Sexual Health EXCHANGE

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Sexual health and the world of work

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SAfAIDS

Sexual health and the world of work

Joost Hoppenbrouwer

When you ask people how they think health and work are related, many will talk about occupational health – the workplace's influence on employees' health status. However, the relationship between health, the world of work and development is much more complex. The World Bank's 1993 World Development Report, Investing in Health, was a landmark publication in introducing a more comprehensive understanding of the many links between a nation's health status and its economic growth produced by the world of work. Apart from discussing how and why economic growth can improve the health status of the poor, it also shows the reciprocal importance of health as a 'commodity' necessary for economic development: health and health services should not be merely seen as a cost to society, but rather as a worthwhile investment.

In the field of sexual health, the HIV pandemic in particular has provided an undeniable example of the impact that health can have on development (also see the 2000/3 issue of the Sexual Health Exchange). HIV/AIDS has come to be recognised as a social, economic and even security problem, – rather than 'just' a public health problem – and as such it requires the urgent attention of all sectors of society.

The impact of HIV/AIDS has convinced many employers – perhaps for the first time – that investing in their employees' health is not only a social responsibility, but also a necessary investment to promote their company's productivity and even long-term survival: investing in workers' health has become part of a company's cost-benefit analysis. This has further resulted in a tendency to incorporate activities and services that started as 'AIDS programmes' in wider sexual health workplace programmes. The articles in this issue of the Exchange from Nicaragua and Bangladesh show how such wider sexual and reproductive health workplace programmes are being designed and implemented.

The world of work: more than making money

Companies are also discovering that investing in health is not just cost-effective from the viewpoint of worker productivity, but can also be used to create a positive company image and attract more customers. There is increasing global pressure from consumer groups to offer decent working conditions, including health-care services for employees. In addition to price and quality of the main product, companies may, for example, advertise that they have an HIV/AIDS programme".

Of course, the world of work is not restricted to the private sector. The public sector also recognises the importance of the workplace for reaching important parts of the population, both men and women. Government ministries, UN agencies and NGOs alike are giving more attention to the world of work in their programmes and interventions. This issue of the Exchange shows how this has been translated into a variety of programmes and activities, including Business Coalitions on AIDS, workplace policies and Codes of Practice regarding AIDS and sexual health, reproductive health services and HIV/STI prevention programmes for both employees and their families, and practical guidelines on workplace activities All of these examples demonstrate the need for public-private partnerships to promote sexual health. ❖

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Ford Motor Company of Southern Africa – leading the way in the auto industry

J. Denise Clement

The HIV/AIDS epidemic continues to have a serious impact on the population and economy of South Africa. In 1999, UNAIDS and WHO estimated that 20% of South African adults were infected with HIV. While many consider this epidemic merely a public health crisis, it is much more. The loss of 20% of the population in their prime productivity and earning years of life is a destabilising force for the sustained economic growth of the country. From a business standpoint this means an HIV infection rate of 20% among potential customers. From an industry viewpoint, it means that potentially 20% of employees are infected, with a declining potential employee pool in the general community. The economic impact upon the consumer and employee populations has a direct impact upon businesses. The HIV/AIDS epidemic is an economic, social and public health crisis. Ford Motor Company of Southern Africa is committed to taking a leadership role in the business community in the fight against the HIV/AIDS epidemic. The company has provided leadership in this field within the South African auto industry by serving as a resource and hosting an HIV/AIDS conference with other employers.

Ford Motor Company is the world's second largest carmaker, selling vehicles in 200 markets. It has manufacturing facilities in 25 countries on six continents. Manufacturing employment accounts for about 80% of the approximately 346,000 people employed by Ford. The Ford Motor Company of Southern Africa (FMCSA) employs more than 3,700 people.

In 1998, FMCSA management recognised HIV/AIDS as a growing business concern with potential impact on employees and their families, customers, suppliers and the economic stability of the country. Employees spend eight hours or more in the workplace, employers are thus in a unique position to provide programmes to help employees and their families address the HIV/AIDS epidemic. Workplace programmes can help to address the stigma that still surrounds HIV infection by promoting open discussions among employees, as well as providing accurate information about HIV prevention. Ford's HIV/AIDS Workplace Programme was developed in the second quarter of 1999, and is led by a steering committee chaired by the FMCSA CEO and Group Managing Director. It meets with management and employee representatives monthly.

The programme focuses on education, testing, counselling, communication, and community involvement in partnership with NUMSA (the largest trade union) and the US Centers for Disease Control and Prevention (CDC). The company developed an HIV/AIDS policy and posted it in prominent areas of all facilities. For HIV/AIDS awareness training, the company shut down each facility for an afternoon during which professional artists performed in an industrial theatre play. By shutting down operations every employee was able to participate in the training.

Two HIV/AIDS Programme coordinators were appointed to lead this initiative in Pretoria and Port Elizabeth, where the company has its facilities. Twenty peer educators have been trained at each facility. The peer educators also give presentations at local schools on HIV prevention. A family HIV/AIDS Awareness Day attracted 2000 participants; parents were given informational brochures on how to talk to their teenagers about HIV/STI prevention. Educational materials are printed in four major languages and distributed to employees.

The HIV/AIDS programme distributes condoms on site, free of charge. Condom distribution was decentralised by making them available in the change rooms, in addition to the medical department. Monthly distribution increased from 700 to 17,000 per month after changing the distribution locations.

The medical benefit plan was revised to align with the company's HIV/AIDS efforts. The on-site medical staff was trained in the latest best practice protocols for STI treatment and related opportunistic infections. The medical clinic also provides directly observed treatments (DOTS) for tuberculosis. Facilities for voluntary counselling and testing were identified for employee and family referrals.

Ford before it had an HIV/AIDS workplace programme

Results and lessons

The steering committee believes that employees no longer hesitate to engage in open discussion on HIV/AIDS, with more and more people seeking advice and clarity. The programme has put a stop to the rhetoric surrounding HIV/AIDS and moved into action in the fight against the spread of the epidemic. The programme is extended to employees, contract workers, pensioners and their families and has reached more than 12,000 people. Ongoing communication on the topic of HIV/AIDS awareness continues in the workplace, aimed at moving from awareness to knowledge.

The programme's success can be attributed to the awareness and actions taken by the company to develop a comprehensive programme, the partnerships with the unions and CDC, and having passionate champions within the company. Next activities for the programme include greater outreach to the community and mentoring programmes for AIDS orphans. ❖

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ILO's response to HIV/AIDS in the world of work

Sonia Smith

A decade ago AIDS was regarded primarily as a health issue. Today it is widely considered a development crisis affecting all social and economic sectors. The International Labour Office (ILO) supports the fight against HIV/AIDS because the very core of its work is being threatened by the epidemic. Its primary goal is to promote opportunities for decent and productive work in conditions of freedom, equity, security and dignity. Each of ILO's four strategic objectives – workers' rights, employment promotion, social protection and social dialogue – is directly undermined by the spread of HIV and its impact on the world of work. Because HIV infections are concentrated among adults, the epidemic affects the labour force even more acutely than the population in general, with far-reaching implications for families, enterprises and national economies. The ILO has a strategic role in the global response to HIV/AIDS through its capacity to mobilise its tripartite constituents – governments, employers and workers – and through its direct access to the workplace.

The impact of HIV/AIDS on the world of work

The majority of the 40 million people infected with HIV are in the prime of their working life: an estimated 25 million workers aged 15-49 years are living with HIV/AIDS. In high-prevalence countries, by 2020 the labour force will be between 10 and 30 per cent smaller than it would have been without AIDS. This affects the world of work in many ways. Workers are losing jobs and livelihoods, either because they become too sick to work or because they are dismissed on the grounds of their HIV status; many individual workers and their families suffer from stigmatisation and discrimination, as the epidemic undermines fundamental rights. Employers are losing skilled workers and seeing productivity fall. At the same time, labour costs are rising sharply due to increased health provision, recruitment and retraining costs, and funeral expenses. Savings are reduced, affecting investment, and market demand contracts for many goods and services. Finally, a contracting tax base, increased public spending, and a loss of skills combine to slow economic growth: the Gross Domestic Product of several African countries is expected to fall over the next decade, according to the World Bank.

The extent of the social and economic dependence on the economically most productive population becomes clear as children, especially girls, are forced out of school and into labour, sometimes under dangerous and exploitative conditions. A culture of blame falls on women in many countries, in addition to the greater part of the burden of care, and AIDS widows are rejected and marginalised. Health services and social security systems become overwhelmed with the needs of those with AIDS. Finally, poverty is growing and the Millennium Development Goals are under threat.

The ILO Programme on HIV/AIDS and the World of Work

The ILO Programme on HIV/AIDS was established in response to requests from its constituents worldwide and on the basis of the analysis of country needs by its field offices. The Programme was formally established in November 2000 with the aim of reducing the spread of HIV/AIDS, mitigating its impact in the world of work, and protecting the rights and dignity of workers and their families affected by the epidemic. It focuses on the following areas:

- research and policy analysis regarding the social, economic, and labour force consequences of HIV/AIDS
- advocacy at all levels regarding the implications of the epidemic for enterprises and for workers' rights
- technical cooperation support for employers' and workers' organisations
- setting standards and providing advisory services to guide national and workplace policies and programmes on HIV/AIDS.

In close collaboration with governments, employers and workers from all regions, ILO has developed a Code of Practice on HIV/AIDS and the World of Work, which was formally launched at the UN General Assembly Special Session on HIV/AIDS in June 2001. It was welcomed by heads of state, workers' and employers' organisations, UN partners, NGOs and a range of other stakeholders, including representatives from the private sector such as the Global Business Council. Using a rights-based approach, the Code establishes principles and provides practical guidance to governments, employers and workers, as well as other stakeholders, in the following key areas:

- prevention through education, gender-aware programmes and practical support for behaviour change
- protection of workers' rights, including employment protection, confidentiality, gender equality, entitlement to benefits and non-discrimination
- care and support, including confidential voluntary counselling and testing, as well as treatment in settings where local health systems are inadequate.

> *"The code is not just about policy and guidelines. It is about respecting the dignity of others and learning to live with the reality of HIV/AIDS."* (Juan Somavia)

ILO's Director General handing over the ILO Code of Practice to the UN Secretary General at the UNGASS on HIV/AIDS (June 2001)

Photo: United Nations

The Code applies to all employers and workers in the public and private sectors, and all aspects of work, formal and informal. The Code is not only intended for countries where the epidemic has a strong grip: it is also designed to prevent infection rates from increasing in relatively unaffected countries. The Code can be used as a basis for national workplace policies, guidelines for enterprises, collective agreements and training programmes. It can be an instrument for advocacy, in particular for strengthening the involvement of the private sector in action against HIV/AIDS, as well as a guide to the development and implementation of programmes in the community.

The UN's Special Session on HIV/AIDS endorsed ILO's role as a key partner in the global fight against HIV/AIDS by including provisions on the world of work in the Declaration of Commitment. The Declaration contains a call for workplace-based action and commits governments to adapting the national legal and policy framework accordingly. ILO's contribution to the UN response was strengthened through its co-sponsorship of the Joint UN Programme on HIV/AIDS (UNAIDS) since October 2001.

Implementing the ILO Code of Practice

ILO is working with several governments to develop or adapt their national labour legislation and AIDS policies on the basis of the Code, and is advising employers' and workers' organisations on sectoral and workplace policies and programmes. A training programme is being developed and an education and training manual is in preparation. Pilot programmes on HIV/AIDS and the world of work are being put in place in selected countries in collaboration with social partners and UN agencies. The Code has been used in the training of labour inspectors in Senegal; a joint programme with UNIFEM has been drawn up to address the issue of informal work and the care economy in relation to HIV/AIDS; and a project agreed with the Commonwealth Secretariat on the education sector in Botswana. The Code has been translated into over 20 languages in response to local demand.

ILO has developed its own personnel policy on HIV/AIDS based on the Code and other UN agencies – notably UNESCO, UNIDO and UNICEF – have approached ILO with an interest in developing personnel policies for their own employees. Copies of the Code (in English, French and Spanish) and the ILO Personnel Policy can be downloaded from the ILO website. ❖

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Special Article

Building the resilience of Cambodian farmers to HIV/AIDS: early action in a low-prevalence country

Jacques du Guerny, Sokunthea Nguon, Sin Chhit Na, Lee-Nah Hsu, Robert Nugent & Tea Phauly

At present, Southeast Asian countries still have low HIV prevalence compared to African countries. With Southeast Asia's economy based on rice farming, it is critical to prevent the spread of HIV among rural rice-farming communities. A major component of any HIV and development strategy in rural areas is to empower farmers to be able to make decisions for their economic survival without exposing them to the risk of HIV infection. If possible, it is better to build empowerment on agricultural production itself, as this is the pillar of the farm-household existence. The Integrated Pest Management (IPM) mode of production can provide such a base. IPM builds on farmers' areas of expertise, focusing on fields and production processes. At this level, farmers feel secure and relatively confident that they are capable of controlling the dynamics between factors influencing production. This could be the starting point for building resistance to HIV.

In an integrated rice-farming system, farmers learn experimentally in their fields to maintain a proper ecological balance so that they do not need pesticides or fertilisers for improving their yields and income. This process of learning a strategy of rice production lasts one growing season (16 weeks) and takes place in the Farmers' Field School (i.e., the rice field itself). The farmers learn to see their field as an ecosystem in which they must conserve and encourage the natural biological diversity. They conduct an Agro-Ecosystem Analysis (AESA) of the field to understand the dynamics between pests and fungi with the rice plant and then carry out field experiments. The farmers work together to solve problems based on their observations. Through this process, the farmers acquire new expertise, experience in the field and in group dynamics, in leadership and self-confidence, which encourages them to consider other complex issues they might have avoided previously.

Farmer life schools

In Cambodia, one project went beyond the traditional IPM approach by introducing a similar methodology, but applied to the farmer's household and living conditions rather than to their rice fields. In this case, the farmers go through a Farmer Life School (FLS) where their previous understanding of the web of life in their crops is transposed to their own community. They observe and analyse the inter-related elements of their lives through a Human Ecosystem Analysis (HESA) directly inspired by the AESA, enabling them to identify threats to their lives and to search for root causes of their vulnerabilities. For example, a farmer might see that incautious borrowing can lead to such a great debt burden that s/he is faced with selling land (a last resort) or sending a daughter to work in a karaoke or beer garden, which can lead to high-risk situations and HIV infection. Through this kind of analysis, the farmers are able to work out causal

chains, options in decision-making and their long-term consequences when implemented.

Using this approach, farmers learn to identify HIV/AIDS as one of a number of threats. The objective of the farmers, after such an analysis, is to think through the long-term implications of their options, to select the best one and to find ways to reduce their vulnerabilities, including HIV/AIDS. This approach leads to the empowerment of the farmers: they analyse their situation with the help of other farmers, discuss the realistic options open to them with their resources and then make their own individual decisions, implement them and face the consequences. Through this collective process, other farmers, aware of their difficulties and decisions, provide moral support. To date, the farmers feel they have particularly benefited from the HESA in the following ways:

- ❖ The Farmers Life School (FLS) has allowed them to discuss and think about life and issues beyond farming.
- ❖ The FLS uses a different approach from other development or health projects. In an indirect way, FLS leads to the prevention of many other life problems and diseases, including HIV/AIDS. This is because the farmers learn about the relationships between various issues and different approaches to solve them.
- ❖ Farmers have learned about different types of resources, including their own internal knowledge, which they did not appreciate previously.
- ❖ In addition to the trained farmers, villagers living near the FLS training houses also atttended the sessions and learned the approach.

The FLS project differs from the usual HIV/AIDS projects because it does not deliver health-related messages about what HIV/AIDS is and how to prevent infection (e.g., through condom use). The FLS aims to identify root causes of general vulnerability to HIV infection in countries with relatively low HIV prevalence and in situations of low levels of development. By confronting the root causes based on their analysis of the situation and available resources, farm households increase their ability to avoid high-risk situations and sexual behaviour. More concretely, whereas the usual HIV/AIDS project approach aims to convince a youngster to use a condom, in this project the farmer realises that greater control over his life can be a form of prevention against HIV. ❖

The Farmers Life School aims to identify the root causes of vulnerability to HIV infection

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Special Article

NGO-private sector partnership in Brazil

Ana Maria Bontempo Dias

According to Brazil's National AIDS Programme, the highest HIV infection rates are found among the socially and economically productive age group of 20-49 years, constituting 87% of the cases in Brazil. In Rio de Janeiro, 84% of the more than 31,000 cases of AIDS belong to that age group. In view of that reality, in 1998 Grupo Pela Vidda started a new HIV-prevention workplace initiative in partnership with private companies. These programmes provide information to the workforce on HIV/STI prevention and the correct use of male and female condoms.

According to the National AIDS Programme, 215,810 cases of AIDS had been diagnosed in Brazil since the beginning of the epidemic through June 2001. The number of people living with HIV/AIDS (PLWHAs) is now estimated at 597,000. In spite of these large numbers it is generally accepted that the growth rate of the epidemic in Brazil is decreasing. This is attributed to prevention measures such as harm-reduction strategies among drug users, media campaigns and continuous education efforts in community centres and schools, which have led to more and more people using male or female condoms. Adequate monitoring of the epidemic, however, is hampered by the relatively low percentage (20%) of sexually active people actually tested for HIV.

Grupo Pela Vidda

Grupo Pela Vidda (GPV: Group for the Recognition, Integration and Dignity of People Living with HIV/AIDS) is a non-profit community-based organisation formed by PLWHAs, their friends and families in 1989. GPV has developed a wide range of activities, involving and empowering PLWHAs through self-help and support meetings, educational programmes about care and prevention, home-based "buddy" care for PLWHAs and a national legal AIDS support service. It also maintains ongoing networking activities with other organisations, such as the International HIV/AIDS Alliance, Schorer Foundation, Project Inform, Treatment Action Campaign.

Some of Grupo Pela Vidda's happily graduated peer educators

In the world of work, GPV aims to sensitise employees on AIDS-related issues and educate them so they do not discriminate against HIV-positive colleagues or those thought to be infected. HIV-positive volunteers give talks to help workers understand what living with AIDS means. Interactive group techniques are used and participants are invited to engage in open discussion. In addition, educational materials giving accurate, up-to-date information on HIV/AIDS and condoms, are distributed. GPV also assists companies in establishing HIV-prevention programmes and conducts peer-education training for employees. To date, 198 interventions have reached more than 9000 workers. Unfortunately, interest in maintaining a continuous HIV-prevention programme in the company is usually restricted to the human resources staff and not shared by the employers. For this reason, educational programmes have often been single-session courses with poor and unsustained results, even though some enterprises officially included HIV-prevention activities as part of their "Quality of Life" programmes for employees.

Partnerships

Establishing partnerships with state governments and groups of companies to promote workplace HIV-prevention activities is another line of action. In 1999, the Rio de Janeiro State Government invited GPV to become a member of the State Consulting Committee for HIV/STI Prevention at the Workplace. The Committee's main objective is to sensitise and mobilise business people and trade unions to develop educational and prevention activities for employees. In addition, it intends to conduct training programmes to prepare managers and workers for developing prevention policies in their companies and promote social marketing of condoms.

The Committee is providing technical support to the recently created Rio de Janeiro Business Council for HIV/STI Prevention, which comprises 15 major enterprises – the first such Council in Brazil. The Council's main goals include development of internal AIDS policies among member companies, facilitating the exchange of experiences on HIV-policy implementation and sponsoring mass-media campaigns. As part of the technical support offered by the Consulting Committee to the Council, GPV has participated in eight courses, sponsored by the State Government, training 126 employees in setting up workplace policies and programmes. GPV is convinced that working together with the companies of the State Business Council will enhance the possibilities of guaranteeing an effective response for the workforce and making prevention available to all employees.

Lessons learned

Experience in implementing workplace prevention programmes has allowed GPV to formulate some concepts concerning the difficulties and perspectives of prevention:

- ❖ The company's commitment is the most important factor for a successful workplace intervention and this requires the support of the highest level of staff.
- ❖ Medium-sized and small companies, in particular, are reluctant to set up workplace HIV/AIDS programmes because they lack human and financial resources; also, persuading companies to allow employees to take part in AIDS activities during work hours can be contentious. The large and multinational companies are more sensitive about developing these programmes. Although they have policies for implementing them, management often does not make sufficient effort to find alternative work for those with HIV/AIDS.
- ❖ Although companies may have relevant policies, management often does not make sufficient efforts to find alternative work for those with HIV/AIDS, if necessary.
- ❖ Even today, some employers consider HIV/AIDS too sensitive an issue or feel uneasy about associating their business or brand name with AIDS.
- ❖ As a result of the government's free distribution of antiretroviral drugs, which helps keep HIV-positive employees at work, companies have not experienced severe absenteeism or loss of experienced personnel due to AIDS-related health problems. This, in turn, makes employers less motivated to promote AIDS workplace activities.
- ❖ Most companies of the State Business Council have recognised the need for developing workplace initiatives and policies in response to HIV/AIDS, but have not yet started to implement them. They seem to be too involved in developing general corporate policies and programmes.

Despite these constraints, GPV has been able to disseminate helpful information about AIDS and contribute to the formulation of better prevention policies. Increasing attention has been given to the process of contacting the companies and GPV has learned that the best strategy to break resistances regarding HIV/AIDS is to investigate the company's culture and employees' level of knowledge. This way, customised approaches can result in relevant and effective programmes. Enhancing the formulation of these approaches is a priority for GPV's workplace activities in the near future. ❖

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Programme Feature

Artisanal and small-scale mines: ticking bombs in need of workplace HIV/STI interventions

R. Goergen, A. Mohamed, E. Mhando C. Hunger & A. Mlay

The term 'workplace interventions' often refers to established industries and companies with a genuine interest in building and maintaining their workforce. However, in developing countries *informal* industries also play an important role in the economy, but often the importance of these industries in preventing the spread of HIV is not sufficiently recognised. In Tanzania, more than 4000 registered artisanal and small-scale mining companies (SSM) employ a labour force of 550,000 workers. The past economic socialist policies and the geological environment favoured the development of this huge mining sector. A single mine might employ between 100 and 1000 or more workers, almost exclusively men. SSM requires low investments, based on informal operational organisation, and uses poor mining and processing technology. The marketing channels are partly recognised, partly underground.

Namungo Mine in Lindi region

Namungo is a recently established SSM area, with deposits of green gemstone (tsavorite). About 400 men and women are living in temporary settlements around the mine. The miners use a simple torch, hammer and chisel in the pits, which are up to 90 feet deep and have poor ventilation and lighting. The deeper the pit, the younger the miners, because only boys or small men called *nyoka* (snakes) are able to work in the deep and narrow spaces. Workers descend underground using ladders and ropes. The local people surrounding the mines serve the camp with services such as selling water, vegetables, firewood, running errands and laundry services. Some of the women living in the mines are involved in petty trading of stones, while others sell food, alcohol and sex. Alcohol and drug use is quite common, especially after a big find. The miners engage in multiple sexual relations with girls and women from the neighbouring village. Often, after a short period in one mine, the miners move to other sites in other regions of the country. For many of them, Namungo mine is the fifth or sixth mining site where they have worked.

Shedding some light on HIV/AIDS for small-scale miners

An HIV/STI workplace intervention

At each mine site, the miners have elected leaders who negotiate their interests with the claim-holders, gemstone brokers and government officials. These leaders are responsible for maintaining order and peace in the camp. In August 2001, the leaders and claim-holders asked Tanzanian health officials to begin a workplace intervention on HIV and sexually transmitted infections (STIs). Acting upon this request, a team of regional and district health experts developed an intervention plan comprising:

- a baseline study on knowledge, attitudes and practices (KAP) with villagers and miners
- a survey on syphilis and HIV infection rates
- STI treatment
- an educational campaign
- plans for continuous collaboration between the mine and the health system.

The KAP study among 467 miners and volunteer villagers available on the day of the study showed that 81% of the respondents knew that sexual intercourse without a condom is the main mode of HIV transmission. Eighty percent correctly stated that an HIV-infected person may remain asymptomatic for a long period. Three-quarters mentioned sex with a stranger or sex worker as risky. Even so, half the respondents said they had paid sex with more than one partner during the last 12 months and 48% reported having used a condom in the past three months. Most said they were willing to have voluntary counselling and testing (VCT) to know their HIV status. Four hundred people came voluntarily for syphilis and HIV testing, confirming their willingness for counselling and testing.

Most of the 429 people who had come with STI symptoms were treated for discharge syndrome (40% males, 24% females) and genital ulcers (38% in males and females). Testing and counselling for syphilis and HIV was offered to STI clients and volunteers. Infection rates

Table 1: Syphilis and HIV infection among people living in the camp and the neighbouring village

Syphilis and HIV status in the mine				
	Volunteers (n=235)		STI Clients (n=133)	
	Male n=189	Female n=46	Male n=101	Female n=32
Syphilis-positive	13.8%	23.9%	11.9%	37.5%
HIV-positive	21.7%	22.2%	17.7%	35.5%
Syphilis and HIV status in the village				
	Volunteers (n=165)		STI Clients (n=120)	
	Male n=134	Female n=31	Male n=101	Female n=32
Syphilis-positive	13.4%	19.4%	25%	30%
HIV-positive	7.5%	22.6%	12.8%	20%

were high in both groups (see Table 1). Women were more affected at both the mine and village. The highest prevalence rate of 38% was in women aged 30-34 years.

The statistics in the table must be interpreted with caution because they pertain to a self-selected sample. Especially in the mine, the vast majority (estimated more than 80%) of people living in the camp participated either as a patient or as a volunteer. The only figures available for comparison with the "normal" population in the area are statistics for women attending antenatal clinics in Lindi Region, which showed rates of 8.9% for HIV and 7.8% for syphilis in 2000. The sexual behaviour in a small-scale mine seems to favour the easy spread of STIs and HIV and creates a highly-infected female population. These women serve the miners in the camp and in the neighbouring village. Namungo is a newly established mine. Higher infection rates are expected among the residential population in older mining areas because they accumulate infection.

The educational campaign in Namungo Mine included videos in Kiswahili on HIV/STIs and the socio-economic consequences of HIV/AIDS. Posters, leaflets and a set of six booklets answering frequently asked questions on sexual and reproductive health were distributed. Questions-and-answer sessions with groups and individual counselling were offered. Condom demonstrations and free distributions were repeatedly carried out. According to the plans established with the miners and claim-holders this start-up activity will be followed by:

- Regular outreach visits by a health team
- Creation of a health fund (by withholding a percentage from the sales of gemstones)
- Establishment of sales points for condoms
- Training of the drug hawker in the camp.

The training of peer educators is still under discussion because the high mobility of miners makes this a difficult option.

Conclusions

The main conclusions that can be drawn so far include:

- Workplace intervention policies need to include informal industries, which should be inventoried, mapped and characterised according to their potential for spreading HIV. SSM will probably rank as a high-priority area for interventions.
- Workplaces must be addressed together with their "sexual environment" including the people with whom the workers have sex. This is especially important when male workers live without permanent partners.
- Districts need support in assessing workplaces in their area and in developing appropriate interventions. ❖

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Special Article

The Malaysian Workplace Code of Practice – insights on its development

Joe Selvaretnam & Marina Mahathir

The HIV/AIDS pandemic is an unfolding human tragedy in Asia, where new infections are increasing faster than anywhere else in the world. The point many government agencies miss is the multifaceted nature of HIV/AIDS, requiring a multi-sectoral response: they are only slowly beginning to understand that HIV/AIDS is more than a medical problem. In recognition of the pervasiveness of HIV/AIDS in all aspects of society, Malaysia initiated a Code of Practice on the Prevention and Management of HIV/AIDS in late 2001 for employers and employees. The Code is probably the first substantive non-health Ministry initiative in the area of HIV/AIDS policy formulation and implementation in Southeast Asia.

HIV/AIDS in Malaysia

In 2000, Malaysia had a population of about 23 million, of whom 9.3 million were employed. By April 2001, a cumulative total of 40,049 HIV infections had been reported to the Ministry of Health, 5103 pertaining to full-blown AIDS cases. Most people had contracted HIV by injecting drugs, while heterosexual transmission accounted for almost 11% of HIV cases and 24% of AIDS cases. From a low prevalence rate at the start of the pandemic in the mid-1980s, Malaysia has progressed into a medium prevalence rate of 0.42%.

A study carried out by the Department of Occupational Safety and Health (DOSH) in 2000, covering 154 enterprises from a wide range of industries, indicated that the level of awareness among employers about HIV/AIDS and its potential destructive impact on business and the economy was still very low. The survey also revealed that more than half of the employers (54%) saw HIV/AIDS as a serious or very serious problem at the national level. However, few employers (18%) considered HIV/AIDS a serious problem at a specific industry level, and only 20% perceived HIV/AIDS as a serious or very serious threat to the economy in general. It appears that most employers consider HIV/AIDS as a serious or very serious problem at the national level, but few see it as a problem for their industry.

Many companies carry out pre- and/or in-employment HIV testing. All foreign (migrant) workers are required by law to show proof of being HIV free at the time of employment. The law does not require the same of expatriate (management) employees, although employers may request pre-employment testing for them as well. Although there are no official figures of the numbers of people living with HIV/AIDS (PLWHAs) in the workforce, dismissals have occurred after in-employment testing. PLWHAs are generally excluded from work-related group hospitalisation schemes. Any inclusion is rare and only because of a hugely compassionate key management figure or a

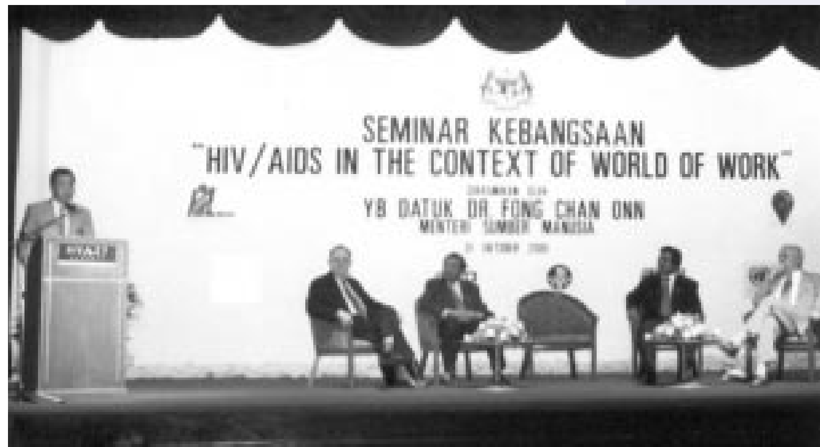
trans-national company extending its parent company's policy position.

Developing the Code

In October 2000, more than 200 participants representing the corporate and public sectors and non-governmental organisations attended a national seminar on "HIV/AIDS in the Context of the World of Work". The participants recommended that guidelines be developed for employees dealing with HIV/AIDS issues at the workplace. DOSH undertook a co-ordinating role to develop these guidelines. A working committee was formed that included the Ministry of Health, Department of Labour, Department for Public Services, Malaysian Trade Union Congress, the Civil Service Employees Union, Malaysian Business Coalition on AIDS, Malaysian Employers Federation, UNAIDS, UNDP, ILO (Bangkok) and the Malaysian AIDS Council (MAC). A key section of the Code is "Managing HIV/AIDS in the Workplace", which includes guidelines for developing a workplace policy and defines the responsibilities of employers and employees.

Some salient points in the Code include:

- A written policy should clearly state the employer's commitment to preventing the spread of the virus as well as discrimination and stigmatisation of HIV-positive employees in the workplace.
- Employment practices should be based on the scientific and epidemiological evidence that PLWHAs do not pose a risk of HIV transmission to co-workers through ordinary workplace contacts.
- HIV status should not be the sole criterion for disqualification from any form of employment.
- HIV-positive employees should have the right to continue in employment as long as they are able to work and as long as they do not pose any danger to themselves, their co-workers or other individuals in the workplace.
- The procedure for termination of employment on medical grounds for HIV-positive employees should be the same as for any other disease.
- An employer should ensure that HIV-positive employees are not required to disclose their HIV status to the employer or anyone at work. In situations where the employee needs to reveal his/her HIV status, confidentiality and privacy regarding all medical information related to his/her status should be maintained at all times.
- Employers should not practice HIV-testing as a precondition to employment, promotion or other employee benefits.
- Employees should not discriminate against, or stigmatise co-workers who are HIV-positive or perceived to be HIV-positive. Disciplinary action should be taken against any employee who does so.
- Employers should recognise the gender dimensions of HIV/AIDS in workplace activities.
- Employers should recognise that HIV/AIDS is a workplace issue that needs to be treated like any other serious illness in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, as an integral part of the local community, has a very significant role to play in the wider struggle to limit the spread and impact of the problem.



The Malaysian Minister of Human Resources opens the National Seminar on HIV/AIDS in the Workplace

Reflections on the process

Although the process of developing the Code did not directly include representatives of PLWHAs, women and youth groups, the involvement of employers' and employees' organisations, AIDS and business organisations, relevant UN and government agencies was as important as the establishment of the Code itself. Most key stakeholders came to recognise the importance of being partners in HIV prevention, treatment and care.

The process also revealed the still lingering moral and judgmental issues regarding HIV/AIDS, e.g., beliefs that HIV infection is a result of "free or promiscuous sex", homosexuality, visiting sex workers or sharing infected needles. Such beliefs lead to misunderstandings about risk groups and risk behaviours.

In Malaysia, issues such as poverty, gender inequity, lack of life/reproductive health education and harm-reduction modalities are still not linked to HIV/AIDS. Transmission of HIV is viewed through a skewed lens of "choice", rather than associating it with a lack of information (i.e.., people are believed to become infected because they choose to be gay, visit sex workers or take drugs).

Next steps

DOSH is organising a road show in the first quarter of 2002 to take the Code to employers nation-wide. Partners will assist DOSH by developing IEC materials and exhibition units; they will provide technical support and train DOSH staff to answer queries regarding HIV/AIDS-related issues during the course of the road shows. Resource persons will be available when necessary to provide back-up support and a manual is being developed to accompany the Code.

The work has just started. DOSH and others must help translate the Code into company policies that work towards creating critical awareness, informed employees about HIV/AIDS and an enabling environment for PLWHAs. Action is necessary now to prevent the devastating HIV/AIDS scenarios of Africa. The loss, as in Africa, will not just be to lives but also to economies. ❖

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Country Watch

Uganda

Uganda was one of the first countries on the African continent to witness the occurrence of AIDS cases. In 1986, during the World Health Assembly, the country bravely reported on the presence of a national HIV/AIDS epidemic. Since then, President Yoweri Museveni has consistently shown strong leadership and promoted openness in the fight against HIV/AIDS, which has contributed to a declining trend in HIV rates among pregnant women attending antenatal clinics, from an estimated 6.8% in 1999 to 6.1% in 2000. Concerned that these positive developments might lead to complacency and that communities and networks might experience fatigue in sustaining their efforts, the Uganda AIDS Commission decided to intensify the national response by involving all possible partners. At the same time, within the context of the International Partnership against AIDS in Africa (IPAA), UNAIDS identified governments, UN agencies, bilateral agencies, civil society organisations and the private sector as the five major partners to be involved in the national response to HIV/AIDS. In Uganda, the private sector had historically been underrepresented so getting it involved in the fight against AIDS would be an important step in implementing IPAA.

In January 2001, a representative of the business sector requested support from the AIDS Commission in defining a sector-specific HIV/AIDS response. Appreciating that this initiative had come from the private sector itself, the Commission saw a unique opportunity to reach out to employees, a group not easily reached without the cooperation of the private sector. During initial discussions among interested managing directors of international companies in Uganda and representatives of the Uganda AIDS Commission, the British High Commission and UNAIDS, it was decided to establish a collaborative network of companies rather than a formal NGO. The network developed a mission statement, an institutional framework and a workplace policy that highlighted the need to ensure a non-discriminatory environment for people living with HIV/AIDS (PLWHAs). The Uganda Business Council on AIDS (UBCOA) was launched at the Candlelight Memorial on 25 May 2001.

Managing directors of private companies have greeted the Business Council with great enthusiasm and since its inception, the Council's membership has increased significantly, with representation from companies such as Standard Chartered Bank, Stanbic Bank, Sheraton Hotel, British American Tobacco Company, Shell and Total Ltd.

The Council has undertaken several initiatives, including: donating a container to Mbarare Hospital to expand its AIDS clinic; establishing HIV awareness programmes among employees of selected companies; and negotiating on the inclusion of antiretroviral drugs in the health-care package. UBCOA intends to share its experiences – including the workplace policy – with interested companies, especially smaller ones. The Council also intends to expand private-public sector partnerships, such as improving AIDS-related health-care delivery through insurance schemes and company clinics. Finally, UBCOA aims to assist HIV/AIDS-related projects, mainly through in-kind support. To keep the momentum going, the Council intends to recruit a coordinator to strengthen its secretariat, which will eventually become a resource centre where smaller companies can borrow education kits free of charge and get advice on business and AIDS- related matters.

The business sector has been questioned about the genuineness of its motives. But apart from the fact that production costs increase due to death of employees, sick leave or absence to attend funerals, companies in Uganda have proven to be genuinely willing to assume their social responsibility in the fight against HIV/AIDS. The comparative advantage of the business sector includes access to a significant network of suppliers, distributors, clients and consumers, and this is helpful for reaching out as far as possible. Multi-national representation is another advantage that will allow the Council to play an active role in advocacy and lobbying, for example in working to expand access to AIDS treatment.

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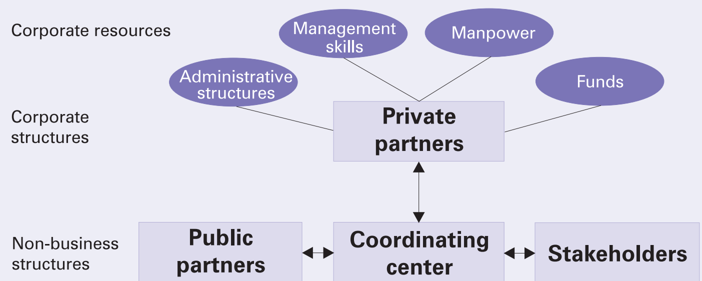
Southeast Asia

The impact of HIV/AIDS in Southeast Asia is felt in every sector of society, including the economic sector. AIDS increasingly depletes human capital, putting large pressure on businesses and dependant communities. Business can gain a lot from HIV prevention among staff and securing equal rights of HIV-positive employees. Especially in societies with relatively high prevalence rates and developing economies, private-sector involvement in the traditionally 'public' fight against HIV/AIDS may have significant results. This is true for large parts of Asia, Africa and Latin America, where government institutions often lack sufficient resources to address HIV/AIDS effectively.

The concept of partnerships between different sections of society to address a common issue is a significant one. E.g., businesses possess organisational structures and other corporate resources (funds, management skills and human resources) that can easily be adopted for public purposes. Where there is a common interest – such as preventing further spread of HIV – public-private partnerships are able to fill gaps in public resources.

The existence of 'Business Coalitions on AIDS' worldwide is a true example of the partnership concept. Instead of adding a new administrative structure to the existing range of government and non-governmental institutions, these coalitions bring together, and complement resources by making use of existing corporate structures. The result is a network of resources, including administrative systems, know-how and corporate funds that are being exploited intelligently for one common goal. An existing public or private organisation usually acts as the network's secretariat centre (see Figure 1).

Figure 1: Business Coalitions on AIDS



There are two conditions that define the degree of success of a partnership. Firstly, common focus and exertion can only be attained if common interests exist. The creation of a 'win-win' situation is therefore essential. Secondly, partnerships that combine different expertise are especially effective when approaching a multidimensional problem, such as AIDS.

The Asian Business Coalition on AIDS

The strategy of the Asian Business Coalition on AIDS ('ABC on AIDS') illustrates the partnership concept. ABC on AIDS is a public-private partnership of ten Asian countries (see Figure 2) to coordinate and expand business activities towards HIV/AIDS. Its mission is to link together organisational resources both 'in-country' and 'inter-country', within and between businesses at all levels, in order to prevent further HIV spreading and ensure non-discriminatory treatment of HIV positive staff.

Two strategies have been developed to facilitate networking between individual partners. The first strategy may be referred to as 'working apart together': each partner develops locally-adapted strategies within a country's existing business administrative structures and applies the corporate resources in the fight against AIDS. The second strategy is to manage information exchange on all levels of the network. This is especially important, as public-private partnerships are susceptible to problems of misunderstanding arising from conflicting interests. The second strategy is implemented by the use of information technology. A website (www.abconaids.org) has been developed to coordinate strategic planning on a coalition level and to provide partners such as business managers, with direct access to information resources. Each partner country has its own section with HIV/AIDS information of national relevance. Topics include management of HIV/AIDS in the workplace, HIV/AIDS business-policy development, workplace education, HIV testing, national HIV/AIDS business response programmes, best practices etc.

As businesses re-evaluate the larger role they play in the functioning of societies, HIV/AIDS becomes a more prominent issue on the corporate agenda. In reaction to this, governments and NGOs have started to acknowledge the importance of creating common values in the fight against AIDS when working together with businesses. They realise public-private partnerships can only be successful if all parties understand its mutual interest.

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Namibia

Over the last decade, HIV/AIDS has become one of Namibia's most pressing social and economic problems. Along with Botswana, Zimbabwe and Swaziland, Namibia now ranks among the countries most affected by HIV in the world, with an overall prevalence of around 20% among sexually active adults. At least one in five Namibians aged 15-49 years is already infected and likely to die within the next seven years. The great majority of Namibia's workforce falls within this age category. Thus, it can be anticipated that HIV/AIDS will have a major disruptive effect on Namibia's labour sector and economy over the next ten years. The indirect costs caused by the HIV/AIDS epidemic are already being felt by economic sectors through loss of productivity, absenteeism, the costs of replacing HIV-infected employees and a reduction in the market for their products or services.

Several years of experience in addressing the epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing HIV transmission and reducing the impact of HIV/AIDS. To this end, the Minister of Labour has promulgated guidelines for implementing a National Code on HIV/AIDS in Employment in terms of the Labour Act. These guidelines:

The Namibian AIDS Law Unit assists employers to establish HIV/AIDS prevention and care programmes

- outlaw discrimination on the basis of HIV status in the context of employment
- prohibit direct or indirect pre-employment tests for HIV
- guarantee confidentiality regarding HIV/AIDS in the workplace
- encourage implementation of workplace HIV prevention and education programmes.

Since implementation, two studies have been conducted to assess employers' knowledge of these guidelines. A national survey in 2000 among 613 employers conducted by the AIDS Law Unit (ALU) at the Legal Assistance Centre – a public interest law centre in Windhoek – indicated that while most employers are aware of the guidelines' provisions, relatively few employers are implementing HIV prevention programmes. Among the employers surveyed, it is mainly medium-to-large (51–500 employees) and large organisations (more than 500 employees) that make both voluntary counselling and testing (VCT) available to their employees. The reported amount spent per year on voluntary or mandatory HIV testing and counselling varied from N$500 for small organisations to N$500,000 for large ones. Few government ministries interviewed acknowledged that they had introduced HIV prevention programmes in their workplaces. This is reason for concern, particularly as government is by far the largest employer in Namibia.

Another survey conducted on behalf of the Namibian Chamber of Commerce and Industry in 2001 revealed that, whereas 78% of employers interviewed in the capital city of Windhoek had HIV prevention programmes in place, the percentage was much lower in the regional towns (25-44%). The employers who had not implemented prevention programmes cited a lack of knowledge about how to implement such programmes and lack of finances as the main reasons for not doing so.

Since 1999, the ALU has collaborated with the AIDS Care Trust of Namibia (ACT). They assist employers and trade unions in establishing HIV/AIDS prevention and care programmes and in addressing HIV/AIDS-related stigma and discrimination in the workplace. Together with management and workers committees, the ALU offers training and awareness-raising activities on the impact of HIV/AIDS on the workplace. It also stresses the importance of a rights-based response to HIV/AIDS, training in the legal and human rights aspects of HIV in the workplace, assistance with the formulation of appropriate HIV/AIDS workplace policies, and the design and implementation of prevention and care programmes using peer educators. As the employers often do not have the personnel or expertise necessary to provide counselling, care and support services, ALU encourages the employers to form links with NGOs that do provide services such as home-based care. Employers are thus encouraged to provide services they would otherwise not be able to provide.

To date, most of the work undertaken in this regard has been with larger companies and parastatals and has been largely Windhoek-based. The survey results indicated the need for more emphasis on small-to-medium-size employers, both in Windhoek and the regions. The small-to-medium employers,

who often cite lack of finances as the reason for not implementing prevention and care programmes, need to be convinced of the cost-effectiveness of these programmes. Smaller employers and employers in the informal sector find it impossible to establish effective programme planning and implementing structures. In these situations, the design and implementation of prevention programmes becomes the responsibility of one already overworked person for whom the programme is not a priority.

Given the above-mentioned situation, the challenge for the future is to develop innovative approaches to assist smaller and informal employers in developing appropriate HIV/AIDS and STI prevention and care programmes. The commercial farming sector, which employs a large number of people, presents a particular challenge because the farms are often isolated and remote. Innovative approaches will inevitably include forming partnerships and pooling resources offered by employers, employees, NGOs and community-based organisations in order to help provide education, care and support services to employees.

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South Africa

DaimlerChrysler South Africa (DCSA), with 4,500 employees in three locations, has developed a comprehensive HIV/AIDS programme covering 23,000 employees and their family members. The programme includes:

- Information, education and communication by trained peer educators, addressing discrimination and HIV prevention
- Condom availability and distribution
- A voluntary counselling and testing (VCT) campaign, combined with a prevalence survey
- A two-year survey on knowledge, attitudes and behaviours
- Extension of existing medical schemes, covering treatment of opportunistic infections, STIs, short-course ARV for prevention of mother-to-child transmission, ARV treatment, monitoring and hospitalisation.

The programme is now being delivered in a public-private partnership project with the German Technical Cooperation (GTZ), with DaimlerChrysler being the principal funder. GTZ's contribution to the programme consists of technical research, development and monitoring. The programme is managed by DCSA's HIV/AIDS Task Force, with representatives from the company's medical and human resources staff, employee representatives, trade unions and GTZ. ARV treatment is delivered in the company's clinics to all HIV-infected employees, their partners and children. DCSA has set aside funds to guarantee access to ARVs to this group over and above the existing medical scheme.

The company hopes these interventions will significantly reduce new infections and enhance life expectancy and quality of life of HIV-positive employees and their families. DCSA and GTZ have built a full monitoring and evaluation system into the programme from the outset, looking at success with target groups, employee participation, changes in knowledge, attitudes, perception and behaviour, HIV prevalence, cost-benefit analysis, and take-up of medical services. ❖

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Programme Feature

Sexual and reproductive health for textile industry workers in Nicaragua

Leonel Argüello, Alba Alvarado, Graciella Marsal & Rosario Cuadra

In 1991, following privatisation of the Nicaraguan industrial sector, local textile factories began to set up in free trade zones. The free trade zones started in the capital Managua and progressively spread to other departments of the Pacific coast and in the north. These textile companies hire young workers, mainly women, who often work in precarious conditions. In addition to work-related health risks, they face many sexual and reproductive health problems as evidenced by high pregnancy rates, increased HIV risk, cervical cancer, and sexual and domestic violence. In July 1998, the United Nations Population Fund (UNFPA) and the Centre for Social Studies and Promotion (CEPS) undertook a joint project to promote sexual and reproductive rights in two free trade zones.

CEPS is an NGO founded in 1990 to improve the living conditions of the most vulnerable populations and strengthen local communities' self-reliance. Since its foundation, CEPS has been active in preventive education projects, especially on HIV/AIDS. In the last four years, it has broadened its work to the field of sexual and reproductive health (SRH). Currently, it is the only organisation with experience in SRH promotion in the textile industry.

The existing provisional health clinics in the free trade zones are characterised by a curative approach. There is a lack of understanding among decision makers in the private sector regarding the importance of reproductive health services as a way to invest in human development. Against this background, CEPS and UNFPA set up a programme aimed at strengthening the textile workers' self-care capacity. CEPS carried out its work in Managua's free trade zone with 12,000 workers, aged 18-26 years, 80% of whom were women. Nearly half (43%) of these women were heads of households and were often single mothers.

Using three strategies, the project sought to strengthen the textile workers' capacity for self-care in the sexual and reproductive health field. The first strategy was to sensitise management of the free trade zone companies through meetings and training workshops. Little by little, as management began to trust CEPS, the interventions started to take off.

The second strategy aimed to strengthen the health services offered to the workers through the free trade

zone's provisional medical clinics. The project provided the clinic with training, basic equipment, medical instruments and supplies. Gradually the clinic was able to provide more services to more patients, including sexual and reproductive health services.

The third, fundamental, strategy was the development of voluntary SRH promoter networks to educate company workers. The volunteers worked inside and outside the factories, depending on circumstances.

Principal achievements and difficulties

Over the project's three years, a major achievement was winning the cooperation of company management, especially the human resource departments. CEPS managed to convince the management that it was interested in the workers' sexual and reproductive health, not in undermining their productivity. As a result, the companies permitted CEPS to carry out its work and assisted in programme administration. Initially, however, the companies did not recognise the cost-effectiveness of the SRH services. This perception changed radically when they saw a reduction in the number of pregnancy-related complications among their workers.

Another important achievement was the improvement of the quality of SRH care by the provisional medical clinics, which fall under Nicaraguan Social Security. At the beginning of the project, the high turnover of medical personnel, including nurses, slowed progress. Policy makers and planners decided to stabilise the clinics' personnel situation and offer them training. They also provide the clinics with materials such as gynaecological beds, Pap test materials, IUD insertion devices, contraceptives (oral and injectable), condoms and educational materials. The most innovative elements were the educational videos and SRH counselling services. Audio-visual education materials were shown in waiting rooms, where they discussed domestic violence, gender perspectives, sex education, detection of breast and cervical cancer, HIV/STI prevention and sexual and reproductive rights.

The higher quality of SRH services resulted in an increased demand, which forced CEPS to broaden the range of services at the clinics. Client satisfaction at the clinics has increased as a result of the counselling services and personal attention received in the SRH field. These activities have been increasing in step with the training of voluntary health promoters by CEPS staff, their educational activities and referrals to the clinic workers.

The formation of a network of voluntary promoters to carry out SRH promotion, using both interpersonal methods and educational materials, has been successful. In addition, popular theatre, referral of patients and provision of oral contraceptives and condoms have all helped to improve the knowledge of the workers in the free trade zone.

Key lessons learned

The principal lessons learned during project implementation were the following:

SHR promotion: a key need among textile workers

❖ It is possible to carry out workplace SRH promotion in the textile industry. There is no single intervention model: it has to be dynamic and adapted to local circumstances.
❖ Sensitising decision makers is a key part of implementing SRH interventions. As a non-profit organisation, CEPS was able to play a facilitating role, creating a space for participation between the private companies and the workers.
❖ Sexual and reproductive health has to be an integral component of the provisional health clinics' services; it should be a compulsory element of the Social Security's tasks, as one of the biggest problems in the country.
❖ To meet the increased demand for SRH services, corresponding health services should complement IEC activities for textile workers.
❖ Experience shows that the SRH approach has favourable win-win effects for all the dimensions of the workplace and workers: health and productivity increase while costs decrease.
❖ Given textile workers' working conditions, SRH promotion activities should use a wide range of complementary communication channels, prioritising a creative and non-formal educational approach.
❖ The contents of the SRH promotion activities have to meet the beneficiaries' needs.

Future perspectives

Based on the experiences of this project, CEPS has set some goals for future SRH work in the textile industry:
❖ Share this SRH promotion experience with other private-sector companies in Nicaragua to show the cost-effectiveness of these kinds of interventions. The earlier exchange of experiences between textile companies in Honduras and Nicaragua, promoted by UNFPA and CEPS, was productive and can be replicated.
❖ Lobby Social Security authorities to include SRH services as part of the rights of insured workers.
❖ Replicate the accumulated experience in other CEPS SRH projects in other textile factory companies in the country. ❖

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Reproductive health services for garment factory workers in Bangladesh

Bayard Roberts

Over the last decade, the number of garment factories in Bangladesh has increased rapidly in response to foreign demand for cheap labour and materials. The factories employ around 1.5 million workers, most of them young women of reproductive age. Many of these women suffer from chronic ill health. Marie Stopes Clinic Society (MSCS) works closely with the factory owners to address these women's needs by providing health services on site. As the owners pay a monthly insurance premium on behalf of each worker, the services are provided free of charge and are almost completely self-funding.

Research has shown that over 40% of the female factory workers suffer from chronic diseases such as gastro-intestinal and sexually transmitted infections (STIs), reproductive tract infections (RTIs), menstrual and blood pressure problems, anaemia and problems related to family planning. The abortion rate among garment workers is also high, with about 18% of interviewed married workers having experienced at least one abortion, usually in unhygienic and unsafe situations.

The Factory Health Insurance Scheme in action

The high rate of illness has had two major outcomes. First is widespread suffering of physical disability and chronic fatigue and second is the knock-on impact on earnings as a result of lower productivity and absenteeism. Each worker loses approximately two days' salary per month due to illness and fatigue. The loss of earnings is exacerbated by the worker having to seek external, often private, medical assistance that could cost up to 9% of his/her monthly wage. Chronic ill health has meant that many employees have had to give up factory work; statistics show that most garment workers last less than three years in the industry.

Factory Health Insurance Scheme

In response to this situation of a poor, largely female workforce almost entirely of reproductive age (the average age is 20 years), MSCS implemented a Factory Health Insurance Scheme in 1997, aimed at providing free, quality reproductive and general health services to workers on-site, financed through monthly health insurance payments made by factory owners. The Scheme currently operates on-site in 172 factories covered by five Marie Stopes Centres. Each Centre acts as a focal point for the Scheme within its vicinity, with factory satellite teams using the Centre clinic as a base. Factory sessions provided by the satellite teams last three hours, with two factories visited by each team every day, six days a week. The team comprises a doctor and a paramedic/counsellor. All staff members undergo an introduction and ongoing training and are subject to regular performance appraisals.

Various criteria are used to select factories for the Health Insurance Scheme. For the scheme to be financially viable, each factory must have a minimum number of workers, of whom some 75% must be women of reproductive age. Existing health services provided by government, private and non-governmental organisations are investigated to determine unmet needs. The location of the factories in relation to the nearest Marie Stopes Centre (for referrals and support services) and with each other also has a bearing on selection.

Health scheme services

The scheme provides reproductive health services, general health checks, antenatal care, STI treatment, treatment for minor infections and immunisations. Educational sessions and other IEC activities also take place at the factory, usually during the workers' lunch hour. These take the form of slide shows/audio stories on reproductive and general health issues, such as ante- and post-natal health, oral contraceptives, condom usage, STIs and HIV/AIDS, nutrition and personal hygiene.

A factory manager is responsible for arranging workers' visits to the satellite health service, with the number of clients limited to around 30-40 per session, to ensure that each receives adequate time for consultation and/or treatment. Approximately 60% of clients require general health services and 40% reproductive health services.

Clients are invited to attend the Marie Stopes Centre for free services that are not provided by the satellite team, such as intrauterine devices and tubal ligation. For any services not provided by MSCS, referral systems are established with other health centres.

MSCS follows various monitoring processes to maintain high standards. Counselling, client relations, infection prevention and cleanliness are audited regularly, while feedback from staff and clients is sought. Factory management/owners and Marie Stopes Centre managers review monthly the service and discuss any issues or suggestions.

Factory owner cooperation

The scheme is only possible and sustainable with the full co-operation of the factory owners. The owners pay a monthly contribution on behalf of each worker. This amount is very small but high enough to cover costs and requires the careful linking of the number of visits by the satellite team to the number of workers. Too many satellite teams per worker would be too expensive; too few would have an impact on the quality of services provided.

Despite the efficient and economic systems put in place at MSCS for satellite service provision, the Factory Health Insurance Scheme represents a considerable financial outlay for the factory owner. Owners are aware, however, that this is offset by other financial benefits:

- Over 90% of Bangladesh's garment products are for export, mainly to European and North American buyers who are under increasing pressure from consumer groups, NGOs and civil society to apply more ethical standards to their modes of production. As a result of this pressure, international buyers have developed ethical codes of conduct with which factory owners must comply. The adoption of the Factory Health Insurance Scheme puts the factory owner in a far stronger position to be awarded international contracts.
- The workers' poor health is clearly linked to poor productivity levels in the factories. Studies have estimated that a medium-sized

factory of about 500 workers loses 237 workdays per month due to illness and an additional work-hour loss through the decreased effectiveness of workers suffering from ill health. Factories that have adopted the Factory Health Insurance Scheme have shown a marked improvement in productivity and job satisfaction among workers as a result of improved health. Absenteeism has also decreased, and medical services on site have reduced the time workers take off to visit often quite distant clinics. Another advantage is a lower rate of turnover of workers as job satisfaction and motivation increase, which translates into lower training costs and higher productivity levels.

Conclusion

The Factory Health Insurance Scheme has proved successful in involving the commercial sector by motivating local factory owners to finance health care. This is increasingly relevant, given the increasing global pressure on international buyers and factory owners to provide health services to their workers. It also offers an efficient and effective way of meeting the general health needs of over 55,000 of the poorest and most under-served women in Bangladesh.

The "buy-in" by local factory owners is key, as this has made the scheme virtually self-sustaining. Establishing similar commercial sector partnership projects is now a high priority for Marie Stopes' activities in other countries. Similar schemes are already being piloted in Latin America, and private sector participation in the social marketing of condoms is also taking place in Nepal. ❖

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Programme Feature

AIDS and sexual health in the world of work: Botswana's Jwaneng Mine experience

Lena Tumelo

Botswana's first AIDS case was diagnosed more than ten years ago. The epidemic was initially concentrated in urban centres but quickly spread to rural villages. Botswana has good roads and a highly mobile population with between two and three dwelling places per household. Currently, the overall HIV rate is estimated at 17% of the population; it is even higher for those aged 15-49 years. AIDS has become a major threat to the country's production and economic development; the average retirement age has been cut in half due to ill health. HIV/AIDS is now at the top of the national policy agenda and the government's budgetary priorities. Government, non-governmental and private sectors are working towards saving the country's population and economic growth. In this context, the Debswana Diamond Company has developed a comprehensive HIV/AIDS policy and strategy, backed by strong top management. Its Jwaneng Mine programme is a good example of the private sector's involvement in the fight against AIDS.

Jwaneng Mine lies on the fringes of the Kgalagadi Desert, one and a half hour's drive Southwest of the capital Gaborone. The mine has been operational since 1982, employing over 2000 workers, predominantly men. Jwaneng town, 11 km from the mine, has almost 17,000 inhabitants. It serves nearby villages and is a stopover for travellers and truckers from Namibia and South Africa. Testing for HIV started in 1989, when the local hospital noticed a high number of clinically suspicious cases. The following year a team from the hospital invited their Town Council counterparts to form the Jwaneng AIDS Committee, whose main functions included community mobilisation and advocacy, AIDS awareness and education, and monitoring HIV prevalence rates through hospital statistics.

Jwaneng Mine AIDS programme

The Jwaneng Mine AIDS programme started in 1992. Its structure resembles a tree with roots and branches joined together by the stem. The supportive roots comprise a pro-active management committee that provides the necessary support for effective management of HIV/AIDS in the workplace. A policy document helps to situate HIV/AIDS as a strategic issue and provides guidelines for programme implementation. Support groups and services act as channels for implementation by reinforcing messages, providing new information and assistance to the target populations.

The stem represents the day-to-day running of the programme: the HIV/AIDS Programme Coordinator coordinates the activities of the various support structures and ensures they are equipped with the necessary knowledge and skills. The coordinator also links up with national AIDS management structures, including AIDS NGOs.

The programme has three main branches:

1) **AIDS awareness** includes daily or weekly activities addressing specific issues for employees and mine catchment area communities. Theatre, music and drama are channels for disseminating information on behaviour change and company policies on HIV/AIDS. Internal publications carry features on AIDS and are distributed among employees and non-mine departments in Jwaneng. Finally, electronic boards carrying HIV messages are strategically placed to catch the attention of large populations.

2) **Education** comprises peer education programmes driven by line management in their respective working areas. Reading materials and videos are placed in the workplace under the supervision of peer educators. The mine's HIV/AIDS education and counselling drop-in centre also has reading materials and videos. Individuals and families can come in for educational sessions during working hours and may arrange with staff for after-hours sessions. The mine runs seminars and workshops with themes addressing different target groups for employees' families and local communities. Jwaneng Mine also conducts in-house training for all internal support

At Jwaneng mine, men seem to be more interested in (female) condoms than women...

structures, as well as for its partners in care (local health staff and community-based groups). The sexual health communication workshops are a good example of opportunities where peer educators can discuss human sexuality with confidence. The course addresses personal attitudes towards men and women and the (dis)advantages of traditional gender roles. The sessions between peer educators and their work mates have yielded clear behaviour change messages.

3) **Care** involves voluntary counselling and HIV-testing services for employees, dependants, contractors and the general public. Home-based care services (e.g., treatment of opportunistic infections) are provided in partnership with the local district health team. Debswana Diamond Company is Botswana's first company to offer anti-retroviral drugs to employees and their wives/husbands through a company subsidy.

Areas of collaboration and support

Apart from Jwaneng Mine's own AIDS programme, the mine has been collaborating with and supporting several other initiatives:

❖ *Youth involvement and community participation:*

- Adolescent reproductive health and sexuality workshops for mine employees' dependants and children in the local communities.
- Resource materials and technical support for schools in the catchment area.
- Peer education and counselling activities, including a vegetable garden in the centre's premises, supplying home-based care clients with food support. A counsellor also facilitates a support group for people living with HIV/AIDS.

❖ *Technical assistance and sponsorship:* transport, human resources training, materials and office facilities for local youth and adult groups. Also, non-mine workplace peer educators and community volunteers attend company-run courses free of charge.

❖ *Men, sex and AIDS:* training and motivational support from the *Men, Sex & AIDS team,* an innovative government programme aimed at fighting AIDS by addressing male sexual behaviour.

❖ *District Multi-sectoral AIDS Committee:* collaboration and partnerships with important stakeholders. Jwaneng Mine's General Manager, Chief Medical Officer and AIDS Programme Coordinator have been members of the Jwaneng District Multi-sectoral AIDS Committee since its inception. Jwaneng Mine has sponsored and participated in many of the committee's activities.

Female condom study

Jwaneng Mine has recently embarked on a female condom acceptability study among men and women. Greater acceptability of the female condom could increase the options for HIV/STI education and behaviour change. Most significant is that, to date, more men than women are interested in knowing about the condom. In Botswana's local communities, men usually decide when to have sex, with whom and whether to use a condom. The study reveals that traditional attitudes on male and female sexuality need to change: in order to curb the HIV epidemic, men must learn to share responsibility with their female partners and replace their traditional "macho" behaviour. Care and love can only be expressed through responsible sexual behaviour.

Success and failure: lessons learned so far

High levels of HIV/AIDS knowledge alone cannot reduce HIV infection rates and the impact of AIDS. The underlying cultural practices and gender roles that act as barriers to changing attitudes and practices, need to be part of our communication and education strategies. As attitudes and behaviour change requires 100% involvement and interest of the people concerned, Jwaneng Mine sees its employees as key stakeholders. Jwaneng Mine's experiences so far have shown that departmental HIV plans are best left with the unit managers, as they understand better the operations and needs in their area. A key lesson learned is that in order to deal with HIV/AIDS effectively, company management and trade unions must decide to sit on the same side of the table and agree when dealing with HIV/AIDS issues. Both stand to lose if their disagreements are not solved quickly enough to save human lives and that of the company. ❖

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Global Bulletin Board

❖ UNIFEM and ILO are developing a 2-year joint global programme on gender, HIV/AIDS and the care economy. The programme will focus on Africa during the first year and draw attention to the urgent need to increase sources of social protection, address income insecurity and improve access to health and basic social services that could alleviate the burden of care, especially for women. Research, training and advocacy work to raise awareness about unpaid care economy issues will be conducted in four pilot countries and involve employers, workers, governments and households. Support will also be given to develop gender-sensitive workplace policies and programmes. For more information, contact stephanie.urdang@undp.org

❖ A framework cooperation agreement between UNAIDS and the Regional Association of Airlines – Cote d'Ivoire (ARC-CI) will be signed in the near future with a view to involving regional airlines in the fight against HIV/AIDS in West and Central Africa. The agreement will involve resource mobilisation, awareness raising and workplace prevention programmes.

❖ HIV in the Workplace is a publication of the Gauteng AIDS Programme (South Africa), intended to support HIV/AIDS training. It specifies a framework and elements of an effective workplace response, as well as a best practice example from the Lesedi project For more information contact the author, Rose Smart, or Mokgadi Phokojoe at rsmart@netactive.co.za or Tel. +27-11-355.33.90/4.

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