections on company level reduced (n=1)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>7</td>
<td>Indebtedness of employees reduced (n=1)</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>

The indicator ‘Number of counselled and tested persons increased,’ which refers to the performance of a company’s risk management, was used by 24 of 30 companies. Almost 80% of the 24 workplace programmes measured the impact of their risk management initiative within a period of three years and could claim an increased uptake of HCT as a result of their activities. Examples are:

- Ohthaver & List from Namibia reported an HCT uptake which increased from 51% to 80% in the supply chain component of their workplace programme (50,000 beneficiaries);
- The Walvis Bay Corridor Group from Namibia reported a corresponding increase in HCT uptake from an average of 50% to about 80% among the transport companies belonging to the group. Companies with longer, more established HCT activities scored better than companies with newly established HCT services (86% vs. 77%);
- Ashoka Cement from Nigeria reported that communities covered by their community outreach programme also made better use of the HCT services. The ratio of users increased from 65% to 81% (10,000 beneficiaries);
- Tobacco farmers from Zimbabwe could motivate 65% of community members to take an HIV test with the help of mobile HCTs (10,000 beneficiaries). Before, it had been 45%;
- In 2007, three quarters of the Lafarge workforce in Africa participated in HCT campaigns;
- Wakulima Tea Company from Tanzania reported an increase of HCT uptake to 50% as a result of their community outreach programme (80,000 beneficiaries) in the years 2004-2005. The uptake rate increased from 17% in 2003-2004.

The case study of Zambian Breweries Group on risk management provides an overview on the benefits of voluntary counselling and testing initiatives at the workplace.
CASE STUDY: Risk management at Zambian Breweries Group

Zambian Breweries Group: HCT at the centre of a workplace HIV programme

The Zambian Breweries Group has three production plants. The core business is the manufacture of beer and carbonated soft drinks. In 2006, the company had a workforce of 790 permanent and seasonal employees. The majority of the workers are male. The Zambian Breweries Group started its first HIV workplace programme at the beginning of 2000, when the company recognized that certain factors inherent in the operations made the company vulnerable to the impact of the epidemic.

Design and Implementation
Zambian Breweries commissioned a needs assessment which resulted in the formulation of a HIV workplace policy and programme with the following components:
- HIV prevention with peer education, sensitization sessions and condom distribution
- Risk management with HCT promotion and the setup of an HCT centre
- Health management with provision of curative services and free medication such as ARVs

An HCT centre was opened in 2004 and accompanied by HCT campaigns (“know your status”). The managers were the first to be tested at the launch of the HCT centre. Peer educators were encouraged to be tested so that they could promote the service. Confidentiality was emphasised from the very beginning.

Reported outcome
After two years, 80% of employees knew their status. The peer educators identified the following benefits of the HCT initiative:
- Knowledge of one’s status frees the mind and removes fear and apprehension;
- HCT is an entry point to access treatment, care and support;
- HCT helps those who are HIV negative to stay that way, and those who are HIV positive to seek care and support to protect others;
- HCT enhances HIV awareness and reduces stigma and discrimination;
- HCT facilitates referrals to service providers;

Lessons learned
Discrimination and stigma by employees and colleagues were recognised as tough challenges, as well as self-denial amongst infected employees. It is of utmost importance that HCT services and campaigns around knowing one’s status reduce HIV-related fear, stigma and discrimination. Further, it is important that the management is involved, but also the family and the community in order to increase acceptance of HCT and eliminate prejudice, stigma and discrimination.

Thirteen of 30 companies (40%) conducted special surveys in order to get information on the outcome of their preventive initiatives. These surveys also serve the purpose of informing HIV programme managers about education needs and the remaining level of stigma in the company. Common KAPB survey questions are related to knowledge (e.g. transmission of HIV or misconceptions concerning HIV), attitude (e.g. questions concerning stigma), practice (e.g. usage of condoms) and behaviour (e.g. questions relat-
ed to testing) and are usually adapted to the specific situation in the country and within the company. Ten of the 13 PPP projects (77%) that monitored misbelief and knowledge levels evaluated the impact of their measures within the PPP period of three years and indicated an increase in knowledge and a decrease in misbeliefs or stigma.37

- The Unilever PPP project from Kenya reported that 80% of their tea farmers (120,000 including family and community members) gained knowledge on HIV and AIDS. Stigmatizing attitudes were reduced from 12% to 7%.
- The Heineken PPP project from Congo reported a general reduction of misbeliefs and specified an increase of knowledge around HIV and AIDS of 60%.
- The PPP community outreach project in Madagascar reported that among the 7,000 visitors living in the neighbourhood of a night club, 22% increased their knowledge on HIV and AIDS.
- In Namibia the Ohlthaver & List Group (50,000 beneficiaries) reported that stigma was reduced. 92% of the workforce expressed that they had no objections to working with an HIV infected person in comparison to 79% three years prior.
- Also, Daimler in South Africa (60,000 beneficiaries) and James Finley Tea Estates in Uganda (8,000 beneficiaries) reported increased knowledge levels and reduced stigmatisation within their target groups.

GIZ itself has workplace programmes in each of its country offices. Stigma management is exemplarily described in a case study from GIZ in Kenya.

**CASE STUDY: Stigma Management at GIZ Kenya**

**GIZ Workplace Programme Kenya: ‘If I Were Positive’ Campaign against Stigma and Discrimination**38

All around the world, people living with HIV are affected by stigma and discrimination. AIDES, a French non-governmental organization, and the International AIDS Society (IAS) joined forces to denounce stigma and discrimination through the awareness campaign ‘If I were HIV-positive’. This campaign began in France in 2007, where it had a great impact. In December 2009, GIZ obtained permission from AIDES to create its own campaign. GIZ Kenya used this opportunity and started its own campaign as part of their workplace programme stigma management.

**Design and Implementation**

Employees of all GIZ projects and programmes, irrespective of their positions in the organisation, were eager to volunteer and take part in the campaign. The GIZ country director and other members of the management team participated, along with other staff members. This campaign took place in June 2010 and was repeated in February 2011.

**Reported outcome**

KAPB Survey results of 2011 report that the majority of employees are less afraid of HIV-related stigma and discrimination at their workplace than they were in 2007. 76% of the employees were not worried about being dismissed in 2011, in comparison to 12% in 2007. Furthermore, they believed that sensitive data like HIV test results are kept confidential (2011 96% in comparison to 83% in 2007). These results validate that stigma management activities (which included the campaign “If I were HIV positive”, peer educator sessions, health talks, brochures and posters) can have a positive impact on decreasing stigma and discrimination at GDC workplaces.

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37 It is difficult to attribute knowledge increase to workplace programmes alone other sources such as TV, radio, internet, newspaper etc also provide information.
38 GDC Kenya: Result-based evaluation study of the Kenyan GDC health-promotion and HIV and AIDS WPP. 2011
Achievements and Challenges of HIV-Centered PPPs

One major advantage of PPPs with companies is the direct access it affords to employees and their families. With an investment of 5.5 Euros per person, German Development Cooperation reached 1.9 million people, mainly in the African regions. There was an almost fifty-fifty division of support between large enterprises and small and medium-sized companies combined. This is especially noteworthy given the fact that it is much more difficult to meet the specific needs of SMEs than those of large enterprises. Considerable improvement of monitored core indicators was reported. Of those programmes measuring the policy indicator, 95% reported progress; of those measuring the number of persons who were HIV-tested, 79% reported an increased uptake; and of those following up on knowledge level and misbeliefs, 77% reported decreases in misbeliefs and increases in knowledge.

The majority of PPPs included outreach activities to communities and suppliers of companies; however, the PPP framework is still being used as a basis to develop the concept further, to experiment with new ideas and approaches and to develop blueprints of activities that can be adapted to other contexts.

A major short-coming of PPPs is their short duration, usually lasting between two to three years. This short project cycle creates a challenge with regard to long-term monitoring. While the PPP framework encourages the collection of baseline data, it runs the risk that project managers will lose access to the respective company target groups after the PPP has ended. It is then up to the company to continue with the monitoring practices established by the PPP. Thus, the data presented here only provides the short-term results of GDC-funded PPPs.

It is expected that the companies will continue evaluating their workplace activities even after termination of the PPP contract. Further, information on the impact of implemented initiatives is sometimes provided by national business coalitions. In South Africa, for example, the South African Business Coalition on HIV and AIDS (SABCOA) created a website in cooperation with the national health information system initiative on where companies can publish their HIV testing results39.

The homepages of companies are another source of impact data on workplace programmes. Many multinational enterprises (e.g. Volkswagen, Daimler, Heineken and Unilever) and national companies (e.g. Olthaver & List from Namibia) publish the results of their workplace programmes on the internet.

Nonetheless, a kind of “Alumni” PPP network would be favourable to long-term impact monitoring. This would allow for the possibility of a follow-up assessment even after a PPP has ended. In addition, GDC partnerships in HIV control and health with companies would benefit from a harmonized monitoring framework with comparable indicators and monitoring procedures in every PPP. The limited number of indicators could still reflect a variety of programme components reflecting the requirements of various companies. Such a framework, however, will certainly require negotiated agreements with companies so as to sufficiently meet their needs and expectations.
Section 4: Working with Business Associations – Achievements of National and Regional Workplace Health Promotion

Business Coalitions: Advocates and Service Providers

Business coalitions on HIV emerged about a decade ago as a joint initiative of the World Bank, the Global Health Initiative of the World Economic Forum and UNAIDS, alongside local private sector champions. The coalitions were seen as an ideal platform to coordinate and facilitate the private sector response to the epidemic. Within a decade, four regional and more than 50 national business coalitions were formed mainly in Sub-Sahara Africa, Southeast Asia and the Caribbean.

Between 2002 and 2007 the regional GIZ project ACCA supported national business coalitions in six African countries in order to strengthen their organizational structures and corresponding networks. ACCA also trained business coalitions in order to build their capacity to respond adequately to the demands and needs of their member companies. This included getting involved in the national HIV response and participating in national structures with access to global financing mechanisms, such as the Global Fund against AIDS, Tuberculosis and Malaria.

Business coalitions offer tools and support processes that help companies to effectively address HIV at the workplace. Although some companies – in particular multinational enterprises – were already effectively addressing HIV at the workplace, other companies were not aware of the impact of HIV or did not know how to respond to HIV. The business coalition model sought to support those companies and to sensitize the business community in general. The new concept was supported by various national employer and employee associations and in some countries the government has been one of the key drivers in the establishment of a national business coalition. The coalitions were expected to represent the private sector and to lobby for business interests and needs in relevant national committees and institutions.

When the coalitions were first established, nearly all of them had an HIV-only focus. In reaction to the diversified needs of many companies in terms of workforce health, most coalitions have since expanded to include services addressing the impact of malaria and TB and promoting the general wellbeing of employees. All partner organizations of ACCA offered the following types of services to their member companies:

- **Sensitization workshops for employees**
  In these usually in-house workshops, the employees are informed about the main knowledge areas related to HIV. Often the families were also invited to sensitization meetings. Business coalitions serve as resources and organizers of such sensitization meetings. Often, representatives of the local health system are also invited to create a continuous partnership between company and health care providers.

- **Management advisory forums and round table discussions**
  Peer learning is a very powerful tool for helping to convince top managers of the benefits of investing in HIV workplace programmes and other health activities. During round table discussion, managers’ share examples of well-established programmes, knowledge on HIV is imparted and experiences are exchanged.

- **Coordinator and peer education trainings**
  Most HIV workplace programmes are established with a coordinator and a group of peer educators who teach HIV basics to their co-workers. Coordinators and peer educators attend trainings in which general programme management issues or – in the case of peer educators – a curriculum of regular information sessions for colleagues are discussed and practiced.

- **Development and distribution of informational material**
  The workplace is a very specific environment for health education. The educational materials must suit this environment and should not interfere with company operations. Peer education at the workplace, in particular, requires well-prepared education materials like the “10-minute talks.” This set of 34 posters was first adapted from the South African context to the East African context of Tanzania and then transferred and adapted.
to other countries like Malawi or Nigeria. Each poster describes visually a piece of knowledge on HIV. On the back of the poster, the peer educator is guided through questions to ask, information to give and correct answers to common misbeliefs.

- **Condom distribution**
  Many business coalitions facilitate the distribution of government or donor-funded condoms to companies.

- **Operational surveys such as KAPB**
  Business coalitions support their members in establishing a sound monitoring system for their activities. This includes a situational analysis during the set-up phase and common monitoring and evaluation tools such as KAPB surveys.

The national business coalitions were a new structure in traditional national systems of employer and employee federations, councils, associations and chambers. They tend to survive to a lesser extent on private sector funding or to a larger extent on donor agency resources. It is a challenge for most of the coalitions to secure funding for their organizational structures and planned activities, in particular for those targeting small and medium sized enterprises and the informal sector. Some coalitions have developed into business development service providers, offering their professional support against consultancy fees. During the last three years, a consolidation process took place during which some coalitions disappeared. In most cases, their tasks were taken over by other national, well-established employer organizations.

The value attributed to national business coalitions to the fight against HIV is reflected by the number of supported companies seen in Table 5. Global data indicates that business coalitions, national employer organizations under the umbrella of ILO and specialist non-governmental organizations like the Global Business Coalition (GBC) supported over a million companies in implementing local HIV workplace programmes.

Most of the business coalitions supported by the ACCA programme in six countries doubled the number of people benefitting from their services between 2004 and 2007. Data of 2010 published by the GBC shows a continuity of this trend in Kenya and Mozambique, while in Namibia, Nigeria and Zambia the membership development was stagnating.

### Table 5: Operating range of GIZ partner business coalitions

<table>
<thead>
<tr>
<th>No</th>
<th>Country &amp; business coalition</th>
<th>Number of supported companies (members of the business coalition)</th>
<th>Beneficiaries (staff + family members)</th>
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<tbody>
<tr>
<td>1</td>
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<td>39</td>
<td>61</td>
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<td>Mozambique: Commercial and Industrial Organisation of Sofala (ACIS)</td>
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<td>85</td>
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<td>3</td>
<td>Namibia: Namibia Business Coalition on AIDS (NABCOA)</td>
<td>44</td>
<td>80</td>
</tr>
<tr>
<td>4</td>
<td>Nigeria: Nigerian Business Coalition Against AIDS (NIBUCCA)</td>
<td>18</td>
<td>39</td>
</tr>
<tr>
<td>5</td>
<td>Tanzania: AIDS Business Coalition Tanzania (ABCT)</td>
<td>24</td>
<td>67</td>
</tr>
<tr>
<td>6</td>
<td>Zambia: Zambian Business Coalition on HIV/AIDS (ZBCA)</td>
<td>54</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>219</td>
<td>404</td>
</tr>
</tbody>
</table>

* Data published by the Global Business Coalition on Health (www.gbcimpact.org)

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The number of beneficiaries derived from the number of member companies provides an incomplete picture of the overall range of influence of national business coalitions. All business coalitions supported by ACCA also offered their services to other donor-financed workplace programmes targeting small and medium-sized enterprises or the informal sector. The Kenya HIV and AIDS Business Council, for example, reported in 2010 in their newsletter\(^{42}\) that apart from their member companies, KHBC is supporting another 200 companies within projects funded by other international organizations.

**The PABC: Coordinating Business Coalitions Continentially**

Companies operating in Africa face workforce health challenges that are far more complex than those in other parts of the world. The double burden of communicable and non-communicable diseases impedes the competitiveness of companies in Africa and other developing countries. Given this situation, regional institutions are required to take charge of the private sector’s needs and interests in terms of workforce health.

From 2008 to 2011, the regional GIZ project SPAA strengthened the African private sector’s contribution to national HIV prevention and health promotion through regional organisations. SPAA supported the Pan-African Business Coalition on HIV and AIDS (PABC) consisting to date of 28 national business coalitions. The programme helped PABC to get registered as a not-for-profit organization in South Africa and to establish a secretariat.

With technical support of GIZ, PABC set up services for the national business coalitions which included training, regular newsletters, information on gender programming and manuals on health issues such as non-communicable diseases. Regular membership surveys with participation rates of around 60–70% documented the development of national business coalitions since 2008. Within the period of support to PABC, the national business coalitions underwent a remarkable change in focus. While in 2008 health issues such as TB, malaria or non-communicable diseases were side issues, in 2011 services for TB and malaria were provided by 80% of those coalitions participating in the survey. Wellness and NCD-related services, which were provided by less than 10% of coalitions in 2008, were almost quadrupled by the end of 2011.

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**Graph 5: Development of health issues covered by PABC member coalitions**

- HIV services
- TB Services
- Malaria services
- Wellness and NCD-related services
- Other Services

Through PABC, the national coalitions were represented in international meetings and gained access to trainings of the Global Fund, the GBC and other partners. An important objective of SPAA was to support national business coalitions in getting a seat in their respective national Country Coordinating Mechanism (CCM) of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Participation in this important national committee would ensure that business coalitions could contribute to national funding proposals in the interest of the private sector. Of the PABC members participating in the various membership surveys over the years, a fairly stable ratio of around 80% were representing business in the CCM either as a full member or – like some – as a rotating member sharing this responsibility with another private sector institution. About a third of the coalitions received funds as sub-recipients throughout the four years; this share increased to over 40% in 2010.

Graph 6: Membership of PABC member coalitions in country coordinating mechanisms of GFATM

From a sociological perspective, companies operate at a micro level in society while business coalitions are active at a meso level. Working with national business coalitions meant working with a support structure detached from the company employee as the target of a development programme. Working with PABC in order to support NBCs further reinforced this detachment from companies and their employees.

Much like business coalitions, PABC is an organization that has been set up as part of the overall creation of special structures for efficient HIV control. PABC served national business coalitions as an important peer-learning and exchange forum; however, the physical distance to the members prevented sufficient internal ownership. Three language groups and very different epidemiological settings, specifically regarding West Africa and East and Southern Africa, complicated technical support. PABC could not respond fast enough to the paradigm change of incorporating HIV control into an overall health perspective. Further, their membership, which was restricted to national business coalitions against HIV, left out financially, more potent partners such as other employer organizations or multinational companies. Given the great financial needs of a continentally active organization and a decreasing availability of funds for vertical HIV programming, PABC’s future today seems insecure.

Tackling Business Issues of Regional Importance: Campaigning at a Regional Level

Apart from the support to PABC as the continental umbrella body of national business coalitions, the regional programme SPAA aimed at opening up new opportunities for mobilizing private sector support. To this end, SPAA also supported

- The Southern African Development Community (SADC) Secretariat HIV/AIDS Unit based in Gaborone, Botswana, and
- The East African Business Council (EABC) in Arusha, Tanzania, an apex body for private sector with observer status of the East African Community (EAC).
Jointly with its two regional partners, SPAA identified private sector issues of regional importance and set out to enhance industries’ responses to health challenges in the regions.

The EABC was established in 1997 as an advocacy body to facilitate private sector participation in the movement towards a common market in the East African region. The EABC works closely with the EAC Secretariat, its legislative assembly, as well as with regional sector committees, economic bodies and the business community in EAC partner states at large.

As practised by other thematic groups EABC created a regional working group focusing on HIV and other health issues. In the five EAC partner states, and with Zanzibar being dealt with as an additional sixth unit, EABC started a unique process that guided the national private sector through a selection and re-selection process of their representation in national and regional health-related committees and institutions. This process was supported by all relevant private sector organizations including unions, government and international development partners such as the ILO. The selected focal point organisations from the partner states formed the new EABC Regional Working Group on HIV and Health, which was chaired by an EABC board member.

Figure 4: The East African Business Council – Linking regional and national level
The regional EABC support strengthened the legitimacy of the national focal point organizations. The Federation of Ugandan Employers (FuE), for example, was officially mandated and called upon by the government to contribute to the development of the national strategy on HIV. Other benefits are reported from Rwanda and Burundi, where national focal point organizations were mobilized by their governments to start HIV prevention and health promotion initiatives.

The activities of the East African Business Council are good-practice examples highlighting the advantages of interconnecting the national and regional levels. The Regional CEO Testing conducted in 2010 in all EAC partner states provides an impression of the potential of regional action.

**CASE STUDY:** East African Business Council - Interconnecting National and Regional Interventions

Design and implementation of the ‘CEO Testing Day’

In an effort to stimulate corporate response to the HIV pandemic, EABC, supported by SPAA, organized a regional CEO Testing Day in November 2010. The one-day event, which marked a significant milestone to increasing the private sector’s response to HIV on a region-wide basis, was simultaneously carried out in all five EAC partner states’ capital cities, as well as on Zanzibar.

Reported outcome

The event was viewed as an overwhelming success – over 350 CEOs were tested at the six different sites. The added value of this regionally coordinated private sector activity was described as follows:

- Promotion of role modelling and peer learning among the regional business community;
- Connecting a social cause of action with regional self-marketing and PR opportunities for companies;
- Leveraging of regional reputation of EABC and EAC to motivate and accelerate national action;
- Access to additional resources, as well as improved utilization of those resources;
- Effective way to increase awareness of business leaders around workplace health opportunities and challenges;
- Opportunity to collaborate more closely with the media on health topics.

Further, the regional event provided a unique platform for business leaders and government officials to discuss openly both opportunities and challenges for addressing workplace health needs on both the national and regional levels.

Although SPAA started its activities only in 2008, there is already evidence that regional exchange and discussions are an effective means of coordinating the formerly fragmented private sector and help business associations to link wellbeing issues at the workplace with occupational health and safety and the better-funded HIV and TB sectors. It can be expected that the EABC Regional Working Group on HIV and Health in cooperation with its network of focal point organizations, will be in a better position to respond to future challenges that lay ahead in the processes leading up to a common market in East Africa. Increased labour movement as one example in the region will create a host of health-related challenges requiring practical solutions, including cross-border transmission of disease or portability of health insurance schemes. A coordinated private sector can contribute to the harmonization process of existing political systems, policies, strategies and legislation with regard to the prevention, treatment and control of HIV or communicable diseases. One success was marked in 2011 when workplace issues were integrated by the EABC and its Regional Working Group into the new EAC HIV Bill, legislation that is currently being discussed in the EAC legislative assembly.
Supporting Employee Health in Industries

In response to company demands, the SPAA programme also adapted its approach to workplace health in cooperation with its partners SADC and EABC. The project’s new objective became the development of industry-specific health standards and guidelines that integrate communicable diseases like HIV and TB, as well as non-communicable chronic ailments in the prevailing structures of occupational safety and health. In a way, this was a kind of return to an earlier approach to workplace health that offered sufficient opportunities for comprehensive health promotion, but which had been side-lined by HIV-only management initiatives at the workplace in the past decade.

Legislation regulating OSH exists, to some extent, in most countries and frequently falls within the responsibility of the ministry of labour. These laws and regulations are binding to companies and ideally supervised by the ministry. HIV policies are usually developed under the responsibility of the ministry of health and a more or less independent AIDS commission rarely includes requirements obligatory to the private sector. On the other side, occupational injuries and diseases as well as chronic ailments tend to incur visible costs, while HIV as a stigmatized disease remains to a large extent hidden from the employer. The macroeconomic costs of occupational injuries and diseases are estimated to reach 4% of the global gross national product. This is more profound than the corresponding estimations for HIV and chronic disease. With the conservative estimation of 2.3 million deaths annually among the working population worldwide, occupational injuries and diseases seem to be equally important at the workplace as HIV.

There is very little data available on health in African industries, data which is required in order to calculate more accurately the costs and benefits of preventive action and, thus, provide more compelling arguments to company managers and owners. Available data from more industrialized countries are hardly applicable due to profound differences in operations, burden of disease and culture; however, many industries have national and even regionally-based associations. Clustering industries and providing them with regional representation is one of the goals of the EABC. Selected regional industry clusters also exist in Southern Africa. In Eastern Africa, SPAA and EABC collaborated with the hotel industry; in Southern Africa the partnering industry of SADC and SPAA was transport.

Both industries had started to embark on self-regulating quality initiatives aimed at improving operations and services. In East Africa, the EAC introduced a star-based accreditation system for accommodation establishments and restaurants in 2009. In this system, employee health was a small factor among bigger ones like services, room quality, cleanliness and many more. In Southern Africa, SADC set out to introduce a self-regulation scheme designed specifically for the transport industry. Drivers’ health was one of four components of this scheme, the other three being vehicle maintenance, vehicle loading and operation processes. Both self-regulation schemes promise benefits for accredited companies – better marketing in the case of the hotel industry and easier cross-border movement in the environment of transport. Combining health with other topics of industry interest increases the acceptance of investments in an economic factor that is not one of the core ones in managers’ minds, and which often requires external support due to missing internal competences.

Based on company visits in several countries and interviews with employers, workers, government authorities and other stakeholders, health standards were developed which reflected the specifics of the two sectors. In transport, detailed consideration was given to, among other topics, safe work time and driving practices, risky sexual behaviour, vaccination needs, healthy life style, and cross-border medical treatment needs. In the hotel guidelines, the decent work environment, gender-specific health needs, prevention of sexual harassment, emergency preparedness and access to health care received special attention.

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43 ILO data published on the website www.ilo.int, accessed 30/01/2012
44 In the 2009 publication “The Changing HIV Landscape”, the World Bank reviewed its earlier estimated of HIV impact on various macroeconomic factors. An annual reduction of GDP between 0.8% and 1.5% did not materialize.
Both guidelines were reviewed and agreed upon by the respective industries. Since they are meant to facilitate the self-regulating endeavours of the companies, industry associations and the general quality initiatives will play an important role in further implementation of the guidelines. The impact of the guidelines can only be evaluated along the line. Baseline data are needed to assess the status quo of employee health in the industries in order to monitor changes and improvements.

Lessons Learned from Working with Business Associations

In contrast to PPPs with companies, the impact of system-relevant support of business associations is harder to quantify. Business coalitions and employer organizations are too far removed from companies’ workforces to allow for indicators like “HIV tested employees”. From the experiences particularly of EABC it becomes clear that the greatest achievements, for example, in influencing policy frameworks, can be made if the connection between regional and national level is dynamic and mutually beneficial. In order to benefit workers, activities have to take place at country and company level.

On the other hand, working with regional and national business associations has the potential to multiply investment in capacity development. As seen from the ACCA programme, training and information materials developed for business coalitions did benefit a large number of companies. Guidelines for drivers’ health management developed and promoted by national and regional transport associations in cooperation with the SPAA programme will motivate not one but many companies in the sector by promoting industry champions and positive incentives. All programmes enhancing capacity regarding workers’ health via business institutions are recommended to have tied links to country level and to companies.

Industry approaches actually combine the benefits of direct PPPs and business association support. Industry associations and company champions have to be involved in order to mobilize the rest of the sector and even to reach out to contractor companies or small and medium-sized businesses. A real innovation is the combination of health with general quality initiatives of the industry. By using such opportunities, workforce health can be promoted as a worthwhile investment improving overall standards in production, operation and service.
From the beginning of the last decade, German Development Cooperation has been very influential regarding workplace health. The agencies of the German Government outlined and tested the components of an HIV workplace programme in many national and multinational companies. They extended services to other diseases and workplace issues such as indebtedness within the framework of the Employee Wellbeing Programme. They also created in-country structures that facilitated the implementation of HIV and other health-related workplace programmes.

From the first PPPs to the most recent ones, GDC developed concepts, approaches and tools have been well-received by other bilateral and international partners. Organizations such as the International Red Cross or the Belgium Development Cooperation turned to German agencies in order to get advice and support for their own endeavours in terms of workforce health. GIZ as one of those agencies has been called upon to participate in various international committees such as the Interagency Task Team for Workplace Programmes under the leadership of ILO or the jury for the annual award of the Global Business Coalition on Health.

The cumulative experiences and knowledge gained so far by the German Development Cooperation around private sector endeavours in workplace health make it flexible to respond to remaining and new challenges. Due to the urgency that had been attached to the HIV epidemic throughout the last three decades, many parallel structures have also been set up in private sector collaborations, which usually side-lined existing occupational safety and health structures in companies. A revitalization of interest for other workplace health problems, accompanied by decreasing financial resources for HIV-only programmes, necessitates the consolidation of approaches that will force a review of the existing structures, so as to identify which ones are the most sustainable and promise the greatest success.

Classic national control systems for occupational health could be in the position to take over the task of promoting the management of communicable and non-communicable diseases in addition to traditional safety and health; however, the capacity of these systems will have to be strengthened in collaboration with the private sector. Further, industry-specific guidelines for integrated health management based on the idea of self-regulation will complement such efforts. More industries can benefit from the experience gained in terms of integrated workplace health and safety management. This will also be an ideal opportunity for strategic alliances with private sector partners and governments. Taking into account the often more advanced level of industrialization of Asian and Latin-American countries and the on-going process of improving workplace health and safety in many industries, south-south and triangular collaboration models between countries’ governments and companies may enhance mutual learning and peer advice for African settings, in particular.

Of great importance is the improvement of the data base of health trends, especially in industries in Africa, but also in other low and middle income countries. This is needed to guide corporate, national and international investment in workplace health. It would also be very useful to collect data on prevalence and incidence of selected diseases from bigger companies per industry. With these data, extrapolations can be done to establish businesses’ health needs and...
to support cost-benefit arguments that demonstrate how workplace efforts to address healthcare needs can positively impact the profitability of a firm.

The workplace is an ideal setting for health promotion aiming at specific target groups like ageing employees or adolescents and young adults. Vocational training can be used to supplement industries' efforts to improve health among the youth. Various development programmes in education integrate health issues into teaching and learning in a vocational setting. With specific knowledge on comprehensive and integrated health management of an industry, these efforts can be scaled up. Such an approach would combine the general health risks that adolescents and young adults are facing in a society with the elevated occupational health and safety risks of young employees in specific work settings.

Reproductive health, especially maternal health, could benefit from a similar approach. Industries employing a large ratio of women can improve maternal health by making working conditions more supportive of maternity and women's roles within families. Targeted health promotion can address women's health issues and contribute to a better health education which can then benefit most family members especially children.

Health is closely connected to environment and business. Climate change is expected to pose new challenges to workplaces, especially in countries located in the southern hemisphere. Businesses themselves compromise the health of communities due to industrial pollution – at the cost of national health systems. Operation and production processes are the major focus of social and ecological standards and certificates. Health should be incorporated as a criterion in these quality control instruments.

Further attention should also be given to companies' contributions to national health systems. Diseases originating from the workplace create a burden to national systems. Basic Occupational Health Services (BOHS) as a supplement to primary health care could be co-financed by companies benefitting bigger and smaller companies in a community. Other potential areas of business support are contributions to health financing and social security. Furthermore, business can contribute significantly to an efficient and effective system for general pandemic preparedness. The examples of community outreach documents how companies provide education, prevention and treatment services beyond company premises. Such a service provision may also be integrated in national emergency planning regarding epidemics from new viruses.

A decade of collaboration with the private sector on HIV control and other health issues has been both rewarding and positive for German support to national and regional HIV responses. A lot has been done and many more challenges need to be tackled. Business partners are invited to share their innovative ideas and to benefit from decades of experience of GDC in development contexts. For GDC, the private sector will remain a highly valued partner for public–private partnerships with common development objectives.

Further support on workplace health is provided by:

GIZ- Regional Coordination Unit for HIV & TB (giz-RECHT) Accra / Ghana
Email: holger.till@giz.de
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## Annex 2: List of Reviewed Projects

**Finalized Public Private Partnerships**

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<tr>
<th>No.</th>
<th>Countries</th>
<th>Programmes</th>
<th>Estimated size of target group</th>
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<tr>
<td>1</td>
<td>DR Congo</td>
<td>HIV Workplace Programme with Heineken / Bralima</td>
<td>4,000</td>
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<td>DR Congo</td>
<td>HIV-2008-015-2008 Improvement of key health outcomes for cocoa communities</td>
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<td>3</td>
<td>Ghana</td>
<td>04.1003.5-103.18 Implementation of a sustainable HIV/AIDS workplace programme at the revenue agencies of Ghana</td>
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<td>Mozambique</td>
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<tr>
<td>11</td>
<td>Namibia</td>
<td>Promotion of regional wellness programme in Ohlthaver List Group</td>
<td>50,000</td>
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<tr>
<td>12</td>
<td>Namibia</td>
<td>HIV/AIDS Help desk: A joint approach of the Walvis Bay Corridor Group</td>
<td>10,000</td>
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<tr>
<td>13</td>
<td>Nigeria</td>
<td>01.1003.5-103.67 HIV/AIDS workplace programme and community health initiative</td>
<td>10,000</td>
</tr>
<tr>
<td>No.</td>
<td>Countries</td>
<td>Finalized PPPs continued: Programmes</td>
<td>Estimated size of target group</td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
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<tr>
<td>14</td>
<td>Nigeria</td>
<td>04.1003.5-404.06 HIV/AIDS workplace programme in supply chain companies of Unilever</td>
<td>2,500</td>
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<tr>
<td>15</td>
<td>Nigeria</td>
<td>04.1003.5-404.07 HIV/AIDS workplace programme in supply chain companies of Guinness</td>
<td>8,500</td>
</tr>
<tr>
<td>16</td>
<td>Nigeria</td>
<td>04.1003.5-404.08 HIV/AIDS workplace programme in supply chain companies of Nigerian Breweries</td>
<td>Information not available</td>
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<tr>
<td>17</td>
<td>South Africa</td>
<td>2007.00042-2007 HIV/AIDS workplace programmes for SMEs in Eastern Cape</td>
<td>12,000</td>
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<tr>
<td>18</td>
<td>South Africa</td>
<td>2004.1003.5-404.04 Kaefer AIDS Relief Programme (KARP)</td>
<td>1,000</td>
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<tr>
<td>19</td>
<td>South Africa</td>
<td>2005-125 Fighting over-indebtedness and introducing financial wellness</td>
<td>2,800</td>
</tr>
<tr>
<td>20</td>
<td>South Africa</td>
<td>98.4203.0-103.08 Daimler HIV/AIDS Project, South Africa</td>
<td>60,000</td>
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<tr>
<td>21</td>
<td>South Africa</td>
<td>01.1003.1-102.20 Established HIV/AIDS workplace programmes in South Africa (Bosch, VW, Rosch, T-Systems)</td>
<td>7,000</td>
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<tr>
<td>22</td>
<td>Tanzania</td>
<td>Comprehensive HIV and AIDS WPP for Mbeya Cement</td>
<td>300</td>
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<tr>
<td>23</td>
<td>Tanzania</td>
<td>04.1003.5-404.09 Comprehensive HIV/AIDS Control in the Tanzanian Tea Industry</td>
<td>180,000</td>
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<tr>
<td>24</td>
<td>Uganda</td>
<td>HIV/AIDS Workplace Programme at Finlays Tea Estates</td>
<td>8,000</td>
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<tr>
<td>25</td>
<td>Zambia</td>
<td>HIV/AIDS WPPs for Agriflora Ltd. In Zambia</td>
<td>15,000</td>
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<tr>
<td>26</td>
<td>Zimbabwe</td>
<td>04.1003.5-404.14 Combating HIV/AIDS at tobacco farmers, their dependants and communities in Zimbabwe</td>
<td>100,000</td>
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<tr>
<td>27</td>
<td>Africa regional</td>
<td>Central-Africa 98.4203.0 HIV and AIDS in the private sector (Heineken/Bralima Breweries)</td>
<td>10,000</td>
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<tr>
<td>28</td>
<td>Africa regional</td>
<td>2007-00043-2007 Improving HIV/AIDS prevention and health care for workers and their families of 8 agro-industrial companies in 5 countries</td>
<td>126,000</td>
</tr>
<tr>
<td>29</td>
<td>Africa regional</td>
<td>2007-00044_2007 Filtisac - HIV Maßnahme im Rahmen von Ivoire Coton</td>
<td>35,000</td>
</tr>
<tr>
<td>30</td>
<td>World</td>
<td>Global Compact and Safety and Health (involving Volkswagen branches in Brasil and South Africa)</td>
<td>Information not available</td>
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<tr>
<td></td>
<td></td>
<td><strong>SUBTOTAL</strong></td>
<td><strong>878,900</strong></td>
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</tbody>
</table>
## Prematurely Terminated Public Private Partnerships

<table>
<thead>
<tr>
<th>No.</th>
<th>Countries</th>
<th>Programmes</th>
<th>Estimated size of target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>China</td>
<td>04.1003.5-404.20</td>
<td>15,000</td>
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<tr>
<td></td>
<td></td>
<td>HIV/AIDS and TB workplace programmes in supplier firms</td>
<td></td>
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<tr>
<td>2</td>
<td>Kenya</td>
<td>01.1003.1-102.28</td>
<td>50,000</td>
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<tr>
<td></td>
<td></td>
<td>Extension of existing HIV/AIDS interventions into the communities and suppliers of General Motors East Africa (GMEA)</td>
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<td></td>
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<td><strong>SUBTOTAL</strong></td>
<td><strong>65,000</strong></td>
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</table>

## Public Private Partnerships in Implementation

<table>
<thead>
<tr>
<th>No.</th>
<th>Countries</th>
<th>Programmes</th>
<th>Estimated size of target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ivory Coast</td>
<td>HIV prevention and health care for families in rural area</td>
<td>350,000</td>
</tr>
<tr>
<td>2</td>
<td>DR Congo</td>
<td>04.1003.5-501.66</td>
<td>13,500</td>
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<tr>
<td></td>
<td></td>
<td>Extending HIV WP programmes to BRALIMA's supply chain</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Ghana</td>
<td>04.1003.5-501.31</td>
<td>150,000</td>
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<tr>
<td></td>
<td></td>
<td>Implementation of sustainable and comprehensive Employee Wellness Programmes (EWP)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Ghana</td>
<td>04.1003.5-404.19</td>
<td>12,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement of key health outcomes for cocoa communities</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Ghana</td>
<td>04.1003.5-501.31</td>
<td>37,960</td>
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<tr>
<td></td>
<td></td>
<td>Implementation of sustainable and comprehensive Employee Wellbeing Programme (GCNet and GRA)</td>
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<tr>
<td>6</td>
<td>Ghana</td>
<td>04.1003.5-503.12</td>
<td>70,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mainstreaming health promotion (Bamburi 2)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Kenya</td>
<td>04.1003.5-503.08</td>
<td>5,000</td>
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<tr>
<td></td>
<td></td>
<td>Basic health insurance scheme for cocoa farmers in Kyela</td>
<td></td>
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<tr>
<td>8</td>
<td>Kenya</td>
<td>05.2161.7-001.60</td>
<td>14,000</td>
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<tr>
<td></td>
<td></td>
<td>Mainstreaming comprehensive wellness programme</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Kenya</td>
<td>04.1003.5-503.12</td>
<td>20,000</td>
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<tr>
<td></td>
<td></td>
<td>Promotion of PMTCT services in rural Kenya</td>
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<tr>
<td>10</td>
<td>Tanzania</td>
<td>04.1003.5-503.08</td>
<td>14,000</td>
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<tr>
<td></td>
<td></td>
<td>Basic health insurance scheme for cocoa farmers in Kyela</td>
<td></td>
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<tr>
<td>11</td>
<td>Uganda</td>
<td>2007-00027-2007</td>
<td>6,000</td>
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<tr>
<td></td>
<td></td>
<td>Extension of medical and social services to the community neighbouring the flower farm Wagagi</td>
<td></td>
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<tr>
<td>12</td>
<td>Ukraine</td>
<td>04.1003.5-505.26</td>
<td>6,000</td>
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<tr>
<td></td>
<td></td>
<td>HIV/AIDS workplace programme for companies</td>
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</table>
### Regional Programmes on Workplace Health

<table>
<thead>
<tr>
<th>No.</th>
<th>Countries</th>
<th>Programmes</th>
<th>Estimated size of target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Africa</td>
<td>AWiSA AIDS Prevention &amp; Health Promotion Workplace Programmes in Southern Africa</td>
<td>100,000</td>
</tr>
<tr>
<td>2</td>
<td>Africa</td>
<td>ACCA AIDS Control in Companies in Africa</td>
<td>630,000</td>
</tr>
<tr>
<td>3</td>
<td>Africa</td>
<td>SPAA Support of the Private Sector in Africa to Fight AIDS</td>
<td>Not estimated</td>
</tr>
</tbody>
</table>

**SUBTOTAL** | **730,000**

**TOTAL target group of all WPP programmes and PPP projects** | **2,651,610**