Making HIV programmes work: The Heineken workplace programme to prevent and treat HIV infection 2001-2010
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Chapter 4:

Title: A successful workplace program for Voluntary Counseling and Testing (VCT) and Treatment of HIV/AIDS at Heineken, Rwanda

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Abstract:
(145 words)

Heineken Breweries launched a workplace HIV/AIDS program at its Rwanda subsidiary in September 2001. By January 25, 2005, 736/2595 eligible individuals had reported for counseling and HIV testing: 380/521 employees (72.9%), 254/412 spouses (61.7%), 99/1517 (6.5%) children and 3/145 (2.0%) retired. As a result, 109 HIV+ individuals were identified: 62 employees, 34 spouses, 12 children and 1 retired. In September 2003 an anonymous HIV seroprevalence survey was performed with a participation rate of 69.4% for employees, 58.2% for spouses and 79.7% for adolescents [1]. Using the survey result, the expected number of HIV+ employees was 71, which implies a program uptake of 87.1% (62/71) in this group. 42 of the identified 109 HIV+ beneficiaries were on highly active antiretroviral treatment (HAART). In November 2003 a qualitative study of awareness and health seeking behavior of the Heineken Rwanda beneficiaries identified key principles contributing to the success of this program.

Key words: HAART, HIV/AIDS, Rwanda, Employee Health Services,
A successful workplace program for Voluntary Counseling and Testing (VCT) and Treatment of HIV/AIDS at Heineken, Rwanda

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Introduction

This paper presents the result of qualitative and quantitative research undertaken to evaluate and improve the program for VCT and HAART at Brasseries et Limonaderies du Rwanda (Bralirwa), a subsidiary of Heineken. This was the first site of a program sponsored by the Dutch brewer to treat HIV/AIDS in the workforce (and dependents) at its African subsidiaries. Bralirwa is located in Rwanda, where the national adult HIV prevalence is estimated to be between 3.4 and 7.6% [2]. Heineken International Health Affairs recognized the threat that the HIV/AIDS epidemic poses to its employees and potentially its business throughout Africa. In response, they contracted with PharmAccess International Foundation (PharmAccess) to jointly launch “Access to HAART,” a voluntary counseling and testing (VCT) program supported by the provision of highly active antiretroviral therapy (HAART) in Heineken Operating Companies (OPCO) in Africa. “Access to HAART” was rolled out in September 2001 at the OPCO in Rwanda, with facilities located in the cities of Gisenyi and Kigali.

The benefit is offered to all employees and their immediate dependents, including children, as an addition to existing medical care services. Once on HAART, a patient retains this right for life, even if he/she is laid off by the OPCO. When a patient decides to leave the company and move to another employer, it is assumed this employer takes over the HAART responsibilities. The availability of VCT is announced on a regular basis to the OPCO employees and dependents while they are visiting the in-house clinic.

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1 The benefit was offered to the employee, spouse and their children. Although employees may have more than one wife and family, polygamy is illegal in Rwanda, and not recognized in Bralirwa policy. Therefore only the officially married wife and her children are eligible for medical benefits, including PMTCT, VCT and HAART.
or by inviting people to prevention and awareness sessions outside this medical facility. Beneficiaries at any of the Heineken OPCO programs in Africa can report any time to the in-house clinics to go through VCT with trained health care staff. The VCT procedure is entirely free to the employee or dependent. Employees may be tested off site, but must report the result to be included in the Bralirwa monitoring and treatment program.

Whenever a person reports for VCT, limited demographic data are collected and the HIV test result is anonymously entered into the Heineken HAART database. If the subjects appear HIV positive, follow-up visits are automatically indicated and key patient data are followed through the HAART database. In order to gain a better understanding of the quality and progress of the Heineken HAART program, two surveys were performed: a qualitative awareness and health-seeking behavior survey in November 2003 and an anonymous HIV prevalence survey in September 2003. We analyzed these surveys in conjunction with the Heineken HAART database in order to assess:

1) the historical events and trends that have had the greatest influence on VCT uptake;
2) the extent to which the program reaches HIV positive employees;
3) the key recommendations for corporate HIV treatment programs that can be drawn from the HAART program at Heineken Rwanda

This paper summarizes the major findings and demonstrates that a good uptake of beneficiaries into a workplace HAART program can be reached. Key behavioral variables that contribute to this uptake are elaborated.
Methods

a. health seeking behavior studies

Qualitative data related to health seeking behavior were collected in November 2003 by Rwanda researchers working with Boston University. Focus groups and individual interviews reached 167 employees (including health workers) and spouses from both Kigali and Gisenyi. This study received IRB approval from Boston University and was reviewed and accepted by local officials at both sites.

b. HIV awareness interventions and VCT uptake

Quantitative uptake data were derived from the Heineken HAART database, which is a Lotus Notes application with a central server in Amsterdam. All Heineken OPCO’s are connected to this system. The database systematically collects patient clinical data, as well as data on laboratory monitoring, antiretroviral medications, adverse effects of HAART and co-medication. Clinicians and laboratory specialists from PharmAccess perform independent quality control using this database. Individual subject data are filled in through a coded system, which excludes linking of confidential clinical information to human resources databases.

For each VCT visit since the program began, a number, date of test and test result have been recorded in the HAART database, including a CD4 count (for those with positive results) at the time of the test. The VCT visits have been grouped by year and month to calculate a per month testing figure for the period January 2001 – January 2005. Facts

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2 Seventy-one of the total 167 were focus group participants (34 males and 33 females), 96 study respondents were interviewed individually (51 males and 45 females).
and trends identified in interviews with managers and employees are displayed along the same timeline to identify potentially critical events and interventions. The qualitative study also identified broader trends in health seeking behavior that may not be marked by a discrete event, but were consistently cited by the employees and management in shaping the progress of the VCT/HAART program at Bralirwa [3].

c. Uptake of HIV positive beneficiaries into the HAART program
HIV status and CD4 count of those who sought VCT were analyzed to determine if the program was reaching those most in need.

HIV testing was performed by drawing blood through venapuncture in EDTA anticoagulated blood tubes. Samples were coded and a rapid HIV testing algorithm was followed using Determine (Abbott) as a first test, followed by Unigold (Trinity) as a confirmatory test. When discrepant results were found, a Capillus (Trinity) rapid HIV test was performed or samples were sent to the national reference laboratory. Positive samples were sent to a reference lab and the coded result sent back to the OPCO clinician, who enters this result in the database and informs the patient through post-test counseling.

The Heineken HAART program uses a CD4 T-cell count of <300/ul whole blood and/or CDC clinical stage C as decision factors for initiating HAART. In the current study predictors for CD4 T-cell counts <300/ul whole blood were assessed to determine what groups of HIV positive subjects were most likely to present for VCT testing. Linear
regression was used to compare the mean CD4 count of those testing positive, using as predictors: age, sex, marital status and calendar time of presenting to a clinic.

The uptake results for the two Bralirwa locations in Kigali and Gisenyi were aggregated. In first instance, the two sites seem different. The Kigali OPCO is essentially the “head office”, in an urban setting, employing management and administration. Kigali produces soft drinks. Gisenyi is a rural site, where most of the blue collar workers are employed. The Gisenyi OPCO produces beer. The qualitative study showed very little actual difference in the attitudes and behaviors of populations on the two sites, and the VCT uptake rates were similar, as shown in Table 1. For the purpose of this analysis, uptake data at the two facilities has been grouped.

The current analysis is focused on employee uptake data, with occasional reference to data from the larger beneficiary population. Although it is important to reach the spouses through this program, including the figures for spouses and children added a level of complexity that did not benefit the analysis. VCT uptake was calculated by comparing the cumulative monthly VCT visit data with statistics on total Bralirwa employment.

Results

Table 1 shows VCT uptake figures for the employees at Bralirwa. The number of employee tests through January 2005 is compared with the number of employees in 2004 to determine the VCT uptake rate (72.9%). Sixty-two of the employees (16.4% of 2004 Bralirwa employment) tested positive for HIV. The final column in Table 1 compares
the number of identified HIV+ employees (N=62) with the number (N=71) that would be expected by extrapolating the results of an anonymous seroprevalence test performed at a company picnic in 2003. At that picnic, employees and family members were offered an opportunity to take the saliva test, but no link was made to those who gave samples. They were urged to obtain a VCT test to learn their status.

87.1% (62/71) of the expected number of HIV positive employees had been identified though VCT by January of 2005. The results of the 2003 anonymous seroprevalence survey were provided to Bralirwa managers and clinicians, and employees were informed through the in-house magazine, Avenir, in August 2004.

Two months after the seroprevalence survey, the qualitative study with 167 participants was performed, which aimed to understand some of the psychosocial motivations informing the uptake of VCT. The main inhibitors for testing for employees were perception and experience of confidentiality breaches in the VCT and HAART programs, and a fear of dismissal based on serostatus. Managers were also concerned about loss of status or demotion if their HIV status became known. Several improvements to the program were implemented in response to the findings and recommendations of the qualitative study, including the establishment of a peer counseling and education program.

At the time of this analysis (January 2005), 380 employees (72.9% of the current total workforce: 380/521) have been tested since program inception in January 2001, with an
average of 8 employee tests monthly. Overall VCT uptake is high: up to the date of the anonymous seroprevalence saliva test (September 2003), 53.1% of the employees had already voluntarily reported for an HIV test. By January, 2005 this figure increased to 72.9%. Assuming that the anonymous seroprevalence test is representative of the full employee population, uptake by HIV positive patients is even higher. Up to the date of the seroprevalence test, 76.6% of the expected HIV+ employees had been identified. This figure increased to 87.1% by January 2005. In all, 109 HIV positive individuals, including 62 employees, have been identified.

The timeline of VCT uptake and historical “events” are plotted graphically for visual comparison and shown in Figure 1. Figure 1 shows the number of employees receiving VCT each month on the y-axis. When VCT uptake data are put in the context of significant historical events or interventions that potentially influence HIV-test seeking behavior, the following observations were made:

*Staff layoffs, March 2002, December 2003 (Not shown in Figure 1), February 2004.*

Unintentionally, the decision of Heineken to offer and implement the “Access to HAART” program coincided with a retrenchment in which 62 staff, approximately a tenth of the work force at the time, were laid off. The months in which significant numbers of people were retrenched did not consistently show low figures of VCT uptake.
The official launch of the program, September 2001. 40 people tested. The testing program began slowly in early 2001, but the official launch of the program motivated the highest monthly number of volunteers up to that time to come forward for VCT.

Education initiative, October 2002. 23 people tested. In late 2002, the company medical officer (CMO) and human resources manager (HR) ran an education initiative coinciding with an increased VCT uptake.

Testimony of a policewoman living with AIDS, June 2003. 82 people tested. The presentation of testimony by an HIV positive policewoman had the single greatest impact on VCT uptake. In that month more than 80 people came forward for VCT.

Kickoff of national program, August 2003. 13 people tested. The announcement of the rollout of the National HIV/AIDS Treatment and VCT program did not result in increased reporting for VCT at Bralirwa.

Seroprevalence test, September 2003. 21 people tested. A small VCT uptake peak can be noticed at the time of the anonymous seroprevalence test.

Change in Medical Personnel. October 2004. 36 people tested. It is possible that the small peak in October 2004 was associated with a change in leadership of the medical team, which may have motivated renewed interest in uptake.
In addition to the pattern of testing associated with these historical events, the qualitative survey highlighted overarching trends critical to the success of the program. These included the concurrent retrenchment program, the significance of the HIV positive speaker, the role of the Chief Medical Officer, and the availability of treatment. Statements by the employees interviewed indicated that the latter two played a key role in reducing stigma over time and continued uptake of VCT.

The second part of the analysis aimed at creating a profile of the beneficiaries reporting for VCT. The analysis shows:

1) Early in the program, those who reported for VCT had a higher risk of HIV infection than the general population of Bralirwa employees.

The anonymous seroprevalence test conducted in September 2003 reached 69.4% of the employees and found a prevalence rate of 10.3% at Gisenyi and 12.2% at Kigali [4]. The prevalence in the population who had tested voluntarily in the program up to that date was 16.0% (85/531), suggesting that HIV positive people were slightly more likely to participate in VCT.

2) Early in the program a higher proportion of those testing positive were in a more advanced stage of the disease, as demonstrated by lower CD4 counts. More recently, the Bralirwa VCT program has been identifying HIV positives with higher CD4 counts.

For this analysis we focused on those who were HIV positive. Although there were 109 positive tests (employees and dependents), we only included the 94 for whom...
CD4 count was recorded. For the first half of the four year analysis period (before November 2002), 65 people tested positive. For the second half of the program this number dropped to 44. However, the average CD4 count of those testing more recently was 437 cells/ul (SD 238), on average 108 cells/ul higher (p=.046) than the average of 329 (SD 261) cells/ul for those who tested in the first part of the program. This demonstrates that the HIV positives who reported earlier in the program had a more advanced stage of the disease.

Figure 2 shows the cumulative number of beneficiaries (employees and dependents) testing positive and the number of beneficiaries on HAART. Despite the initially slow uptake, the program is now treating with HAART 39% (42) of those testing positive. The increasing time gap between the number of HIV positives and those on HAART supports the finding that those identified later in the program are in an earlier stage of the disease and many do not yet require antiretroviral therapy. Because CD4 counts are regularly obtained for all who test HIV positive, HAART is offered promptly when indicated by treatment protocols. With only two exceptions (who were in denial about having HIV/AIDS), all program beneficiaries who have been offered HAART have accepted the treatment.

**Discussion**

Overall, the VCT uptake figures from 2001 through 2004 show the Heineken HAART program in Rwanda to be a success. The percentage of the workforce tested in both the anonymous seroprevalence survey and in VCT is well above the averages seen in other
settings [5-7]. Based on the HIV infection rates in different groups tested in the 2003 anonymous seroprevalence survey, we estimated that there would be a total of 121 HIV positives in all beneficiary groups as of 2003 [4]. Assuming a stable epidemic in a stable employee population, an annual incidence rate of 0.1 times the HIV prevalence linked to an average survival time of 10 years after infection [5], 14 additional seroconversions would occur in the period between the seroprevalence survey and January 2005, leading to a total of 135 infections. This would make the expected number of HIV positive beneficiaries at Bralirwa 135. By January 2005, 109 positive beneficiaries (80.6% of the expected total) have been identified. Compared to documented programs in comparable settings, the Rwandan figures are a considerable achievement [6-8]. The program continues today, and is possibly the longest running corporate VCT/HAART program in Africa.

Stigma and mistrust have been shown in numerous settings to be the greatest factors influencing uptake of VCT services [9,10]. They are repeatedly cited as more important than cost, convenience etc. This is confirmed by the history of the Bralirwa program. The proportion of HIV positives identified and participating in the treatment program has grown as employees observe successful treatment outcomes and see that Bralirwa is honoring its commitment not to discriminate against those with AIDS. The qualitative

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3 In the Wolff study uptake rates were below 10% without the intervention, and increased to 37% with a home based VCT (lower than those achieved by Bralirwa).
4 Anglogold estimates that only 25% of employees needing treatment are accessing it, reported in Plus News, April 22nd 2005 [www.plusnews.org/AIDSReport.asp?ReportID=4733]
5 Castle’s 2003 study from Mali found that educated people were most likely to be skeptical about HIV and AIDS, and were least likely to participate in VCT. On the other hand, those most likely to participate in VCT were generally from lower educational groups who had had actually seen people of their own communities suffering from the disease. Similarly in Rwanda, it seems that the personal testimony of the police woman was the most significant contributor to VCT uptake.
research confirms that initiatives to reduce stigma have also encouraged additional employees and families to come forward for testing.

The event associated with the largest increase in VCT uptake addressed stigma directly. An HIV positive Rwandan policewoman addressed employees at both Bralirwa sites in June 2003. She openly discussed her status and issues around living with AIDS and parenting HIV positive children. While one should be careful not to overstate the effect of this visit, it is the primary event in the month when VCT figures doubled, peaking at 82 tests. The face-to-face reality of a personal testimony made the disease more credible and immediate, motivating participation in VCT. One of the employees said of this presentation:

“Had it not been [for] the testimony of the policewoman accompanied by the Director of Human Relations, nobody would have taken the test at Bralirwa.”

At the time of the qualitative report, Heineken stated that it had decided to make use of people living with HIV and AIDS (PLWHAs), peers and outsiders, to assist in workforce education. Education or counseling from PLWHA shows that HIV positive people can live openly with their illness, and can adhere to a treatment regimen that improves their quality and length of life.

The importance for VCT uptake of in-person testimony from PLWHA was demonstrated in the HIV test data. Spouses were not included in the work site presentation by the policewoman. There was no increase in the monthly tests of spouses (see Figure 3), in contrast to the spike in testing of the employees who were exposed to the presentation. This strongly suggests that the message was a strong incentive for employees to go for
VCT, but these same employees did not transfer this message to their spouses. As a consequence, Heineken has decided to increase efforts to reach out to spouses and children in its pan-African HAART program.

The second most dramatic spike in testing was in the month the program was launched. The launch included public presentations by Bralirwa’s Chief Medical Officer and Human Resources Director; this encouraged higher VCT uptake in September 2001. As with the later visit by the PLWHA, employees’ uptake was quite high compared to spouses; probably due to the more frequent, targeted publicity at the plant sites. The importance of direct, in-person education and awareness methods is again illustrated by the third peak, which corresponds to the education initiative in October 2002.

The pattern in VCT and the overall success of the program may be related to several factors that emerged in the qualitative interviews, but were not captured in specific historical events. Three are worth mentioning here.

The retrenchment program had a negative effect on the initial success of the VCT drive. Although this is not fully reflected in the monthly test data, and the education and awareness messages emphasized confidentiality and AIDS rights, the qualitative survey showed that employees associated the retrenchment exercise with the HAART program [3]. This increased mistrust and fear, as employees drew the conclusion that HIV status would influence the chances of continued employment. It is likely that this contributed to the low uptake in the early months of the program. Over time, employees have seen that
those accessing treatment are not targeted for redundancy, and it is likely that this fear has diminished.

Secondly, Bralirwa had two AIDS champions, the Chief Medical Officer and the Human Resources Director both took the cause of HIV seriously, and were committed to setting up and publicizing the VCT program. Interviews indicated that these men were trusted by employees, and were active in explaining and promoting the program. As one of the managers said:

"Without (the Bralirwa doctor’s) sensitization, employees when tested at BRALIRWA thought their results will be known by the whole town."

The third critical factor in the success of this program is the provision of HAART following VCT. There can be little doubt that the availability of treatment is one of the greatest motivators for VCT uptake in this setting. As one employee observed,

“Above all it is the trust in the effectiveness of the treatment that encouraged the Bralirwa workers……since at the beginning people were not convinced about the effectiveness of the drugs” [11].

With treatment available, VCT can be the first step in the path to living a healthier life, regardless of status. The availability of treatment not only spurs the decision to go ahead with VCT, but also undermines the stigma surrounding AIDS in the longer term. Although there was much mistrust associated with the retrenchment implemented at the same time as the “Access to HAART” launch, this has been overcome by subsequent events and attitude shifts over the four year history of the program. Education and
awareness have certainly played some role, but one should not underestimate the daily influence of seeing those who were known to be sick from HIV-related illnesses improve their health and keep their jobs. Another employee noted the “strength and hope to the seropositives” as a major positive aspect of the program [12].

The increasing CD4 count during the time of testing is a real victory for the program. These recently identified seropositives may benefit even more, since they are at a less advanced stage of the disease [13]. With long term monitoring and care and good health information, they should be able to stay healthy for longer without HAART, and benefit the most from a well-timed introduction of antiretrovirals. By starting treatment at a CD4 count higher than 300, many of the opportunistic infections associated with AIDS will be avoided. HIV+ employees identified when CD4 counts are higher will likely miss fewer days of work, and remain productive on the job longer: a gain for Bralirwa as well.

As the Access to HAART program has reached most of the expected number of HIV positive people at the firm, it is likely that the numbers coming forward and testing positive will now decrease. However the program will remain beneficial for new employees, and more importantly as a valuable exercise in keeping people HIV negative [14]. Finding HIV positive employees early, before the onset of AIDS, is a great achievement. However, motivating those who test negative to stay that way is probably the best outcome for VCT. Any VCT program can achieve optimal benefit by maximizing the opportunity for preventative education, preserving the health status of those who test negative.
Recommendations

The high levels of VCT uptake and the apparent success in reaching and treating HIV positives show that the Heineken program is an important health intervention that could be implemented by other employers with similar commitment. Although the paper has primarily considered employees, the experience of spouses was an important finding of the qualitative survey of 2003 [3]. The uptake in spouse VCT has been much lower than that of employees, and spouses had limited access to education and participation. Reaching more spouses would improve overall utilization of the health benefits and increase access to treatment [16]⁶. Other studies suggest that treatment for a positive spouse is likely to help the support and adherence of the employee, and promote HIV prevention interventions [16]⁷.

A second recommendation is to consider a stand-alone or off-site testing facility. This excerpt from the qualitative study sums up one of the major concerns of Bralirwa employees:

“[I]t is not clear from our findings that people’s doubts about confidentiality could be allayed even if every effort to make improvements to the existent process and facility were made”.

This deep distrust is seen in respondent statements such as:

“Drugs are well-managed, but I prefer to go somewhere else” and

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⁶ The Semrau K et al. study found that women were more likely to accept VCT when counseled as a couple- more focus on spouses could indirectly increase employee uptake.
⁷ The Farquhar C et al. study found that partner notification was associated with a four fold increase in condom use, and improved uptake of nevirapine and formula feeding.
“Building is good [quality] but the testing site location with other medical services makes people suspect those who are tested.”

The basic problem may be, as several respondents noted, that people don’t feel comfortable being tested and treated by fellow employees who are well known to them. Given this distrust, it is not surprising that interviewees’ most common recommendation for improving confidentiality was to have off-site testing and treatment, and reimburse those costs [3]. There may be problems in quality control and confirmation of eligibility when working with an off site treatment facility. However, these complications may be worth resolving if workers do not risk being identified to their peers as HIV positive when seeking treatment. PharmAccess is currently studying the possibility of outsourcing the Bralirwa medical services to other private health care facilities in Kigali and Gisenyi.

Echoing the effectiveness of PLWHAs (the HIV positive policewoman) observed here, we recommend that a firm planning VCT use lay counselors. Preferably, the counselor should be a respected employee, HIV positive if possible, who is trained and compensated by the company for his/her counseling activities. The Zambia 2003 study cited above also asked VCT participants about the quality of counselors. Lay counselors (non health care practitioners) achieved better performance than all other health care practitioners except nurses [17]. Using lay counselors should be less expensive, leveraging the health practitioners time for clinical care. If the firm is able to find PLWHAs to participate as lay counselors, this may also help reduce stigma, as evidenced by the policewoman’s testimony.
Conclusions

The Heineken Rwanda VCT program is an encouraging example of the role that employer based programs can play in helping HIV positive employees and dependents gain access to care while reducing the negative impact of AIDS in the workforce. The “Access to HAART” program showed that in spite of stigma and initial reluctance, education, personal testimony and management commitment can play a powerful role in encouraging VCT uptake. Our qualitative findings also confirm an intuitive expectation: seeing people thrive on treatment is a long term motivator for others to seek testing and care. Our key recommendations are:

1. Offer HAART as part of a comprehensive employer AIDS program. This will increase uptake of VCT when is offered.
2. Encourage couple testing (with targeted outreach to spouses)
3. Ensure strong support from local management (empowerment of an AIDS Champion).
4. Use PLWHA in worker education programs from the very beginning.
5. Attempt to decouple program milestones from any redundancy.
6. Design the program to assure confidentiality, and the perception of confidentiality. Consider using a contracted off-site provider for such purpose.
Table 1: Summary of VCT Uptake by Bralirwa Employees

<table>
<thead>
<tr>
<th>Location</th>
<th>VCT Tests Performed Jan 2001 – Jan 2005</th>
<th>VCT uptake (as % of 2004 employment)</th>
<th>HIV+ Test results</th>
<th>HIV+ uptake as % of estimated HIV+ population based on 2003 seroprevalence survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gisenyi</td>
<td>181</td>
<td>76.4%</td>
<td>27</td>
<td>88.5%</td>
</tr>
<tr>
<td>Kigali</td>
<td>199</td>
<td>70.1%</td>
<td>35</td>
<td>86.0%</td>
</tr>
<tr>
<td>Total</td>
<td>380</td>
<td>72.9%</td>
<td>62</td>
<td>87.1%</td>
</tr>
</tbody>
</table>
Figure 1: VCT and HAART uptake at Bralirwa Breweries 2001-2004

- Launch of HIV program
- 62 employees retrenched
- Education initiative
- Seroprevalence study
- 27 employees retrenched
- Presentation by HIV positive policewoman
Figure 2. Cumulative Number of Beneficiaries Testing Positive and Receiving HAART
Figure 3. Effect of HIV+ police woman on employees versus spouses (Kigali site)
Glossary

**HAART**  Highly Active (triple drug combination) Retroviral Therapy for the treatment of AIDS

**OPCO**  Operating Company. The term used by Heineken to refer to subsidiaries or joint ventures operating in other countries. The Rwandan firm, Bralirwa, is an OPCO

**PLWHA**  People living with HIV and AIDS. Collective term referring to all those who are infected with HIV, regardless of the stage of the disease.

**VCT**  Voluntary Counseling and Testing for HIV/AIDS

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