Making HIV programmes work: The Heineken workplace programme to prevent and treat HIV infection 2001-2010
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Chapter 1:

Introduction:
HIV in Africa and the private sector.
1. HIV in Africa

It is commonly accepted that both the human immunodeficiency virus type 1 (HIV-1) and type 2 (HIV-2) epidemics originated in Africa. From there, the HIV-1 epidemic spread to Haiti and the communities of gay men in the US, where it was first described in 1981. Initially perceived as a disease exclusive to homosexuals, it soon became visible in the community of injecting drug users. Shortly afterwards, the first cases in haemophiliacs were found. When the first cases of ‘slim disease’ were described in Uganda, the problem started to appear as a global threat. It was then discovered that heterosexual transmission was contributing substantially to the total number of infected people and, certainly in Africa, it was the main mode of transmission.

Kinshasa, the capital of the former Zaire, was one of the places where the scientific community tried to understand the disease and its propagation. A surveillance project that was started by Projet Sida in 1984 estimated the incidence rate in Kinshasa to be 0.5-1 per 1000 per year at that time.

In 1986, the World Health Organisation (WHO) created the Global Programme on AIDS. The head of WHO, Dr. Hafdan Mahler, could ‘not imagine a worse health problem in this century’.

In recent years, the epicentre of the epidemic has shifted from central to southern Africa, where prevalence rates of more than 20% among adults are now reported in Botswana, Lesotho, and Swaziland. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 33.4 million people have HIV worldwide, of whom 22.4 million live in Africa. Every year, 2.0 million people die from the consequences of the infection, 1.4 millions of them in sub-Saharan Africa (SSA).

The HIV epidemic has an impact on different levels: that of the individual, the household level, the community and business level, and the nation as a whole; it is also considered an international security threat.

2. HIV interventions before 2001

During the first years of the epidemic, the focus of preventive interventions against HIV was on homosexual men and intravenous drug users, since these were the most visibly affected groups in industrialised countries. Later it became clear that the socio-demographic characteristics of infected people in Africa were entirely different, with heterosexual contact being the most frequent route of transmission. The following
paragraphs describe and compare HIV prevention and treatment efforts in the industrialised world and in low-income countries during the early years of the epidemic.

### 2.1. Prevention and treatment in the industrialised world

The early prevention efforts were targeted at the affected groups most visible in industrialised countries. The main message was that sexual behaviour in these groups had to change. Haemophiliacs and others infected by blood products were not subjected to this message, since they are at risk from blood transfusions and not behaviour.

The community of men who have sex with men (MSM) was an important actor in the preparation and dissemination of prevention messages, and its tight-knit social network contributed to the prevention successes of these first years. As knowledge increased as to the ways of sexual transmission, the messages became more and more specific. The appeals for behavioural change focused on ‘safe-sex’ messages, and the campaigns led to a decline in HIV seroconversion rates among MSM in industrialised countries.\(^\text{11}\)

Condoms proved effective to stop sexual transmission\(^\text{12}\) and became an essential part of the safe sex messages in the public information campaigns, which took hold in the later 1980’s in many countries.\(^\text{13}\) Social marketing of condoms started with Population Services International in 1987 in Zaïre.\(^\text{14}\)

The discovery of the human immunodeficiency virus (HIV) in 1983\(^\text{15}\) and the subsequent development and licensing of a test to detect antibodies in the blood\(^\text{16}\) made it possible to assure the safety of blood transfusions. Subsequently, tests were developed for the measurement of HIV-1 viral load, based on the detection of viral antigens like p24.\(^\text{17}\) Later assays were developed for the detection of viral RNA (copies RNA per ml), based on various molecular amplification techniques.\(^\text{18,19}\) These assays enabled measurement of the effects of various new drugs and drug combinations that were developed against HIV-1.

The positive effects of zidovudine (ZDV or AZT), a nucleoside analogue reverse transcriptase inhibitor (NRTI), were first described in 1987,\(^\text{20}\) but resistance to this drug appeared rather quickly.\(^\text{21,22}\) Other NRTI drugs followed: didanosine (ddI) in 1989, zalcitabine (ddC) in 1991, lamivudine (3TC) in 1993, stavudine (d4T) in 1994. A new class of drugs were the protease inhibitors (PI) like saquinavir; approved for use with
HIV patients in 1995, and a third class was introduced with nevirapine, the first non-nucleoside reverse transcriptase inhibitor (NNRTI) in 1996. The latter drugs, discovered at the end of the 1980’s, would lead to rapid resistance development when used in monotherapy, but they proved to be essential for rapid and efficient viral suppression when combined with two NRTIs. The combination of a drug with low genetic resistance with two other drugs became the guiding principles in treatment guidelines. Combinations of two drugs proved more effective than zidovudine mono-therapy, and shortly before the International AIDS Conference in Vancouver (1996), treatment with three drugs (PI, NNRTI and NRTI in different combinations) proved to extend considerably the period of viral suppression and to reduce mortality. This progress induced optimism that the disease could be cured or at least reduced to a chronic rather than a lethal disease. Due to the use of tritherapy, the number of AIDS deaths in the US started to drop in 1996.

In 1994, performance of elective Caesarean section was described as a way to reduce mother-to-child transmission (MTCT) of HIV infection. Also in 1994, a pharmaceutical intervention to interrupt MTCT was shown to be effective. However, this chemoprophylaxis was complicated and necessitated long-term and intravenous use of zidovudine.

In low-income countries, the situation proved quite different, and options for both prevention and treatment remain far more limited. The risk-group prevention messages that led to good results among MSM in the industrialised world appeared inappropriate for the developing world, where whole countries were affected and their people had to be targeted with understanding of their different social, economic, and cultural backgrounds. Most important, HIV in Africa is mostly transmitted through heterosexual contacts, and the position of African women rarely empowers them to take control of their own sexuality, for example through using the female condom. Mass education campaigns succeeded in increasing the knowledge of the public about AIDS, but they probably had little impact on individual behaviour if not combined with other interventions.

Condoms will prevent transmission of HIV when correctly and consistently used. However, in many cultures and particularly in Africa, it is the decision of the male partner to use a condom, leaving women in a difficult position. The effectiveness of condoms to reduce
infections in a population is compromised by the vulnerable social position of women in relationships and society as a whole.\textsuperscript{36}

A core group singled out to receive HIV prevention messages in resource-poor settings were the commercial sex workers (CSW). They act as an incubator for the epidemic, while men having sex with them serve as a bridge to spread the infection to the general population.\textsuperscript{37,38} Targeting CSW is more effective than targeting married women, whose husbands may be sources of infection.\textsuperscript{39}

After sexual transmission, mother-to-child transmission is the second most important route for HIV spread in resource-poor settings. Zidovudine chemoprophylaxis was shown to decrease MTCT in 1994, but it could not be expanded to poor countries because of its complexity. MTCT prevention in poor countries only became feasible with the development of less complex, short-course interventions notably the use of a single dose of nevirapine for mother and child.\textsuperscript{40,41}

Blood transfusion continues to be an important mode of HIV transmission in resource-poor settings. In most African countries, tests to assure blood safety were only slowly introduced, and the early tests were not adapted to the realities of remote areas.\textsuperscript{42} For example, in towns without electricity or running water the relatively complex enzyme-linked immunosorbent assay (ELISA) cannot be used.\textsuperscript{1} The objective of safe blood became more attainable when risk assessment questionnaires were combined with the use of rapid HIV tests in selection of donors.\textsuperscript{43} The widespread practice of paid donors nevertheless continues to complicate the problem.\textsuperscript{44,45}

Finally, many cases of HIV are transmitted by unsafe medical practices involving soiled needles, unsterilised razor blades, and dirty medical equipment. Their number is unclear, but clearly, these practices contribute to the epidemic in less developed countries. Re-use of infected needles in cash-strapped health services is a common practice.\textsuperscript{46}

The progress on HIV treatment with highly active antiretroviral therapy (HAART), as announced at the 11\textsuperscript{th} World AIDS Conference in Vancouver of 1996, was eagerly followed by those patients in Africa who knew their HIV-positive status. However, HAART was still no solution for them, as the drugs were prohibitively expensive and not available in Africa. The price of combination therapy with protease inhibitors was about $10,000 per person for one year,\textsuperscript{47} a price truly unaffordable for the large majority of Africans. So although most of the world’s HIV-infected persons were living in sub-Saharan Africa (SSA),

\textsuperscript{1} Angola 1990 EU safe blood project. Personal experience.
access to therapy was virtually absent on that continent.

The 12th AIDS conference, in Geneva in 1998, further dampened expectations. Despite the conference theme of ‘Bridging the Gap,’ the high price of HAART effectively kept treatment out of reach for the poor people on the planet. In 2000, at the 13th World AIDS Conference, the need for access to these life-saving drugs for resource-limited countries became apparent to a wider public. Set in Durban, South Africa, it was the first World AIDS Conference to be held on the hardest hit continent. Africa’s plight remained in focus throughout the conference.

Influenced by treatment activists and also the announcement that generic manufacturers would start to produce cheaper versions of brand-name drugs, UNAIDS, WHO, the United Nations Children Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank, and five (later seven) research-based pharmaceutical companies2 formed the Accelerating Access Initiative48 (AAI) in May 2000. Through the AAI, antiretroviral drugs were offered to people living in resource-poor settings at approximately 10% of their price in the industrialised world. The uptake of the offer was slow during the first months: about 12,000 patients used one or more drugs obtained through AAI by the end of 2000, and some 25,000 by the end of 2001. Later, the AAI gained momentum and, as of October 1, 2007, approximately 830,000 patients in developing countries were taking one or more medicines supplied at preferential prices by an AAI company.50

Another initiative took off in 2001: the World Bank Multi-Country HIV/AIDS Programme (MAP). Envisioned as a 15-year commitment, it offered African countries substantial long-term funding to scale up their HIV/AIDS programmes.51 Over the next few years, other worldwide initiatives followed:

The Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), was officially created in 2002 and has already distributed $11.4 billion for more than 550 in 136 countries. About 61% of the funding has been used for HIV/AIDS programmes, and 2 million people are receiving GFATM-financed antiretroviral treatment.52

The Clinton HIV/AIDS initiative (CHAI) was established in 2002 to negotiate lower prices for antiretrovirals and to improve the national health care systems required to deliver crucial medicines.53

In 2003, the US government announced the President’s Emergency Plan for AIDS Relief (PEPFAR), focusing on 15 countries and supporting

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2 Abbott Laboratories, Boehringer-Ingelheim, Bristol-Myers Squibb, GlaxoSmithKline, Gilead Sciences, Merck & Co., Inc. and F. Hoffmann-La Roche.
prevention, treatment and care. It has helped provide antiretroviral treatment to 1.4 million individuals.\textsuperscript{54}

3. HIV and the corporate business sector

3.1. Macroeconomic impact

In areas of high HIV prevalence, the infection and the ensuing decreased productivity and increased costs will reduce the international competitiveness of local businesses. When no longer competitive, they may cease operations, leading to a generalised economic downturn in the region. In this sense, the cost of HIV can be considered a payroll tax: companies pay direct costs for care of sick employees and higher benefits while also paying the indirect costs of lower productivity.\textsuperscript{55} Apart from these internal effects, companies that are producing and selling fast-moving consumer goods will see the effects of the epidemic on their consumer base. To summarise the demand-side effects:

- The purchasing power of customers will be eroded: disposable income will be used to buy health care, including drugs, and income will diminish due to sickness.\textsuperscript{56} This will mainly affect the poorest segments of society.\textsuperscript{57}
- Untreated HIV infection leads to higher mortality and shrinks the consumer base, especially for products aimed at young adults.\textsuperscript{58}

Estimating the impact of HIV on developing economies proved to be very difficult, and opposing conclusions were reached.\textsuperscript{59,60} Some economic studies concluded that the macroeconomic impact would be limited: low wages, easy recruitment of unskilled workers, and adapting contracts of workers would help to cap the cost.\textsuperscript{61} A study in South Africa estimated that growth of gross domestic product (GDP) would diminish from 4\% to 3.2\% annually, while a study in Botswana predicted a drop to 1.5–2.5\% from 5.5\% annually.\textsuperscript{62} Impact on total GDP was in general estimated to lead to a reduction in growth rate of 0.5\% to 1.5\% over a 10- to 20-year period.\textsuperscript{63} Impact on GDP per capita appeared smaller since important mortality and reduced fertility would reduce population growth, in effect reducing the denominator.

Recently it has been argued that these GDP calculations overlooked several factors. The HIV epidemic reduces foreign direct investment (FDI),\textsuperscript{64} and high mortality leads to disruption of organisations.\textsuperscript{65}

Also, GDP changes do not accurately reflect changes in the situation
at household level. Since distribution of wealth is often unequal, particularly in developing countries, poorer households will be proportionally more affected. Demand-side effects will include lower purchasing power. Individual behaviour and decisions will change as well: children might stop going to school if one of the parents dies. The ability of individuals to pay for long-term benefits like health insurance and pensions further decreases.\textsuperscript{66} Measuring and capturing only the main aggregate economic variables will miss many of the microeconomic effects of HIV/AIDS.\textsuperscript{67}

Papers that examined methodologically sound studies showed no conclusive evidence for a large negative impact; nor was conclusive evidence found for the opposite.\textsuperscript{68} This shows why it has proven difficult to use exclusively economic data for strategic planning: the evidence is not convincing. More empirical studies, using real life data in various economic and epidemiological settings, are needed to elucidate the impact of HIV on economic growth.

### 3.2. Impact on the workplace

Businesses are part of the society in which they operate. Problems that threaten the social fabric greatly influence the economic environment and the economic operators.

The workplace is a place of interactions amongst many types of people. If some persons believe that HIV can be transmitted by shaking hands, sharing of combs, or being close together, they will also believe that HIV can be transmitted in the workplace. If people believe that an infected co-worker can infect them through day-to-day casual contact, they might display discriminatory behaviour. If managers are no better informed than the staff on the work floor, they will mirror their behaviour and discriminate as well. In 1987, at the 42\textsuperscript{nd} Session of the United Nations General Assembly, Jonathan Mann, the leader of WHO’s Global Programme on AIDS, described the social reaction and response to HIV as the ‘third epidemic’ that would follow the HIV and the AIDS epidemics.\textsuperscript{69} He feared that ‘this epidemic will lead to moral judgments, stigma, discrimination, and even ostracism.’

As several countries began to adopt non-discrimination laws, an important theme was how businesses had to deal with HIV-infected employees.\textsuperscript{70,71} Legal obligations, discrimination, and stigmatisation were key topics of debate. The International Labour Organisation (ILO) and the WHO issued a first consensus statement in 1989.\textsuperscript{72} In that statement and in general, HIV prevention, treatment, and care were
left to the government in most cases. During those first years, most African employers did not consider they were able to contribute to solutions.

When HIV prevalence increased and related costs started to appear on company books, some employers changed their benefits package or began to rely more heavily on contracted labour instead of permanent employees. These steps increased the burden on governments even further.

In 1997, a World Bank study concluded that the HIV epidemic would have a major impact on business operations if two conditions exist: HIV prevalence is high, leading to a high rate of sickness leave, and the resulting high attrition of employees adversely affects operational costs and performance.

Businesses started examining what the effect of HIV would be if prevalence became high. Unlike other infectious diseases (malaria, diarrhoeal diseases), HIV primarily affects young and middle-aged adults. This group is most economically active and thus most important to African businesses. Not only the poor and unskilled, but also the people with higher skills, knowledge, and income (managers, technically skilled people) would be at risk. In the era of globalisation, in order to compete effectively, African companies facing HIV problems would also face challenges to reduce costs, raise productivity, and improve quality.

The impact of the HIV infection on business can be categorised on different levels:

- Sickness will lead to absenteeism and reduced productivity of the worker.
- Employees will seek more medical care when infected, increasing the company’s health care costs.
- Deaths will lead to increased turnover and a constant need to train and integrate new employees.
- Funeral benefits, training costs, educational costs will rise.
- The ongoing process of colleagues and friends falling ill and eventually dying will lower morale.

Studies looking at the economic impact on individual businesses were rare during the first ten years of the epidemic, but figures on mortality were easier to come by. When the impact on individual companies was calculated, it was estimated that costs would increase from 0.5% to 15% of the total labour costs. Other studies yielded
lower estimates. In either case, a major part of these expenses would be medical and health care costs. This meant that the costs were higher if a company had a comprehensive health care programme.

### 3.3. The response of businesses

**The front-runners: multinationals and large companies**

When and where prevalence of HIV increased, it became clear to some businesses that their engagement had to go beyond the issues of non-discrimination and non-stigmatisation. The workplace is a captive environment and offers possibilities of education and communication with the target group of workers. Business leaders became alert to the possible loss of key workers or managers, the effect that HIV would have on life expectancy, the increasing cost of dealing with a high HIV infection rate in the workforce, etc. At that time, most of the activities that business undertook were aimed only at employees; initiatives targeting spouses, dependents, customers, and suppliers were rare.

Amongst the businesses that reacted, multinational companies and companies with well-structured human resources and health departments were the first. A typical comprehensive workplace package would include:

- Establishment of an HIV/AIDS Committee.
- Condom provision: making condoms available to workers at little or no cost.
- Sexually transmitted disease (STD) control: rapid diagnosis and appropriate treatment of sexually transmitted infections.
- Information Education and Communication (IEC) campaigns: to educate the workers on HIV and other STD.
- Voluntary Counselling and Testing (VCT) campaigns: to detect HIV-infected persons by encouraging voluntary use of counselling and testing services.
- Antiretroviral treatment: access to antivirals from quality health care providers can be arranged with on-site clinics, private clinics, and local insurance operations.

In 1997, UNAIDS distinguished four types of company responses to HIV/AIDS:

- Safeguarding direct commercial interests
- Contributing to the protection of other stakeholders
- Acting philanthropically
- Adopting a leadership role
These four responses involve activities in the outside world. Surprisingly, UNAIDS did not mention in-company responses, although they were actually more opportune, particularly in the early years of the epidemic. Regarding internal responses, companies can combine two basic strategies: prevent HIV infections and, when people are infected, try to mitigate costs associated with treatment and care. The simple business message would be, ‘Zero new infections and zero deaths’. Other, less positive ways of internally dealing with HIV can include:

- Replacement of permanent employees by contract workers.
- Reductions of benefit packages or shifts from a defined benefit to a defined contribution system.
- Seeking alternatives to labour intensive production processes.
- Laying off the HIV-positive workers.
- Considering only HIV-negative persons for hiring.
- Referral of HIV-infected employees to the public sector health systems for care (known as ‘crowding out’).

These more perverse coping mechanisms are at odds with fulfilling the principles of corporate social responsibilities.

For large companies in South Africa, one paper described the following incentives to take action:

- **Legal requirements**: often result in pro forma compliance.
- **Voluntary regulation**: required by the image of a ‘good company.’
- **The business case, or cost-benefit analyses**: prone to variable interpretations, dependent on the assumptions made for their modelling.
- **Social pressure, particularly inter-businesses peer-pressure**: can be positive or negative.
- **Visibility**: increased prevalence makes HIV damage more visible, shifting concern from occupational health to basic individual and public health.
- **Internal agents**: an internal agent or group can start a corporate response even in the absence of a strategic company policy; the influence and prestige of this agent will then determine whether a company is a rapid mover or a slow mover.

The extent to which companies in Africa have taken positive steps varies greatly. Some businesses are acting as global leaders and attracting much media attention. However, when aggregated numbers are compiled for all businesses and enterprises, the overall result is less positive. Most observers agree that initially the reaction of
businesses to the HIV epidemic in Africa was slow. The first company policies only appeared in the early nineties, 10 years after the emergence of HIV. In Zimbabwe in 1991, only a third of the companies had an HIV policy; more than 20% considered that screening before or after employment was justified, and 40% felt that pre-employment screening could protect company interests. The main reasons for companies to take action appeared to be: the welfare of employees with HIV/AIDS (in 46% of the cases), employee safety and prevention (33%), legal implications (24%), and health care costs (17%).

In the 1990’s, non-governmental organisations (NGO), with support of international donors, played a leading role the first HIV prevention activities. The public sector was considered the primary NGO partner; the private sector was not involved in those early days.

At the turn of the century, however, several multinationals started to move. In fact, for a couple of years they became antiretroviral pioneers in several countries in Africa. Amongst those front-runners one can mention Daimler-Benz, Anglo-American, and BMW in South Africa, Debswana in Botswana, Alucam-Pechiney in Cameroon, and Heineken in central Africa and Nigeria.

Small and medium companies

In contrast to a few leading multinationals, the African small and medium enterprises reacted slowly or not at all. Their key difficulties included infrastructure and human resources, which appeared inadequate to pay sufficient attention to HIV. Many small enterprises were not directly confronted with HIV cases, because of low numbers of employees (although losing one key person can be more dramatic in a small company). In addition, it proved more difficult to create workplace HIV/AIDS committees because of small staff, lack of confidentiality, stigma, etc.

The World Economic Forum business survey in 2004 concluded that companies with over 500 employees had higher levels of ‘current concern’ on the HIV epidemic than small firms. In part, this might reflect the greater likelihood that a large firm’s workforce or customer base will contain individuals infected with HIV/AIDS.

Many of Africa’s small to medium companies are suppliers to the multinationals and other large companies. In order to bring smaller companies along, some larger companies have created HIV-related programmes within their supply chains.
3.4. Businesses getting organised

Over time, various organisations emerged that sought to bring together companies committed to the fight against HIV/AIDS. At the same time, NGO’s developed expertise in assisting private companies to improve their workplace programme. Some of these efforts are briefly described below.

3.4.1. Business organisations and multilateral organisations

The Global Business Coalition (GBC)

The GBC is probably the most visible and important business organisation bringing together international companies. An outgrowth of the G7 meeting in Edinburgh in 1997, it was created as the Global Business Council on HIV/AIDS to promote public/NGO/private partnership. Currently the coalition counts more than 220 member companies, mostly from the Americas and Europe.

The GBC seeks to represent the ‘good’ side of business and therefore uses case studies and best practices to illustrate the efforts of the member companies and the business sector in general. The organisation publicises efforts made by private companies to help the fight against HIV/AIDS. For example, businesses can introduce nominations for yearly awards for prize performers in the fight against HIV; the award jury is constituted of peer companies.

The disadvantage of using case studies is that they highlight the performance of some excelling companies but fail to give an overall view of the reaction of businesses. However, with only 220 member companies (including 27 in Africa in only 5 countries), the coalition cannot represent the whole global business sector.

The GBC has published business surveys it conducted amongst the member companies, providing examples of positive business actions. The 2006 survey covered 75 companies and was meant to establish a baseline. The 2008 follow-up report covered 83 companies and focused on HIV/AIDS, tuberculosis, and malaria. The surveys used an index to measure the alignment of the surveyed businesses with the Best Practices AIDS Standard developed by the GBC. A change in indicators between surveys makes comparison difficult, but in both reports, ‘Stakeholder partnership’, ‘Prevention education and behavioural change,’ and ‘Non-discrimination’ are the three most often mentioned areas of the business response. In recent years, the GBC has initiated projects that foster cooperation among business, NGOs, and the public sector.
The Global Health Initiative (GHI) of the World Economic Forum

The World Economic Forum, best known for its annual Davos conference and the regional meetings, started the GHI in 2002 in response to an appeal by Kofi Annan, then UN Secretary General. Its mission is ‘to engage businesses in public-private partnerships to tackle HIV/AIDS, TB, malaria’ and build better health systems. The emphasis of GHI is on disseminating information amongst businesses, producing toolkits, and compiling learning from practice.

Initially, the World Economic Forum provided the focal point for the private sector delegations to GFATM, Roll Back Malaria, and Stop TB and organised elections for the private sector representatives for the coordinating board(s) of these partnerships. The GHI is now the focal point for the last two. Since 2005, the GBC is coordinating the private sector delegation for the GFATM. In 2004 and 2006, the GHI organised business surveys to question businesses globally on HIV, tuberculosis, and malaria. The 2006 survey covered 1,653 SSA firms and demonstrates increasing percentages of companies with a written HIV/AIDS policy (27% in 2004; 38% in 2006). Of the SSA companies with a policy:

- 69% provide information on HIV/AIDS
- 57% provide condoms
- 43% provide VCT
- 26% provide antiretrovirals
- 26% address the issue of discrimination in promotion, pay, and benefits

The figures in these surveys tend to obscure the unequal reaction of businesses, especially those from South Africa as compared to those from other African countries. For example, in Nigeria, a survey of manufacturing firms found that only one in three is taking action to prevent HIV/AIDS amongst employees.

National business coalitions against AIDS

In several African countries, businesses have joined forces to improve the way businesses deal with HIV/AIDS. These coalitions typically advocate for business action, help mobilize business efforts, ensure a coordinated and nationally aligned business response, and facilitate sharing of best practices between businesses. Almost all African countries have at least one business coalition. How they function and what they achieve is very unequal and differs from country to country.
The ILO signed the UNAIDS charter in 2001 and thus became a co-sponsor of UNAIDS, created five years earlier. In its position as a tripartite organisation of governments, employers, and employees, ILO attempts to manage and mitigate the workplace impact of HIV/AIDS while helping to prevent the spread of the infection. In 2001, it published a code of practice titled ‘HIV/AIDS and the world of work’. Experts that were mandated by governments, workers, employers and international organisations elaborated these guidelines. The guidelines cover the following areas:

- Prevention of HIV/AIDS
- Management and mitigation of the impact of HIV/AIDS on the world of work
- Care and support of infected and affected workers
- Elimination of stigma and discrimination

IFC, the private sector arm of the World Bank, considers HIV a threat to sustainable development. “IFC against AIDS” engages the clients of the IFC to understand the HIV/AIDS business case and helps them to set up a workplace HIV/AIDS programme. The implementation of these programmes can be done by the client company, but IFC against AIDS can also identify NGO’s to assist on the implementation side. Using a ‘Roadmap for Action’ based on roadmaps developed by Unilever and Heineken for their African companies, IFC against AIDS defines the three pillars of its programme as Guidance, Training, and Development and Research. The training pillar gives mainly attention to small and medium-sized enterprises.

Some of the large companies in Africa have been trying to foster HIV workplace programmes in their supply chain companies, thereby hoping to multiply the effect generated by business in view of the generalised HIV epidemic. To create an effective supply chain intervention, several conditions need to be fulfilled:

- The supply chain company needs to have a structured approach to human resources.
- It needs to see its own interest in developing an HIV policy.
- The tasks should be assigned to a designated individual in the company.
- The supply chain company should bear part of the costs; otherwise it is likely that all costs incurred will be borne by the ‘mother company’
An example of a successful combination of a corporate workplace programme and a supply chain programme is described in paragraph 3.5.3.

3.4.2. Nongovernmental organisations supporting businesses

Gesellschaft für Technische Zusammenarbeit (GTZ) and AIDS Control in Companies in Africa (ACCA)

GTZ, the operational branch of the German development cooperation, has long been active in establishing HIV-related workplace programmes in Africa. Its model is based on the concept of public-private partnerships, which was initially developed in pilot projects in South Africa (Daimler Chrysler) and the Democratic Republic of Congo (Bralima-Heineken). As early as 2002, the first successes leading to increased awareness of HIV/AIDS and decreased mortality rates became apparent in these projects, according to GTZ.

Its subsequent ACCA initiative took the concept further and applied it to medium-sized companies in a variety of economic sectors. Since April 2004, ACCA has cooperated with business associations in order to sensitise their members to the need for HIV/AIDS workplace programmes. ACCA provides support in the following areas:

- Advocacy: arguments and tools for use in sensitising business associations’ members.
- Service delivery: information and education materials, training of peer educators and human resource managers, reaching out to smaller enterprises, negotiations for a common AIDS fund, etc.
- Application for international funding: membership of Country Coordinating Mechanisms, the gateway to GFATM funds
- Monitoring and evaluation, including cost-benefit analyses.

PharmAccess Foundation

PharmAccess was created in 2000 to increase the accessibility of lifesaving antiretroviral treatment in Africa. From the start of the Heineken Workplace programme in 2001, PharmAccess was the essential partner, providing the expertise and credibility needed to develop guidelines, train the health workers, perform the gap analysis to create appropriate conditions for HIV treatment, and to assess and to assure the continuous supply of medication. Even today, PharmAccess’ experts are monitoring the quality of the treatment programme. Several aspects of this
cooperation will be illustrated in the next chapters.

Based on its Heineken experience, PharmAccess expanded its activities to workplace programmes with Celtel/Zain, Shell, the Netherlands Development Organisation (SNV), the Royal Netherlands Embassies in 17 countries in Africa, the Tanzanian Defence and Police Forces, and other entities.

In 2004, the organisation broadened its focus from AIDS alone to health care in general. It developed innovative programmes, with private voluntary health insurance as its central model. PharmAccess pioneered private health insurance programmes in Namibia, which resulted in the establishment of the first Risk Equalization Fund for HIV/AIDS in Africa. Based on the lessons learned from this experience, PharmAccess co-founded the Health Insurance Fund. In 2006 the Fund received a multimillion grant from the Netherlands Ministry of Foreign Affairs to support health insurance plans in four African countries for a period of six years. PharmAccess also initiated the development of a new Investment Fund for Health in Africa, which was established in 2007 in collaboration with three large Dutch insurers and three Dutch multinationals. In 2009, PharmAccess established the first Medical Credit Fund for physicians in Africa.

Its decision to embed HIV/AIDS programmes in a general healthcare programme to reinforce health service delivery is innovative and reflects its concern for the poor condition of most health services in less developed countries. Currently PharmAccess’ attention is focused mainly on sustainable financing and quality medical performance.

3.5. Description of some workplace programmes

This thesis presents studies of one of the pioneering multinational workplace programmes in Africa: the programme of Heineken. Here, a brief summary is provided of the activities of other players in this field. As few peer-reviewed articles on these activities have been published, most of the information comes from the companies themselves.

3.5.1. Anglo American

This mining company with a vast workforce in South Africa (> 100,000) started HIV prevention programmes in the 1980’s. The ambition for the current workplace targets is huge: zero new infections, zero employees falling sick or dying, and
zero babies born HIV-positive in employees’ families. The prevention programmes and the VCT (voluntary counselling and testing) are the key entry points to the programmes. The uptake of VCT was low during the first years (10%, when tested in 2001), but increased later (to 31% in 2005 and 63% in 2007).\(^\text{114}\) For treatment, Anglo has an HIV disease management programme (DMP). The standardisation of guidelines, management of the data, and the evaluation are performed by an external partner (Aurum Institute), while the drugs are provided by company clinics or by contracted doctors. Anglo has 70 delivery sites for antiretrovirals in South Africa. Its DMP started in 2002 and is currently very successful: 94% of those on treatment by the end of 2007 were sufficiently fit to continue their normal work. Absenteeism has fallen from approximately 7 days per HIV-infected worker per year to 2 days per worker per year. Still, there are high attrition rates, approximately 30%.\(^\text{115}\) Attrition is mostly explained by defaulting on treatment, leaving the company, or death. If HIV-infected employees participate in a contributory health insurance arrangement, their family members are provided general medical care.

The company has developed a community HIV/AIDS partnership programme, now running since 2003, and has contracted an NGO (Love Life) to organise prevention activities for the youth community.

3.5.2. Debswana Diamond Company\(^\text{116}\)

This company, owned for 50% by the Government of Botswana Government and for 50% by De Beers Centenary AG has three diamond mines in Botswana. Minerals are the largest single component of revenues of the Government of Botswana (over 45%). Debswana started AIDS education and awareness programmes in 1988/89. Already in 1991 full time AIDS programme coordinators were appointed in two of the mines. The impact of HIV morbidity and mortality started to show from 1996 onwards. This was easily observed since the company has its own hospitals. In 1999 almost 60% of the deaths in the workforce were AIDS-related.

When a prevalence study using saliva testing was undertaken in 1999, 28.8% of the 5261 tested employees were HIV-positive. This was very similar to the prevalence in the general population in Botswana at that time. Apparently, AIDS education campaigns sponsored by the company had had no major impact.

After compilation of an audit report undertaken by company personnel, working groups were established and this led to the
formulation of a company HIV strategy. The strategy included provision of antiretroviral drugs, even though it was estimated that ARV costs would comprise 11.9% of the total payroll. Requiring employees to contribute 10% of the treatment costs could reduce the payroll proportion to 10.7%. This requirement was dropped in 2003.

The provision of ART started in May 2001, and each employee and one legally married spouse per employee were eligible. Initially, children were not eligible for the treatment programme. In 2006 this policy was changed and up to three children per employee were eligible for ART.117

The ARV treatment and supervision was outsourced to the private sector in South Africa (Aid for AIDS). Debswana negotiated reduced drug prices with some pharmaceutical companies.

The annual expenses on the HIV workplace programme are $1.9 million, of which $1.1 million is for treatment of more than 700 registered HIV-infected beneficiaries.

Contractors to Debswana are required to adopt standards of quality assurance with regards to their own policies for their workforce in relation to HIV/AIDS: 

\textit{HIV/AIDS compliance}.

In 2005 Debswana set up an HIV/AIDS operating Committee that aims to encourage best practices between operations in Botswana, Namibia, South Africa, and Tanzania. This committee is chaired by the de Beers Board Director.118

3.5.3. Coca Cola and the Coca Cola Foundation

The Coca Cola Company was, apart from the pharmaceutical sector, probably the company most criticised by treatment activists on its HIV/AIDS practice. Action groups protested at a GBC award meeting in 2002 in New York. During the World AIDS conference in Barcelona, in the same year, a huge inflatable bottle of Coke bore the slogan ‘Coke Kills’. The company replied to these accusations by stating that most Coca Cola companies in Africa are run by independent bottlers, whose employees were not Coca Cola employees. As the access to antiretrovirals was a medical benefit only for employees of Coca Cola, the employees of independent bottlers had no right to the ARV’s. Nevertheless, probably as a result of activist and consumer pressure, a solution was sought with the Coca Cola Foundation, the primary international philanthropic arm of the company.
The employees of the bottlers who operate with Coca Cola on a franchise basis are called ‘associates’. Some 90,500 of these associates exist worldwide, of which more than 60,000 live in Africa. Since 2003, the Coca-Cola Africa Foundation has funded 50% of a HIV/AIDS programme launched for the bottlers. It combines prevention, awareness, and treatment (including free condoms), confidential VCT for associates, and their dependents. Antiretroviral drugs are free for the patients who need them.\footnote{A Coca Cola HIV/AIDS charter governs the African policy with implementation handled through several partnerships, notably ILO and Population Services International (PSI). Of 44 bottling partners [in Africa], 26 took up Coca Cola’s offer. The rest, including SAB-Miller (5 bottlers) and Heineken (4 bottlers), did not receive any co-funding and financed similar programmes for themselves. In 2006, the Coca Cola Foundation spent $662,000 on its programme in Africa, where 13,740 associates took an HIV test, and 1115 associates received antiretrovirals. At the beginning of 2007, the programme was transferred from the Coca Cola Foundation to the departments of human resources at the Coca Cola Company in Africa. This was meant to bring it closer to the heart of each division. While being seen during those first years as a corporate social responsibility, it has now become part of local business operations. Perhaps due to this change, it is hard to find aggregated information on the Coca Cola HIV/AIDS workplace programmes for the period after 2006.}

\subsection*{3.5.4. Unilever Tea Kenya}

Unilever Tea Kenya is one of the largest commercial enterprises in Kenya, providing employment to more than 20,000 people. It owns 20 tea estates and 8 factories that produce an average of 32 million kg of tea per year.

As part of the GHI’s ‘Beyond Big Business’ programme, Unilever has extended its own workplace programme to the employees of 75 small and medium-sized suppliers.\footnote{Information on HIV/AIDS is provided by specially trained co-workers, since the peer approach is deemed more successful than education efforts implemented by management or outside experts.} The programme is a public-private partnership between Unilever, GTZ, and the government of Kenya. HIV treatment is funded by PEPFAR and executed under a public-private partnership with the US Army Medical Research Unit. It is a ‘special foreign activity’ of the Walter Reed Army Institute of Research, a research facility managed by the US Department of Defence.\footnote{The programme is a public-private partnership between Unilever, GTZ, and the government of Kenya. HIV treatment is funded by PEPFAR and executed under a public-private partnership with the US Army Medical Research Unit. It is a ‘special foreign activity’ of the Walter Reed Army Institute of Research, a research facility managed by the US Department of Defence.}
The Zain company (formerly Celtel) is an important mobile telephone operator in Africa. It has operations in 16 African countries and over 8,000 employees. Its ongoing workplace programme aims to ‘keep HIV-negative employees and dependants negative and keep HIV-positive employees and dependants healthy and productive.’ The core components are prevention and awareness of HIV/AIDS and access to free, confidential, and high-quality care and treatment for HIV-positive employees and their dependents. Treatment is covered by a group-wide health insurance plan. To realise this programme, Zain is collaborating with PharmAccess Foundation to roll it out gradually over all the sites of operation. In 2007, three years after the start, 40 clinics had been contracted, and 46 medical doctors had received training in the use of antiretrovirals. The programme is now providing access to quality HIV/AIDS care and treatment at most of its sites.

Heineken is an international brewing group with its headquarters in the Netherlands. Its origin dates back to 1864, when the first Heineken brewery opened in Amsterdam. Since the beginning of the 20th century, the group has been continuously expanding its operations in different countries on all continents. The countries of Central Africa and West Africa have been important for the Heineken companies for several decades. In the Democratic Republic of the Congo (DRC),...
the group has been operating since 1935, while other brewery sites in Central Africa (Rwanda and Burundi, Republic of Congo) joined the group in 1971. In Lagos, Heineken opened Nigerian Breweries in 1946, in cooperation with Unilever UAC; it acquired majority control at the end of the 20th century. In Sierra Leone, a brewery is run in partnership with Diageo (Guinness), the British spirits and beer group. Construction of a Heineken brewery in South Africa was finished in 2009. Until about 1997, the Heineken breweries in Africa were very labour-intensive, but an upgrade of the production tools took place, and automation has diminished manual labour. Over these last ten years, the number of employees in Africa has decreased steadily, from around 10,000 in the year 1997 to the 6,250 women and men working for Heineken Operating Companies (OPCO’s) in the beginning of the year 2008.

4.2. Heineken and health care in Africa

In 1989, Heineken established its own medical programmes in Africa. The beneficiaries of these programmes include spouses and children; in some OPCO’s they also include retired workers and their families. The target population decreased from over 40,000 in 1997 to about 30,000 by 2008.

The choice for Heineken to become a health care provider was not an immediate one, but rather a consequence of the decline of the public health care services in the African countries where Heineken operated. In each of these countries (DRC, Congo, Rwanda, Burundi, Nigeria, Sierra Leone), the governments had launched ambitious health care plans after gaining independence. However, the health care services degraded over time due to civil unrest and a lack of adequate management, finances, and human resources to support a public health care system. Experienced and well-trained health staff fled the unrest or simply emigrated.125,126

In DRC, for example, the government health care budget dropped over time to near zero. Therefore, the hospitals and health care providers became ‘autonomous’ and had to raise funds by charging individual patients. Eventually, patients were expected to pay for all services and bring their own medicines, perfusions and compresses to the hospitals. In Burundi and DRC, there was a widespread practice of keeping patients hostage in the hospital until the bill was paid. At times, the local Heineken brewery in Burundi had to liberate these health care prisoners as an act of good citizenship.127

The labour laws in the Central African countries of DRC, Rwanda, and
Burundi oblige companies to cover the health care expenses of their workers and their dependents. When tariffs for health services were introduced in the DRC, the employees of private companies and their family members had to pay five times the amount paid by persons not in private employment. Public service employees received care free of charge. This extra taxation did not bring any quality guarantee. For this reason, Heineken decided to take responsibility for providing health care to employees and dependents in its OPCO’s in resource-poor settings. This proved to be a more affordable solution and, in addition, a certain medical quality could be assured.

The Heineken system was rolled out in the same manner in Rwanda, Burundi, and Congo-Brazzaville. In Nigeria, it was preferred to work through Health Maintenance Organisations, paying capitation fees for the health care of the family members while the employees were still given care in the OPCO clinics.

Some of the data from the different medical services are presented in Table 1.

**Table 1: Selected indicators on Heineken health services in Sub-Saharan Africa**

<table>
<thead>
<tr>
<th></th>
<th>Numbers of MD</th>
<th>Number of paramedics</th>
<th>Number of beneficiaries 31/12/2007</th>
<th>Health care recurrent expenses in 2007 (Euro)</th>
<th>Number of in-house clinic visits 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Democratic Republic of Congo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinshasa</td>
<td>1</td>
<td>14</td>
<td>5,593</td>
<td>116,428</td>
<td>32,917</td>
</tr>
<tr>
<td>Boma</td>
<td>1</td>
<td>3</td>
<td>1,060</td>
<td>89,693</td>
<td>4,632</td>
</tr>
<tr>
<td>Kisangani</td>
<td>1</td>
<td>1</td>
<td>646</td>
<td>28,900</td>
<td>2,717</td>
</tr>
<tr>
<td>Bukavu</td>
<td>1</td>
<td>7</td>
<td>1,715</td>
<td>85,181</td>
<td>14,160</td>
</tr>
<tr>
<td><strong>Republic of Congo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazzaville</td>
<td>1</td>
<td>8</td>
<td>1,876</td>
<td>138,505</td>
<td>8,652</td>
</tr>
<tr>
<td>Pointe Noire</td>
<td>1</td>
<td>8</td>
<td>1,881</td>
<td>156,120</td>
<td>14,071</td>
</tr>
<tr>
<td><strong>Rwanda</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kigali</td>
<td>0</td>
<td>4</td>
<td>1,346</td>
<td>70,712</td>
<td>5,232</td>
</tr>
<tr>
<td>Gisenyi</td>
<td>0</td>
<td>4</td>
<td>1,346</td>
<td>30,419</td>
<td>3,844</td>
</tr>
<tr>
<td><strong>Burundi</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bujumbura</td>
<td>1</td>
<td>6</td>
<td>2,570</td>
<td>113,617</td>
<td>12,960</td>
</tr>
<tr>
<td>Gitega</td>
<td>2</td>
<td>2</td>
<td>459</td>
<td>14,396</td>
<td>2,964</td>
</tr>
<tr>
<td><strong>Nigeria</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lagos</td>
<td>2</td>
<td>6</td>
<td>2,570</td>
<td>606,248</td>
<td>5,727</td>
</tr>
<tr>
<td>Ibadan</td>
<td>1</td>
<td>5</td>
<td>1,945</td>
<td>174,400</td>
<td>4,097</td>
</tr>
<tr>
<td>Kaduna</td>
<td>1</td>
<td>5</td>
<td>1,430</td>
<td>153,118</td>
<td>7,180</td>
</tr>
<tr>
<td>Enugu</td>
<td>1</td>
<td>5</td>
<td>1,430</td>
<td>83,375</td>
<td>7,180</td>
</tr>
<tr>
<td>Aba</td>
<td>0,5</td>
<td>5</td>
<td>325</td>
<td>47,230</td>
<td>1,862</td>
</tr>
<tr>
<td><strong>Sierra Leone</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freetown</td>
<td>0</td>
<td>1</td>
<td>171</td>
<td>36,004</td>
<td>1,308</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13.5</td>
<td>84</td>
<td>26,353</td>
<td>1,944,166</td>
<td>122,323</td>
</tr>
</tbody>
</table>
The most obvious causes of disease and absenteeism in the 1980’s were infectious diseases; malaria was very important. From 1997 onwards, the main cause of employee health problems and mortality was HIV-related, even if documented proof was initially sketchy.

### 4.3. Heineken and HIV in Africa

#### 4.3.1. Scattered baseline information

As mentioned in earlier chapters, during the 1990’s, several reports were written describing the impact of HIV on the situation in DRC and also measuring the influence of the disease on health-seeking behaviour inside a company. The management of Bralima, the Heineken OPCO, in DRC, declined to participate in these impact studies. They feared that public awareness of HIV at Bralima would impact the sales of its beer and soft drinks. However, management of Bralima was kept closely informed on several descriptive studies that were performed in a textile factory and a large bank. Some studies tried to quantify the impact of HIV/AIDS on other businesses.

There was clearly an HIV problem, but it remained difficult for Heineken to quantify the problem in all its OPCO’s in Africa. Until early 2000, Heineken organised only sporadic prevention activities, while treatment was not even mentioned.

#### 4.3.2. Pioneering in Kinshasa

Kinshasa has been a focus of HIV research since the start of the epidemic. In the early 1980’s, Projet Sida did important studies to elucidate basic facts on HIV.

Bralima, the Heineken subsidiary in Kinshasa, was approached by Projet Sida to launch a workplace-based prevention programme in 1989. Bralima agreed, but its sales and marketing staff were hesitant to link the disease to the products: the reaction of the consumer was unpredictable. Therefore, an HIV programme was embedded in a healthy lifestyle programme, and messages on HIV prevention were combined with advice on how to stop smoking and how to improve personal hygiene. The subsequent prevention efforts were not sustained and poorly integrated into business practice. As soon as the external support provided by Projet Sida disappeared, the programme also disappeared.

During the next years, most African Heineken companies developed some occasional prevention activities, but these were never truly
incorporated in the business. Haphazard HIV information and education sessions were organised, mostly by external parties, for the benefit of the Heineken employees. The doctors of the OPCO health care services were providing some information about HIV during personal patient contacts, and some of the nurses were trained in the syndromic approach of STD. External organisations like PSI occasionally provided condoms for distribution among OPCO employees.

Traditionally, the health services of the Heineken OPCO’s provide medical care for spouses and children, as well as employees. When short-course chemoprophylaxis for prevention of MTCT of HIV was first reported, Kinshasa medical staff considered a new activity. Even with the high price of zidovudine, this intervention would yield a positive cost-benefit ratio. HIV infection in newborn children could be prevented. Normally, when a child was found to be HIV-infected, the company’s medical service incurred many expenses, and death would be the inevitable consequence. Encouraged by the international scientific results and further simplification of the MTCT prevention protocol, the Heineken brewery in Kinshasa started a programme to offer voluntary testing and prevention of MTCT to pregnant women in 1998. The project was developed in collaboration with a downsized Projet Sida. It was responsible for counselling and testing the women, who were driven once a week by a company bus to the General Hospital of Kinshasa. The initial drug supply came from the Institute of Tropical Medicine in Antwerp; no local zidovudine was available.

Despite initial fears that women would refuse testing, it was discovered that when the reasons for testing were explained properly and when the possibility to reduce MTCT was offered, the women did not refuse. Today, the responsibility of VCT has been shifted from Projet Sida to the OPCO health staff, and these activities have been incorporated into the in-house medical services. So far, almost 1,500 pregnant women have been tested, and approximately 1% of mothers were found HIV-seropositive. Today in Kinshasa, over 90% of all pregnant women belonging to the Bralima beneficiaries group have been offered a HIV test and only 1% of these refused (Figure 2)
The early results and the high acceptance of the test by pregnant women in the Kinshasa MTCT programme were reason to implement the testing and chemoprophylaxis of pregnant women at all African OPCOs. This coincided with the start of the Heineken HAART programme in September 2001 (see below).

The results of the MTCT programme in the different African OPCOs are summarised in Table 2.

### Table 2 Results from the Prevention of Mother to Child Transmission Programme

| Number of infected pregnant women | 54 | 100% |
| Number of pregnancies            | 67 | 100% |
| Number of births                 | 64 | 100% |
| Number of deliveries             | 61 | 100% |

**Interventions**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancies on triple therapy</td>
<td>52/61</td>
<td>85%</td>
</tr>
<tr>
<td>Deliveries with single dose NVP</td>
<td>5/61</td>
<td>8%</td>
</tr>
<tr>
<td>Deliveries without PMTCT mother</td>
<td>4/61</td>
<td>7%</td>
</tr>
<tr>
<td>Caesarean section done</td>
<td>15/61</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Outcomes**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillborn or immediate postnatal death</td>
<td>3/64</td>
<td>5%</td>
</tr>
<tr>
<td>HIV-infected, confirmed at 18 months</td>
<td>3/64</td>
<td>5%</td>
</tr>
<tr>
<td>Child died after neonatal period, but before 18m</td>
<td>10/64</td>
<td>16%</td>
</tr>
</tbody>
</table>
4.3.3. The road to treatment

Although the quality of the medical services at the Heineken OPCOs in Africa was acknowledged within the company, the failure to reduce mortality among workers and family members was disappointing. Around the turn of the century, half of employee deaths were regarded as HIV-related (Table 3).

Table 3. Mortality of employees in Kinshasa (pre-HAART era)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number employees</th>
<th>Number of deaths</th>
<th>Number of HIV-related deaths</th>
<th>All deaths per 1000</th>
<th>HIV deaths per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>2575</td>
<td>10</td>
<td>5</td>
<td>3.88</td>
<td>1.94</td>
</tr>
<tr>
<td>2000</td>
<td>2416</td>
<td>23</td>
<td>13</td>
<td>9.52</td>
<td>5.38</td>
</tr>
<tr>
<td>2001</td>
<td>1400(^1)</td>
<td>14</td>
<td>7</td>
<td>10.00</td>
<td>5.00</td>
</tr>
</tbody>
</table>


\(^1\) The number of employees was reduced from 2000 to 2001 by outsourcing and automation of production processes.

The challenge by the treatment activists for general access to treatment at the World AIDS conference in Durban in 2000, in conjunction with the important price reductions made possible by the pharmaceutical companies in the AAI initiative, and the promises of the generic drug producers made the management of Heineken International rethink its position on providing treatment to seropositive workers. Discussions were started with the newly created PharmAccess International Foundation. The main points of discussion were the price of the available treatment and the potential to acquire the expertise to start an in-house treatment programme of unquestionable quality.

Heineken decided to set up a steering committee with representation from different departments. A Heineken HIV policy was written, and the Futures Group was asked to present a cost-benefit analysis and to examine what the consequences would be if treatment were not offered. Although the Futures Group concluded that the cost of HIV treatment would be higher than the ensuing benefits, the Executive
Board decided nevertheless to include it in the existing medical benefits. Its main argument was that providing treatment at AAI prices was affordable, even if the worst-case scenario, as presented by Heineken’s department of Health Affairs, would consume 3% of the annual profit in Africa.

Subsequently, a service contract was negotiated with PharmAccess International, which would be responsible for training, drug supply, and quality control for clinicians and laboratory personnel. Since the transfer of technology that had to take place was a big task, the rollout in the different countries was phased. In Burundi and Rwanda, the programme started in September 2001; in Congo Brazzaville, the first patients were treated in July 2002. Kinshasa followed in September 2002, Nigeria in the first quarter of 2003, and Bukavu (DRC) in July 2003. In Sierra Leone, the first seropositive patients were detected in 2004, and the treatment programme in Freetown began that year but relies on external medical assistance, as the brewery is small (80 employees) and has no in-house company doctor.

4.3.4. Advocacy

When the Heineken Executive Board approved the inclusion of HIV care in the medical benefits, the board members urged that this policy should be discussed with other multinational companies in an effort to convince them to make the same decision. This has proven to be a difficult challenge.

During the exploration phase before Heineken’s final decision was taken, it emerged that only one other company was providing free antiretrovirals to its workers in SSA. This was Alucam, an aluminium smelter in Edea, Cameroon, at that time part of the Pechiney group.136 Alucam had received drugs from different pharmaceutical companies to treat 40 patients. At about the same time, other companies held discussions about the possibility of treatment, notably in Southern Africa. Early adopters were Anglo-American, a mining company, and Debswana Diamond mining in Botswana. Several companies could rely on the services of insurers or outside health care providers to treat HIV-positive patients; some were providing therapy through in-house clinics.

Heineken decided to restrict outside communication about its treatment programme, and certainly not to use it for commercial purposes or to improve its corporate image. An exception was made for communications serving the collection of scientific evidence. For example, a prospective computerised database was implemented that allows for documented clinical follow-up of HIV/
AIDS patients (and was a major source for this doctoral thesis).

The scientific manuscripts resulting from analysing the Heineken programme have certainly played an advocacy role. In addition, Heineken grasped opportunities that might help to convince other companies to follow the same path, taking various roles in the Business Exchange on AIDS and Development, Royal Society of Occupational Medicine, WHO, and World Bank symposia. Heineken also became an active participant in the World Economic Forum’s Global Health Initiative (GHI) and the Global Business Coalition (GBC). For several companies active in Africa, presentations about the Heineken programme helped them to shed some of their initial apprehensions. In one notable experience, a PharmAccess and Heineken presentation convinced Mohammed Ibrahim, the then CEO of Celtel, on the spot to start an HIV/AIDS prevention and treatment programme at his company.

During the eight years that the Heineken programme has been running, much experience has been gained and many lessons learned. It is important that these experiences are documented and subjected to scientific scrutiny. Although the absolute number of sero-positive persons in the Heineken target population was not high, practical solutions could be sought and analysis was possible to gain insight into the dynamics of the epidemic within the workforce and the ways to lessen its current and future impact.

5. This thesis

This thesis describes experiences of the Heineken HIV Workplace Programme since 2001, and draws lessons from it. The chapters cover various aspects of the programme but cannot provide a comprehensive picture of the entire African Heineken HIV/AIDS operation.

Chapter 2 lists several arguments that companies make in order to evade treating their HIV-infected employees. The Heineken experience is described as way of refuting these arguments.

Chapter 3 outlines the Accelerated Access Initiative in the context of the Heineken Programme. The AAI-induced price reduction of antiretrovirals has enabled affordable treatment of employees. The Chapter nevertheless shows that much more than affordable prices is required in order to get the drugs to the patients who need them.

Chapter 4 details a clinical mentoring tool available to assist a
multinational company with an HIV/AIDS treatment programme in Africa. For quality assurance purposes, regular data-supported teleconferences are conducted between the company doctors and external experts. These teleconferences include review of clinical questions pertaining to individual patients.

Chapter 5 describes the Voluntary Counselling and Testing part of the Workplace Programme in the Rwandan Heineken branch. To examine if it reached the intended group of beneficiaries, a study was undertaken to compare the HIV prevalence found during in-house VCT with the HIV prevalence amongst the workers and their spouses.

Chapter 6 examines the VCT uptake dynamics of the entire Heineken operation in Africa. To be able to offer HIV treatment, a company needs its employees to know their HIV status. Who comes for testing, and who does not? How can a company influence these dynamics?

Chapter 7 describes the results of over five years of patient follow-up, in terms of morbidity and mortality, of the Heineken workplace HAART programme.

Finally, in Chapter 8, several general lessons are drawn from the experiences in the Heineken HIV Workplace Programme.

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