KNOWING OUR STATUS AND BEYOND

WORKPLACE VCT and HIV and AIDS MANAGEMENT

A SWHAP REPORT

Based on a regional conference held in Johannesburg, South Africa

5th & 6th July 2007

"The death of men and women due to HIV and Aids deprives their families, society and economy of many years of productive life... Illness for a period prior to death also reduces the economic contribution of otherwise economically active men and women."

HIV/AIDS and the Workplace: A Documentary on Why and How to Fight a Pandemic

SWHAP Chairperson's Foreword

HIV and Aids took the life of 3 million people in 2006. Some 40 million people globally are living with HIV and Aids, which makes it one of our time's most devastating epidemics. It has a dramatic impact on the individual, their families, the society at large and thus also on the economy. It is against this background that the Swedish Workplace HIV and Aids Programme (SWHAP) was initiated in 2004, and operates in six countries in Sub-Saharan Africa.

I am pleased that this report is based upon an important conference where we came together as SWHAP to reflect on our programme so far, and to explore future options. Indeed, I would like to congratulate all the delegates who attended and their colleagues in the workplaces on the amazing progress SWHAP has achieved so far; progress that is due to your hard work and commitment.

I believe that the workplace is a unique forum to influence attitudes and behaviours of people; it is also imperative that we remember that with successful HIV and Aids programmes everyone wins – the employees, his/her family as well as the company and surrounding communities. Workplace interventions are an integral part of a national response to the HIV and Aids epidemic, and as such must work with the communities in which they are situated.

Experience from SWHAP has shown that a successful HIV and Aids programme should be guided by three words: **Confidence**, **Leadership** and **Inspiration**. Confidence between management and employees is key to ensure joint programmes that are trusted by employees and supported by management. Leadership, from both labour leaders and management, will raise awareness and show it is an organisational priority. And inspiration is needed to take the programme beyond its initial launch and sustain it. The two days of deliberations reinforced these three factors as key.

This report reflects on SWHAP's successes to date and on how to maximise these; on hindrances in our work and how to overcome them; and finally on broader responses to HIV and Aids in other workplaces, communities, nationally and internationally and discusses how to link more effectively to these. The importance of networking, sharing good practice and learning from each other became a key theme during the conference and I urge SWHAP members to use all resources available including the SWHAP newsletter and website.

Following both the theme and the deliberations during the conference, it is clear that we need to embrace the importance of moving beyond Voluntary Counselling and Testing, to the Three 'One Hundreds' – 100% Prevention, 100% Know Your Status and 100% Treatment and Care. We believe that embracing this holistic response is key for successful workplace programmes. To date the focus of the three 'one hundreds' has been the workplace itself. Our next step is to focus on the families and then on our suppliers, to ensure that there are ever widening circles of HIV and Aids compliance.

Finally, let me say a little on SWHAP itself. This dynamic programme is a joint initiative from the International Council of Swedish Industry and the Swedish Industrial and Metalworkers' Union, and on a workplace level between employees and management through representative committees. It is funded by the Swedish International Development Cooperation Agency, SIDA. We are currently seeking additional funding for 2008, and thereafter we will undertake a comprehensive programme review of SWHAP's role and purpose and agree a way forward.

I should like to conclude with a tribute and an observation. In tribute I want to say that I have been privileged to meet with 'big leaders' all over the world I have met with, amongst others, presidents, and captains of industry and with astronauts.

But I think that during this conference I have had the privilege to meet, probably with the biggest of them all, Henry Chihana, a truly big man. His bravery in disclosing his status to his family, to his community, to his workplace and to all anywhere who will listen, and his courage in living a productive, full life are a testimony that I will take with me for ever. I salute him and those like him. And I am confident, that with the experience, commitment and collegiality shown at this regional conference by people like Henry and by all of you who fight against HIV and Aids, your workplaces will make a long-term impact on those who work in them as well as on their families and communities. Congratulations, thank you, and keep up your inspiring work.

Lars G Malmer

SWHAP Chairperson

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Conference Attendees

SWHAP Delegates			
Birgersson-Brorsson	Birgit	Ms	SWHAP Sweden
Ferbe	Anders	Mr	SWHAP Sweden
Graaff	Jacob	Mr	SWHAP SA
Holmgren	Christer	Mr	SWHAP Zambia
Hubendick	Ludvig	Mr	SWHAP Sweden
Kiondo	Chris	Mr	SWHAP Tanzania
Malmer	Lars G	Mr	SWHAP Sweden
Maziofa	Edith	Ms	SWHAP Zimbabwe
Molin	Erica	Ms	SWHAP Sweden
Mwaura	Daniel	Mr	SWHAP Kenya
Svensson	Mars	Mr	SWHAP Sweden
Svingby	Sofia	Ms	SWHAP Sweden
Guests			
Coutinho	Alex	Dr	TASO
Fridh	Åsa	Ms	Embassy of Sweden
Källstig	Ulf	Mr	Sida
Lack	Annette	Ms	IF Metall
Mabusa	Mpuni	Mr	Swedish Trade Council
Mears	Brad	Mr	Sabcoha
Motau	Hlokoza	Mr	Numsa
Schoeman	Ria	Ms	Embassy of Sweden
Soting	Lars	Mr	IF Metall
Sunter	Clem	Mr	Anglo American

KENYA			
Bundi	Bernard	Mr	Sandvik
Ireri	James	Mr	Sandvik
Jhuti	Sheela	Ms	Tetra Pak
Kamwenji	Githaiga	Mr	Scania
Kiljambya	Jackson	Mr	Amazon Motors
Mwihia	Njoki	Ms	Tetra Pak
Ndegwe	Judy	Ms	Tetra Pak
Ngugi	Elizabeth	Ms	Amazon Motors
Njenga	David	Mr	Amazon Motors
Ouna	Stephean	Mr	Scania
Rashid	Mwanaisha	Ms	Tetra Pak
SOUTH AFRICA			
Bird	Jess	Ms	Tetrapak
Bosman	Hilda	Ms	Scania
Buffa-Pace	Wendy	Ms	Atlas Copco
Crookes	Chris	Mr	Scania
Du Randt	Maxime	Ms	Tetrapak
Fox	Jenny	Ms	Alfalaval
Garland	Gavin	Mr	SKF
Grobler	Corlé	Ms	SKF
Hlatywayo	Emily	Ms	Sandvik
Kanyane	Motswale	Ms	Sandvik
Kretschmer	David	Mr	Autoliv
Kumalo	Elizabeth	Ms	Sandvik
Leys	Piet	Mr	Atlas Copco

SOUTH AFRICA cont.			
Lubelo	Themba	Mr	ABB
Maganedisa	Bushy	Mr	ABB
Manganye	Moses	Mr	ABB
Marx	Sunet	Ms	Sandvik
Maseko	Rachel	Ms	Saab
Masela	John	Mr	Autoliv
Mavuso	Azron	Mr	Alfalaval
Melato	Lucky	Mr	ABB
Mhlangu	Gabriel	Mr	Ericsson
Mogoru	Mmaphefo	Ms	ABB
Motsumi	Shadrack	Mr	Sandvik
Msimango	Patricia	Ms	Assa Abloy
Nkatlo	Lucky	Mr	Assa Abloy
Pardon	Heidi	Ms	Ericsson
Phillips	Alice	Ms	Autoliv
Phoko	Christine	Ms	Assa Abloy
Posthuma	Sharon	Ms	Swedish Match
Rosengren	Håkan	Mr	Alfalaval
Shawinsky	Jack	Mr	Scania
Smith	Mike	Mr	Tetrapak
Steinbach	Susan	Mr	Saab
Thage	Mpho	Ms	Scania
Van Wyk	Beverley	Ms	Autoliv
Williams	Mandy	Ms	ABB
Zungu	Mdudzi	Mr	Swedish Match

TANZANIA			
Chanimbaga	Rehema	Ms	Scania
Kogo	Evelyn	Ms	Sandvik
Legga	Margaret	Ms	Scania
Mayagila	Joyce	Ms	Scania
Mkenda	Gabriel	Mr	ABB Tanelec
Mwenda	Edrick	Mr	ABB Tanelec
Rweikiza	Doreen	Ms	Sandvik
UGANDA			
Wengi	Gregory	Mr	Skenya
ZAMBIA			
Chanda	Patrick	Mr	AtlasCopco
Chihana	Henry	Mr	Sandvik
Chilesha	Benedict	Mr	Dyno Nobel
Lungu	Rhoda	Ms	AtlasCopco
Mubita	Ruth	Ms	Sandvik
Mulubwa	Conwell	Mr	Dyno Nobel
Musonda	Elias	Mr	AtlasCopco
Mutwale	Dorothy	Ms	Sandvik
Ngwira	Justin	Mr	Dyno Nobel
Oberg	John	Mr	Sandvik
Sikozi	David	Mr	AtlasCopco
Siwo	Annie	Ms	SWHAP Zambia

ZIMBABWE			
Chiganga	Austen	Mr	Dyno Nobel
Dambudzo	Desmond	Mr	Frexzim
Dangakurahwa	M	Mr	Scania
Fato	Christopher	Mr	Dyno Nobel
Gwama	Willard	Mr	Scania
Kabo	Aleck	Mr	Dyno Nobel
Maddox	Basil	Mr	Atlas Copco
Munetsi	Patricia	Ms	Sandvik
Musika	Maria	Ms	Ericom
Mwayi	Tendayi	Mr	Atlas Copco
Ndlovu	Nolwazi	Ms	Atlas Copco
Ndlovu	Marketshani	Mr	Scania
Nembaware	Grace	Ms	Sandvik
Zaranyika	Sandi	Mr	Sandvik

List of Acronyms

ABC	**Abstain, Be (mutually) Faithful and Condomise**
AIDS	**Acquired Immune Deficiency Syndrome**
ART	**Anti-retroviral therapy**
ARV	**Anti-retroviral**
CEO	**Chief Executive Officer**
EAP	**Employee Assistance Programme**
HIV	**Human Immunodeficiency Virus**
KAP	**Knowledge, Attitudes and Practice**
IF Metall	**The Swedish Industrial and Metalworkers' Union**
ISO	**International Standards Organisation**
NIR	**International Council of Swedish Industry**
NUMSA	**National Union of Metal Workers, South Africa**
PEP	**Post-exposure Prophylaxis**
PITC	**Provider-Initiated Testing and Counselling**
P LWA	**People Living with HIV and Aids**
PPE	**Personal Protective Equipment**
PPTC	**Prevention of Parent to Child Transmission**
SABCOHA	**South African Business Coalition Against HIV and Aids**
SADC	**Southern African Development Community**
Sida	**Swedish International Development Cooperation Agency**
STI	**Sexually Transmitted Infection**
SWHAP	**Swedish Workplace HIV and Aids Programme**
VCT	**Voluntary Counselling and Testing**
WHO	**World Health Organisation**
UNAIDS	**Joint United Nations Programme on HIV and AIDS**

1. Executive Summary

This regional conference brought practitioners from SWHAP workplaces together with HIV and Aids experts in order to share ideas, experiences, solutions and ways forward in responding to HIV and AIDS in the workplace.

The conference concurred with global thinking that in order to succeed companies need to have: healthy employees, a positive and supportive organisational culture, and a good reputation in the marketplace. Furthermore, delegates stressed that their workplaces are not islands and that what we do in our workplaces is profoundly influenced by, and in turn, influences our surrounding communities.

Therefore in order to be successful companies should develop, or strengthen existing, comprehensive HIV and Aids programmes that are effectively mainstreamed across the organisation. A key component of these programmes is that as many employees as possible know their status via testing and that voluntary counselling and testing is thus available to all employees and their sexual partners and their families.

Five very major 'findings' dominated the conference:

- HIV and AIDS HIV and AIDS responses are an integral part of companies' policies and operations. As such they should be **mainstreamed** into normal operations of companies in all spheres and be bedded down for long-term sustainability

- Testing can never be seen in isolation from comprehensive responses to HIV and AIDS. Any type of testing – including VCT – should thus be seen as one component of the 3 'one hundreds': **100% prevention, 100% knowing your status, and 100% treatment and care**. These 3 'one hundreds' represent ideals for which companies' should strive

- Employees cannot be understood or assisted in isolation from their **partners, families and communities**. This has implications for all aspects of programmes but particularly for testing and treatment components. It also speaks to a contextual understanding and accommodation that takes culture and the nature of the epidemics in respective countries into account.

- Effective responses require management and **leadership** from all constituencies in companies. The role of senior managers has long been recognised and was re-emphasised. The role of middle managers arose as a key challenge to implementation and mainstreamed responses. Adapting key performance areas (KPAs) and key performance indicators (KPIs) and linking health to productivity are effective interventions. A relative lack of emphasis in most programmes on sufficient labour participation in real programme management and design was highlighted and the key need to build the capacity of stakeholders to participate was emphasised.

- Company programmes and strategy needs at all times to tapping into **international cutting edge thinking and practice.** By synergising with country programmes and initiatives best use of resources is ensured.

The conference summarised that most companies were well into comprehensive programmes and that success needed to be built upon. Another focus is to strengthen the knowledge sharing component of SWHAP by building of the regional capacity to support countries and workplaces as well as visiting successful programs in other companies.

2. Background to SWHAP

The International Council of Swedish Industry (NIR) and the Swedish Industrial and Metalworkers' Union (IF Metall) decided in 2004 to initiate and implement a long-term strategy to contribute to the establishment and/or support of HIV and Aids programmes at Swedish related workplaces in Sub-Saharan Africa. The Swedish Workplace HIV and Aids programme (SWHAP) presently operates in Kenya, South Africa, Tanzania, Uganda, Zambia and Zimbabwe and is co-financed by the Swedish International Development Cooperation Agency, Sida.

SWHAP recognises the importance of mainstreaming HIV and Aids into the workplace, and sees the workplace as an ideal arena to address the causes and impacts of the pandemic. For the SWHAP a key element for success is that the formulation and implementation of HIV and Aids policies and programmes should be the joint responsibility of management and workers, through workplace committees.

The Programme Objectives include:

- To assist employers and employees at Swedish related workplaces to combat the HIV and Aids pandemic;
- To make these workplaces the national spearheads of workplace related HIV and Aids activities; and
- To enhance corporate engagement globally.

SWHAP aims to achieve this by:

- Inspiring and supporting existing HIV and Aids programmes or supporting the creation of new ones
- Co-funding HIV and Aids activities
- Supporting and identifying service providers
- Facilitating networks for information sharing within and between companies
- Ensuring the workplaces have forums for exchanging experiences
- Enhanced coordination between workplaces
- Companies disseminating information within corporate information structures and participating in networks such as the global Business Coalition on AIDS and similar national level coalitions as well as the Global Trade Union movements.

Since SWHAP was launched it has made an impact on the lives of many employees across the six countries. There are approximately 40 workplaces involved in SWHAP. As of mid-2007, more then 9300 employees are directly benefiting from workplace programmes co-financed by SWHAP. Additionally, this programme has also assisted secondary beneficiaries, in many cases the employees' families and in surrounding communities.

Progress to date has been very exciting, with some companies in Kenya reporting 100% uptake of voluntary counselling and testing, and at one point in South Africa more then 80% of the employees across all workplaces had been tested. SWHAP is particularly pleased with these uptake figures as many companies in the region do not see similarly high figures.

- *HIV/AIDS and the Workplace: A Documentary on Why and How to Fight a Pandemic, produced by SWHAP and edited by Åke Magnusson in 2005. (Copies can be ordered from SWHAP, www.swhap.org) It is a comprehensive compilation of extracts from key documents, guidelines and programmes, it looks at the global HIV/AIDS picture and then focuses on what can be done in the workplace. It is an excellent rationale for the important role that SWHAP programmes can play in the struggle against HIV and Aids .*

3. Background to the conference & the programme

The conference arose from a clear need to network and share learnings between SWHAP workplaces and countries. Some workplaces have been hard at work on HIV and Aids programmes within SWHAP for some time whilst others are new in the system and just beginning. The value-add that would be gained by all members of SWHAP interacting, sharing lessons and updating themselves on the epidemic, and on cutting-edge responses to the epidemic was obvious and timeous.

The theme for the conference was chosen from the pivotal component of any HIV and Aids workplace programme: the need for people in the workplace to know their status and to take action on it, and, therefore, the need for voluntary counselling and testing. The eventual title of the conference, ***Knowing Our Status and Beyond: Workplace VCT and HIV and Aids Management***, reflected emerging knowledge and practice in SWHAP that VCT alone is not enough. It is the interaction and interdependencies between VCT and other components of workplace programmes that set the scene for all of the conference's deliberations.

The conference purpose was given as:

- To share and collate experiences, knowledge and ideas on workplace VCT and HIV and Aids management in practice,
- To document these via a conference report/ 'best practices' publication, and
- To advice on strategic choices for the way forward for SWHAP and participating companies.

In the end the conference was a pivotal and exciting meeting as over one hundred delegates from the six SWHAP countries and from Sweden, as well as external experts gathered to reflect on SWHAP successes to date, and discuss how to maximise on these in the context of the continent-wide fight against HIV and Aids. Delegates also identified challenges facing HIV and Aids workplace programmes generally and in particular SWHAP challenges and agreed strategies for addressing these.

The conference programme was designed in order to allow SWHAP colleagues to share ideas, receive exposure to new ideas and relevant thinking and to collectively design solutions for the way forward. It was accomplished through expert inputs, experience sharing sessions and a concept of sessions called 'cafes'. The cafes were work spaces in which an area of the conference became the space for thinking, debate and future-design around a particular issue or topic. Conference delegates then moved at will around these spaces, contributing and learning until they felt the need to move on. Continuity in the cafes was provided by a 'café owner' and a rapporteur.

4. New ways of seeing VCT

The 3 'one hundreds'

The conference concurred with global thinking that in order to succeed companies need to have: healthy employees, a positive and supportive organisational culture, and a good reputation in the marketplace. Furthermore, delegates stressed that the workplace is not an island and that what we do in our workplaces is profoundly influenced by, and in turn, influences our surrounding communities.

Therefore in order to be successful companies should develop, or strengthen existing, comprehensive HIV and Aids programmes that are effectively mainstreamed across the organisation. A key component of these programmes is that as many employees as possible know their status via testing and that voluntary counselling and testing is thus available to all employees and their sexual partners.

VCT is thus seen as one component of the 3 'one hundreds':

- 100% prevention
- 100% knowing your status
- 100% treatment and care

These 'one hundreds' should always include partners of employees, where possible employee families, and, ideally, then reach out into communities in which employees live.

These workplace HIV and Aids programmes will themselves be mainstreamed into normal company policies and practices, often having a major impact on wellness programmes, among other aspects of company life.

Workplaces as empowering environments

The 3 'one hundreds' of a workplace HIV and Aids programme need to be underpinned by an empowering environment consisting of:

Promoting and realising rights and responsibilities

All HIV and Aids programmes should be based on the recognition of **basic rights** of all people at the workplace. These rights include:

- Choosing whether or not to test
- Choosing whether or not to disclose one's personal status in the workplace
- Confidentiality of all personal HIV related information in the workplace
- Accurate, up to date information on issues affecting personal and family wellness, and on company policies on wellness, wellness support and other issues affecting employees
- Fair treatment and protection from discrimination, irrespective of HIV status or disclosure

Along with these rights come **responsibilities** that people in the workplace should exercise. These include:

- Know their personal HIV status
- Be aware of their general health and act to maintain or improve their general state of well-being
- Be aware of workplace health or wellness policies and programmes – including those for HIV and Aids – and of support available through these programmes
- Communicate openly and accurately about one's HIV status with sexual partners and act responsibly by taking appropriate measures to prevent HIV transmission to e.g. sexual partner or to unborn child

Congruency with external good practice

It is crucial that workplaces are aware of, and informed by, key international and national developments and good practices. There are many international guidelines, policies and examples of good practice and workplace programmes should be informed by these and keep abreast of new developments. Similarly, workplaces need to be harmonising with, while at the same time informing, national responses to the epidemic. This includes the responsibility on workplaces to be aware of and compliant with their country National Strategic Plan, national targets and national guidelines. Furthermore, many success stories reflect on the effectiveness of linking workplace and community services such as clinics. This is an excellent opportunity to share resources and skills with the wider network of AIDS service providers in the country.

In order to promote congruency in the workplace, throughout this report we have highlighted key external documents and guidelines that are relevant to workplace programmes. Workplaces should take note, however, that a focus on comprehensiveness and good practice does not mean an 'all or nothing' approach. In particular, small workplaces should not be intimidated by the range of possible actions or interventions open to them. All companies should concentrate on what is possible given their respective circumstances.

Embracing, and acting on, the inter-connectedness of workplace, community & family

Key to the success of workplace programmes is the recognition and valuing of people in the workplace as members of their communities.

Workplaces are clearly not islands in society; they impact on surrounding communities, and in turn are dependant on these communities for labour and sometimes markets. Good practices show many examples of workplace HIV and Aids programmes that embrace a holistic response to HIV and Aids. There are a number of sound business reasons for doing this as well as an overwhelming moral reason. Some of the reasons include:

- In Africa HIV is a mainly sexually transmitted infection. Transmission involves sexual activity and thus more than one person. To simply focus on one partner for prevention, testing, or care and treatment is to focus on 50% of a sexual couple. This logic is further reinforced by extremely high figures for discordance[1] in parts of Africa meaning that a focus on one sexual partner becomes actively negligent in many cases. **Partners** are thus an essential part of any workplace policy and programme.
- **Families** are those closest to people in our workplaces and their physical and general wellness impacts immediately and heavily. Taking steps to improve their wellness will have a positive impact both on individuals in our workplaces as well as on the general perception of our companies as caring of those who work in them.
- The **communities** where the employees live impact on social lives, attitudes and values and actions. They are also places of interaction in which perceptions are formed of our companies, the values we hold true and our commitment to people around us. Communities are also places in which health services such as clinics and home & community based care are to be found. For all of these, and many more, reasons, the ability of a workplace HIV and Aids programme to reach out into its surrounding communities will have a profound effect both inside and outside of the company.

[1] When sexual partners have different HIV status's for example one partner is HIV positive and another is HIV negative.

5. Context of our workplace programmes

The Epidemic in Sub-Saharan Africa

In 2006, 39.5 million people globally were living with HIV and Aids, and 2.9 million people died from AIDS-related deaths. Sub-Saharan Africa **-** home to an estimated 24.7 million people living with HIV - continues to bear the brunt of the global epidemic. In this region 59% of people with HIV are women; for every ten adult men living with HIV there are about 14 adult women who are infected with the virus.

Provision of antiretroviral therapy has expanded dramatically in sub-Saharan Africa; more than one million people were receiving antiretroviral treatment by June 2006, a tenfold increase since December 2003. However, the sheer scale of need in this region means that only 23% of the estimated 4.6 million people in need of antiretroviral therapy are receiving it[2]. Universal access to prevention, treatment, care and support for all by 2010 has become the global target since the UNGASS review in May 2006. Most organisations, national governments and international agencies and donors are joining forces in an attempt to achieve this and African leaders expressed their commitment to this target at an AU meeting in May 2006 (See the AU Brazzaville Commitment to Universal Access). Most African governments have set national level targets aiming to reach as close as possible to this shared vision to beat HIV and Aids.

An important part of this coordinated international response is the call for the **'Three Ones'** agreed in 2004. If achieved they should ensure strengthened national level responses to the epidemic.

One agreed HIV and Aids Action Framework, providing the basis for coordinating the work of all partners

One National AIDS Coordinating Authority, with a broad-based multisectoral mandate

One agreed country-level Monitoring and Evaluation System

Table: Country contexts

Country	National prevalence '05	Type of epidemic	No. of people living with HIV and Aids in '05	AIDS-related deaths in '05	Life expectancy		% of people living on less than US$2 per day
					Women	Men	
Kenya	6%	Generalised	1,300,000	140,000	50	51	58.3%
South Africa	19%	Hyper-endemic	5,500,000	320,000	49	47	34%
Tanzania	6.5%	Generalised	1,400,000	140,000	49	47	89.9%
Uganda	6.7%	Generalised	1,000,000	91,000	51	48	Not available
Zambia	17%	Hyper-endemic	1,100,000	98,000	40	40	94%
Zimbabwe	20%	Hyper-endemic	1,700,000	180,000	34	37	83%

Source: www.unaids.org, sourced 3 July 2007 and Human Development Report, 2006

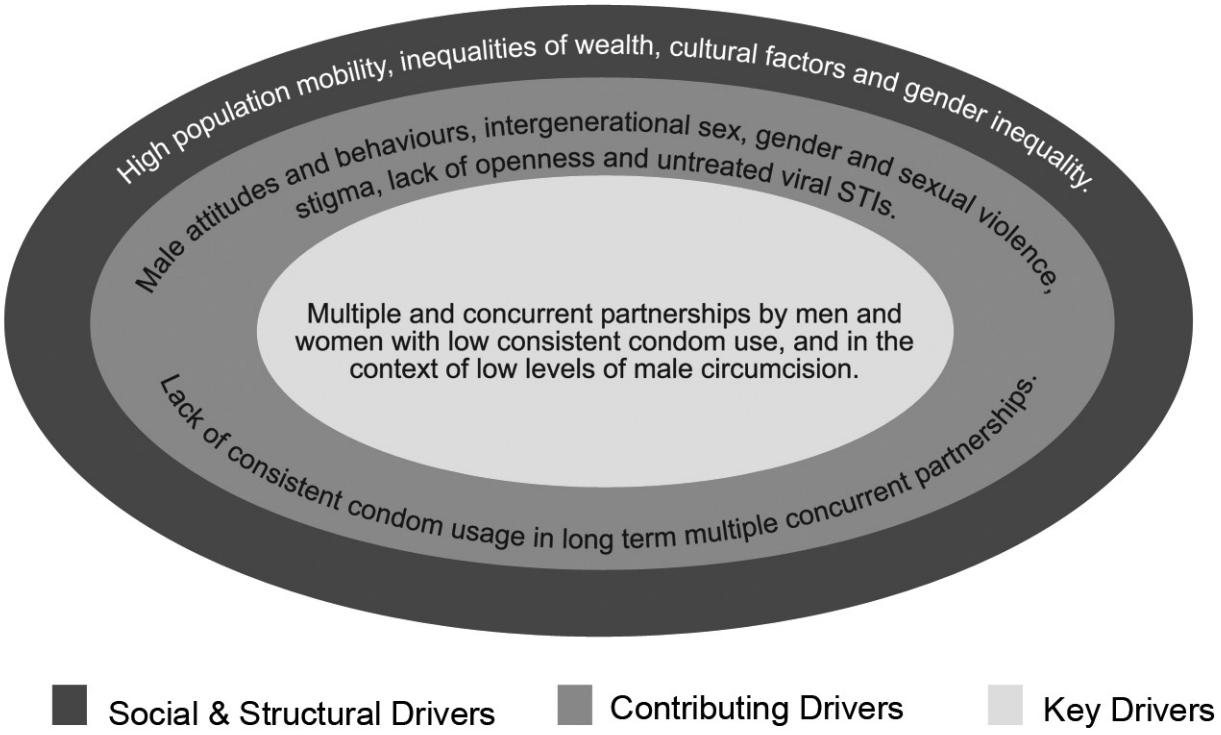
[2] This section draws heavily form the UNAIDS AIDS Epidemic Update, December 2006

Drivers of the Epidemic in the Region

"High levels of multiple and concurrent sexual partnerships by men and women with insufficient consistent, correct condom use, combined with low levels of male circumcision are the key drivers of the epidemic in the sub-region.[3]"

This was the finding of a recent SADC meeting where experts in the field gathered to review the evidence as to why the epidemic continues to ravage Southern Africa. Additional drivers that were highlighted as being significant included: male attitudes and behaviours, inter-generational sex; gender-based violence; stigma; lack of openness about the epidemic; untreated viral sexually transmitted infections (STI's); lack of consistent condom use in long-term multiple concurrent partnerships; high mobility; inequalities of wealth and gender inequality.

Figure 1: Drivers of the HIV Epidemic in SADC



Source: SADC Expert Think Tank Meeting on HIV Prevention, pp 3

[3] SADC Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa - Report, Maseru, May 2006, pp 5.

The epidemic and the private sector

Voices from the private sector

Sofia Svingby, a SWHAP Steering Committee member, laid the framework for talking about the private sector and workplace responses to HIV and Aids when she stated that,

> *"Business should be involved in responding to the HIV and Aid pandemic because productivity and profits are affected. But more importantly, because working with HIV and Aids is just the right thing to do.[4]"*

She went on to highlight that the business sector have good systems and innovative approaches that could be very useful in the struggle against HIV and Aids. Indeed, globally many companies are becoming key players with high success rates, but sadly not all businesses have recognised that they have a key role to play.

The conference was addressed by Clem Sunter, Chair of Anglo American Chairman's Fund. Clem reviewed what he believed was an initially 'lacklustre' response on the part of the private sector, and others, in South Africa to the epidemic. In the late 1980s and even early 1990s when the epidemic could have nipped in the bud, South Africa slept. Clem Sunter believes that,

> "We, as human beings, allowed this pandemic to silently erupt because as human beings we are not programmed well to respond to gradual threats such as HIV and Aids and global warming. We are much better at responding to immediate threats like the Tsunami."

Clem went on to say that companies should be actively involved in the struggle against HIV and Aids. He believes that testing is an important first step, yet he stresses that without visible management commitment uptake is often low. He strongly suggested that the effective achievement of high, regular testing uptake should be in managers Key Performance Indicators and Key Performance Appraisals. This sentiment was echoed during a meeting of CEO's during the conference. He also suggested that for managers who simply do not seem to comprehend the magnitude of the crisis, it is often useful to expose them to the 'real situation' - through visits to local children's homes, and clinics on a regular basis. "Make line management more accountable and responsible." was a statement by Clem that was echoed from many quarters throughout the conference.

Clem Sunter also raised the idea of companies using their 'muscle' to encourage other companies to develop comprehensive HIV and Aids policies where they do not exist. He suggested strategies such as only working with suppliers who are 'HIV and Aids compliant' themselves. Many participants agreed and there seemed consensus among delegates that there are good practice examples in the private sector where companies encourage other companies to develop good HIV and Aids programmes by holding out the sanction of cutting ties with companies that refuse to do so.

Clem Sunter concluded by lamenting the fact that, generally speaking, companies do not appear to value the overall health of their employees. He briefly reflected on prevention, treatment and care – again arguing that employers should offer a comprehensive package, but recognising that treatment adherence is difficult. He reflected that in terms of care and support 25-30% of Anglo Chairman's Funds are allocated to HIV and Aids and he encouraged other programmes such as corporate social investment (CSI) to do similarly; suggesting that more money be allocated to the excellent work of many NGO's delivering home-based care.

Brad Mears, CEO of the South African Business Coalition Against HIV and Aids (SABCOHA), also addressed the conference and reiterated that the business sector has an important role to play in dealing with HIV and Aids. He stated that a crucial tool in the private sector's fight against the epidemic is the development of transparent, accessible minimum standards for responding to HIV and Aids. As an example of this he noted that an international first will be launched in July in South Africa - the Standard 16001 on HIV and Aids Workplace Programmes. It will be jointly launched by SABCOHA and the South African Bureau of Standards. This will create a powerful tool against which to measure companies and hold them to account.

He noted that micro businesses seem to be much more aware of the impacts of HIV and Aids and appropriate responses, while often the small and medium companies are not as responsive to the epidemic. He also stressed the importance of looking beyond formal, permanent employees as, increasingly, companies realise that they need to provide programmes for the informal workers as well. Dr Alex Coutinho supported this point, in later discussions, by stressing the importance of recognising the informal workers that support each workplace such as contract workers as well as others like women who sell oranges and biscuits to employees outside a factory. Increasingly workplace policies are recognising the challenge of providing holistic HIV and Aids programmes that extend beyond the immediate formal workforce.

[4] Sofia Svingby, SWHAP Conference, Johannesburg, South Africa, 5 July 2007

Additionally, Brad Mears, like Clem Sunter, believes that there needs to be closer cooperation between the private sector and government and he urged SWHAP workplaces to play a constructive leadership role in this cooperation. He illustrated this point with the South African experience; SABCOHA was a key player in developing the new National HIV and Aids Strategic Plan (2007-2011) and is on the implementation steering committee. Finally, he urged everyone present to share and network more as there are many examples of good practice that should be shared. On that note he referred to the SABCOHA Workplace Toolkit that has already been customised in Kenya, and could work well in any other interested countries.

David Kretchmer, CEO of Autoliv presented their very successful workplace programme to the conference. This report has highlighted a few key points about this programme.

The Autoliv AIDS Forum was established by the employees in March 2000, and the mission statement is: "Stop New Infections, Support Affected Associates and Create an Open Culture Which is Non Discriminatory"

The Forum provides the following services:

- An extensive Information Centre on site
- Training for all employees, in-house during working hours: as part of induction and on an ongoing basis
- Open days twice a year, held to raise awareness within the company
- The Forum extends into the community and the supplier base
- Periodic prevalence studies are undertaken with all employees
- A strategy for the Forum was devised in 2004, and is updated annually

Successes to date:

- There have only been two new infections, among 196 permanent employees, since the forum was launched
- Prevalence studies give all leaders and forums accurate information on HIV and AIDS trends in the company
- Funds have been raised through the sale of AZA AIDS pins, and other campaigns. These funds have been used to assist where the greatest need is
- The Forum assists local HIV and Aids Hospice centres and has also adopted a local children's home for children affected by HIV and Aids
- With the assistance of SWHAP, Autoliv is able to fund the tertiary education for a young girl, who lost her mother as a result of AIDS and who was an employee of Autoliv at the time
- Working together with SWHAP has assisted Autoliv in having information evenings and open days with employee's spouses and children

Autoliv highlighted important issues for success:

- Management participation and ownership of the process
- The process must be repetitive and managed over years
- Thinking and analysis should be based on good evidence
- Use prevalence studies to give good base data for evidence-based analysis and planning and for monitoring and evaluation
- Good analysis is important to design the strategy and also to measure the programs effectiveness

Key Principles of the ILO Code of Practice on HIV/AIDS and the World of Work

The ILO has undertaken substantial work on HIV and Aids in the workplace that reinforces the messages coming from this conference. Of particular use is the ILO's 10 Key Principles that captures the essence *The ILO Code of Practice on HIV/AIDS and the world of work* (2001). This provides an excellent guideline and benchmark for workplace programmes.

1. **A workplace issue**: HIV and Aids is a workplace issue because it affects the workforce, and because the workplace can play a vital role in limiting the spread and effects of the epidemic.

2. **Non-discrimination**: There should be no discrimination or stigma against workers on the basis of real or perceived HIV status - casual contact at the workplace carries no risk of infection.

3. **Gender equality**: More equal gender relations and the empowerment of women are vital to preventing the spread of HIV infection and helping people manage its impact.

4. **Healthy work environment**: The workplace should minimize occupational risk, and be adapted to the health and capabilities of workers.

5. **Social dialogue**: Successful HIV and Aids policies and programmes need cooperation and trust between employers, workers, and governments.

6. **No screening for purposes of employment**: Testing for HIV at the workplace should be carried out as specified in the Code, should be voluntary and confidential, and never used to screen job applicants or employees.

7. **Confidentiality**: Access to personal data, including a worker's HIV status, should be bound by the rules of confidentiality set out in existing ILO instruments.

8. **Continuing the employment relationship**: Workers with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

9. **Prevention**: The social partners are in a unique position to promote prevention efforts through information, education and support for behaviour change.

10. **Care and support**: Workers are entitled to affordable health services and to benefits from statutory and occupational schemes.[5]

International Standards Organisation

In addition to the work of the ILO, a very exciting development for setting standards for HIV and Aids programmes is taking place in South Africa with the International Standards Organisation. The ISO, SABCOHA and the South African Bureau of Standards (SABS) are developing *SANS 16001 - the HIV and Aids workplace quality management system standard*. It is being launched on 18 July 2007 by the SABS.

[5] ILO Programme on HIV/AIDS and the world of work. International Labour Organization. Switzerland

web: www.ilo.org/aids HIV/AIDS in the workplace

The standard will give companies a benchmark against which to voluntarily measure their HIV and Aids programmes. Once a company has decided to use the standard as the benchmark against which their programme will be measured, there will be a set of absolute requirements that they will have to achieve. These requirements will achieve specific outcomes through actions deemed to be in line with currently accepted good practice and must be objectively verifiable by a suitably qualified auditor. If the company is found to be compliant with the standard requirements, the auditor will recommend the company for certification.[6]

- *African Union, Brazzaville Commitment on scaling up towards universal access in Africa by 2010, Addis Abba, 2006*
- *Expert Think Tank Meeting on HIV Prevention in High-prevalence countries in Southern Africa,* report, May 2006, Maseru
- *HIV/AIDS and the Workplace: A Documentary on Why and How to Fight a Pandemic*, SIDA edited by Åke Magnusson
- *UNAIDS The Three Ones in Action http://data.unaids.org/publications/irc-pub06/jc935-3onesinaction_en.pdf*
- *The ILO Code of Practice on HIV/AIDS and the world of work (2001) http://www.ilo.org/public/english/protection/trav/aids/publ/code.htm*

6. SWHAP Experiences and Lessons

In the short existence of SWHAP, associated workplaces have gained a great deal of experience. Several opportunities were created at the conference for delegates to reflect on their learnings and to create some meaning out of these in order to improve future actions. Three key areas were examined in some depth; issues of context, key success factors in workplace programmes, and key hindrances to success in workplace programmes.

The context is key

Other HIV and Aids initiatives

Workplace interventions need to be mindful of the parallel community and government HIV and Aids responses. National governments and many NGO's in all SWHAP countries are rolling out prevention, treatment, care and support programmes, and workplace programmes need to complement these. Additionally, the public health sector in all these countries is weak, and the workplace needs to consider how its programmes might assist in providing care to communities who do not have access to health care. Zimbabwe, for example, has only 56 public ART sites with 80,000 people on treatment, yet 450,000 require treatment in a public health system that appears too weak to meet this need. On the other hand, the Zambian government's programme for rolling out AIDS treatment is reaching a number of people in need, raising questions about how the workplace and government treatment programmes can compliment each other. Workplace programmes in each country must bear this reality in mind and think, plan and act accordingly.

The nature of the epidemic & social responses

The nature of the epidemic and social responses conditioned by the epidemic in each country and community must be considered when designing and implementing programmes. National statistics are important to know, bearing in mind that they may mask local differences and groups at risk.

[6] All information sourced from SABCOHA, http://www.sabcoha.org/media/3.html on 15 July 2007

The categories below are also useful indicators to assist in assessing the national or contextual scale of the problem.

UNAIDS and WHO categorise HIV epidemics in the following way[7]:

- ***Low-level Epidemic:*** HIV prevalence levels of below 1% and HIV has not spread to any significant levels among any sub-population group.
- ***Concentrated Epidemic:*** HIV prevalence is high in one or more sub-population group, but the virus is still not circulating in the general population.
- ***Generalised Epidemic****:* HIV prevalence is between 1-15% in pregnant women attending antenatal clinics, indicating the HIV is present among the general population at sufficient levels to enable sexual networking to drive the epidemic.
- ***Hyper-endemic Epidemic*****:** where HIV prevalence exceeds 15% in the adult population driven through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use.

Examples of how the nature of the epidemic affect workplaces can be seen in, for example, Tanzania that has a generalised epidemic, yet has comparatively low prevalence rates, compared to many sub-Saharan African countries. These rates in turn appear to lead to low perceptions of personal risk and at the same time a high stigma attached to HIV and Aids. The general context in Tanzania will impact on how employees respond to both workplace programmes and colleagues who are living with HIV and Aids. Zambia on the other hand has both a mature and a hyper-endemic epidemic with HIV prevalence among adults at 17%, and high levels of awareness, leading to a much more conducive environment for rolling out programmes around testing and treatment.

Social and cultural issues

Social realities such as high migrancy, poverty, gender inequalities, and in one case hyper-inflation, all contribute to an increased need for, and impact on the efficacy of, HIV and Aids workplace programmes.

There are also many traditional and cultural issues at play, including the strong influence of the African Churches. In some cases these churches are playing a positive role in HIV and Aids prevention, care and support, lead by strong advocates such as Rev Cannon Gideon Byamugisha of T*he African Network of Religious Leaders Living with or Affected by HIV and Aids*. But in other instances the churches spread messages that clash with 'good practice' messages, and can be very unrealistic in their approaches to prevention. This creates confusion and tension among the many community responses.

Equally, domestic violence at home contributes significantly to women's vulnerability, and it is difficult for the workplace to intervene in the homes. Nonetheless, awareness raising can be undertaken at the workplace, both for the victims and perpetrators. Equally sexual harassment in the workplace must be addressed to reduce risk. The conference also discussed some traditional practises that place both men and women at risk, these include: 'wife inheritance', unclean initiation ceremonies and dry sex.

While social-cultural issues can be very sensitive, it is important that the workplace programmes are mindful of them, and consider them in the contextual analysis undertaken when developing a strategy and programme. Delegates stressed that we need to recognise that these issues are very different across sub-Sahara Africa, and we must avoid generalising, or trying to develop 'one-size fits all' programmes.

[7] UNAIDS Practical Guidelines for intensifying HIV Prevention. P.6

Key success factors

Leadership

Many workplace experiences showed that visible senior management support is a fundamental requirement for successful programmes. Such programmes have managers who understand the significance of the programme and the importance of mainstreaming an HIV and Aids response and who then allocate the necessary resources. The CEOs meeting, during the conference, endorsed this, and one CEO suggested that an aspect of this leadership might be to complement the CEOs outreach role by appointing 'HIV and Aids ambassadors' at the workplace who could be used to inspire top management and international headquarters' employees. In addition to leadership shown by management is the key role of leadership shown by worker leaders be they in trade unions, worker associations or simply recognised by fellow employees. The relationship between all leaders in a company is essential to building and deepening a relationship of trust and open communication between employers and employees - another important element for success.

Organisational culture

The organisational culture in the workplace itself is key. Workplaces that have a holistic approach to wellness that includes care and support have found it easier to integrate HIV and Aids care and support programmes. Similarly, relationships of trust between employers and employees make collaboration more effective. Equally questions about supporting employees not on private medical aid, and their families, will be influenced by the general ethos of the organisation.

An holistic approach

SWHAP experience shows that successful workplace programmes need to be holistic and based on complimentary ideas of employees' rights and wellness. HIV and Aids programmes should be based on policies developed together with employees and local trade unions if it is present at the workplace, once developed awareness campaigns should be used to ensure maximum engagement and acceptance from employees. The policies should consider a number of elements (noting that not all may be feasible in all companies). These elements could include:

- assurance of confidentiality
- active champions
- employee and peer educator driven
- voluntary counselling and testing
- comprehensive education
- prevention, treatment, care and support
- couple counselling and out-reach programmes such as 'family days'
- extending beyond HIV and Aids to related health matters such as opportunistic versions including TB and malaria
- the establishment of 'women's clubs' as an effective means to address women-specific issues and gender relationships
- the necessary resources, both financial and human, made available by management

Key hindrances

As could be expected the key hindrances relate directly to the success factors listed above and are in many cases

the negative of a success factor.

Many SWHAP programmes reported that the greatest hindrance was a **lack of ongoing management support**, which can be exacerbated by changes in management. Furthermore, some noted that a lack of middle management commitment is also key as they are often the drivers and implementers of programmes. Middle managers are hardest hit by production demands and this constitutes their training and, most often, their performance appraisal. Without special training and support it cannot be assumed that they will, even where supportive, play a constructive role.

Many companies are **not effectively mainstreaming HIV and Aids** across the organisation. **Trust** was significant, noting that some employees were wary of management motivations and that without trust, uptake is hampered.

Another organisational challenge relates to the company or industry working below capacity in a situation where competing priorities then lead to "**additional, softer" programmes often being de-prioritised**. David Kretchmer, CEO Autoliv South Africa, addressed this issue when he challenged management not to "neglect important issues, for urgent issues". He stressed that HIV and Aids must always be a key issue in companies.

The conference heard from SWHAP countries that **poor programme design, implementation and monitoring** can limit effectiveness. Similarly, weak committees, or uninformed committee members hamper the programmes. Some companies report low uptake of voluntary counselling and testing and this significantly limits ongoing knowledge of personal status and prevalence within the company, leading to less information on which to design effective programmes. Additionally, many programmes focus on testing and do not look at the broader issues of prevention, treatment, care and support, limiting effectiveness and straining trust.

Finally, the importance of mainstreaming HIV and Aids into all strategic decisions and Human Resource policies is not always recognised and/or prioritised and these programmes are in danger of becoming stand-alone, testing and - sometimes - treatment programmes, ignoring the broader personal, organisational and strategic factors.

7. Achieving the 3 'One Hundreds' in our workplaces

100% Prevention

In 2007, for every person placed on AIDS treatment, 6 people become newly infected. This clearly illustrates that prevention campaigns must remain a priority, a response based on treatment alone is unsustainable.

Furthermore, we see many successes that illustrate that prevention campaigns are more effective if they are broader than the workplace and extend to families and communities. The NUMSA International Secretary noted that the trade unions are particularly concerned about employees who do not disclose their status to their partners. Indeed, this is further exacerbated with migrant workers who sometimes have two families, and are even less likely to inform their 'rural' families. This highlights the urgency of ensuring that prevention work is undertaken with the communities where the employees come from, since broader knowledge reduces the stigma around a positive diagnosis and raises awareness amongst sexual partners. This challenge is greater with migrant workers, but it remains an important challenge at all times. Workplace committees should link with communities to ensure that workplace, community and government programmes support each other and do not duplicate activities.

When designing effective prevention programmes context and specificity must be taken into account. 'One-size fits all' programmes are often not appropriate, it is important to know the drivers in the particular community and workplace, and to have an understanding of what has failed and succeeded previously. The Maseru SADC meeting referred to earlier, undertook a comprehensive review of realities in the region and made strong recommendations on prevention that are relevant to workplace programmes.

This report has consolidated deliberations from the conference and external good practice and guidelines and proposes the following elements as key in all workplace programmes aiming to achieve 100% prevention.

Prevention campaigns need to offer employees and their families a basket of prevention options including:

- ***Information that persuades people in the workplace and their partners to stick to one sexual partner at a time***

Africa has significantly higher incidences of concurrent partners, and this is recognised as a major driver of the pandemic in Southern Africa. The danger is that with multiple, concurrent partners once the HI virus is in a sexual network it places everyone in that network at very high risk. A recent study in Likoma, Malawi found that 65% of the population interviewed was part of **one sexual network**. The Maseru SADC meeting identified reducing multiple concurrent sexual partners as a key intervention for scaling up HIV prevention.

- ***Positive prevention***

It is important to recognise, and respect, the sexuality of people living with HIV and Aids To love, to be loved, to parent children, to have sex is all part of 'normal life', and people living with HIV and Aids should not be denied this. Pre and post- test counselling needs to include information on how to have responsible sex, to conceive and to give birth if one is living with HIV and Aids. Similarly, we need to undertake awareness campaigns so that people living with HIV and Aids are not stigmatised as 'asexual' or as 'sexual predators' if they wish to responsibly continue with their sex life.

- ***Preventing parent to child transmission (PPCT)***

There is generally very low uptake of PPCT measures, despite proven high effectiveness. The conference recommended that an excellent way to integrate PPCT into the workplace would be through family planning and sexual reproductive health services. The workplace is well placed to offer these services, providing an entry point to many female employees and extending these services to the female partners of male employees. In this way the workplace becomes an excellent space through which to provide information and services to realise high take up of PPCT. Workplaces should also enable women to exclusively breastfeed, if they wish, by providing facilities to have the babies nearby, alternatively if women wish to formula feed companies could subsidise this. Information on baby feeding is crucial and could be well distributed through people who work at the workplace.

- ***Male circumcision***

Research shows that male circumcision reduces the risk to the male of contracting HIV between 50-60%.[8] However, there are still many obstacles to implementing a circumcision campaign, not least cultural barriers and fear. With this prevention method the messaging is very important, it is NOT 100% effective, and must still be used alongside condoms and reducing concurrent partners. Workplaces need to provide information about the benefits of circumcision, and perhaps even to move courageously to offer such a service.

[8] World Health Organisation, 2007. *New Data on Male Circumcision and HIV Prevention: Policy and Programme Implication.* pp2

Messages on increasing correct, regular condom use & condom distribution

If used correctly and regularly condoms can be 80-90% effective. However, use is still low in many communities. UNAIDS estimates male condom usage in sub-Saharan Africa at only 19%[9]. This figure illustrates why campaigns must continue to emphasise this aspect, especially for use in high-risk situations and among young people. The actual distribution of quality condoms in the workplace and their normalisation as part of health and safety awareness remains essential.

Increasing workplace awareness of gender based violence & preventing its occurrence

Gender based violence at home and in the workplace is a major driver of risk to HIV for two reasons: (1) because forced and violent sex is likely to be more abrasive and therefore create a greater biological risk of infection, and (2) because gender based violence places many women in a very vulnerable position where they are not able to negotiate when, if, or how to have sex. The workplace creates a space to raise awareness about the need for change, provide support for survivors and challenge the culture of violence. Workplace codes of conduct and role modelling by workplace leaders are important elements in this area.

Reality-based message on Abstain and Be mutually faithful (the AB of ABC)

The Abstain and Be mutually faithful approach on its own has shown to be ineffective, especially as it ignores the realities of the factors driving many sexual encounters such as poverty, inequality, sexual assault and transactional sex. In addition, it ignores some of the realities of healthy sexual encounters. However, as a part of a comprehensive package it offers opportunities that some can exercise. Indeed, sexual debut has been delayed in a number of countries, (e.g. in Uganda by two years). However, such delay offers no protection once a person embarks on sexual activities, and in some cases there is evidence of faster rates of HIV infection by previously abstinent young people in their twenties (a 'catch-up' phenomena).[10] 'Getting real' about these messages – and in particular recognising that the workplace itself is a driver to sexual activity and sexual networks – is a step in the process of delivering messages that reach home and lead to behaviour change.

Increased access to counselling and testing

This remains a key element of all effective prevention campaigns. Testing in any format needs to provide post-test services including counselling and treatment access for both HIV-negative and positive people as an essential component of providing incentive to test. It is further essential in the workplace to assist in monitoring prevention programmes.

Prevention practices suggested by the conference

- Ensure visible commitment and engagement from all levels of management
- Introduce the policy during employee induction – use creative means such as personal testimonies from people living with HIV and Aids and development theatre
- Discuss and **research** broader drivers of the epidemic in the workplace and home such as alcohol and drug abuse and domestic violence
- Bring the families and community into the workplace to become constructive partners in prevention
- Draw and train peer educators from all levels across the company
- Distribute condoms in high profile ways and as an integral part of health and safety
- Undertake regular surveys/surveillance to establish accurate baseline information and ongoing time series monitoring of the programme
- Use fun and engaging activities such as sports to raise the issues in the programme
- Undertake training on human rights and individual responsibilities
- Address broad issues that limit disclosure, including social-cultural issues and sexism

[9] *SADC Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa* - Report, Maseru, May 2006, pp 6

[10] ibid

- *SADC Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa - Report, Maseru, May 2006. This provides an excellent summary of the key drivers in Southern Africa and recommendations for effective prevention. http://data.unaids.org/pub/Report/2006/20060601_sadc_meeting_report_en.pdf*

- *UNAIDS Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access (2007) http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf*

- *CDC HIV/AIDS Science Facts: Male Circumcision and Risk for HIV Transmission: It is a very useful resource to explain the science behind how male circumcision can protect one from HIV transmission. http://www.cdc.gov/hiv/resources/factsheets/PDF/circumcision.pdf*

- *Positive Prevention: Prevention Strategies for People Living with AIDS, AIDS Alliance. http://alliance-uk.inforce.dk/graphics/secretariat/publications/ppr0703_positive_prevention.pdf*

100% Know Your Status

The purpose of testing should be to ensure that eventually 100% of employees and their families know their status. Knowing one's status is key for both the individual and the workplace. At the workplace the three possible outcomes11 of testing provide important information for programme design and for implementers to ensure constantly monitoring of effectiveness.

At an individual level, in the case of an employee being positive, it is important that s/he is offered the necessary psycho-social support; nutritional advise; CD4 test; screening and treatment for opportunistic infections or AIDS; referred to family planning services and offered advise on practising positive prevention in his/her sex life.

Regrettably, 'know your status' campaigns frequently do not place enough emphasis on how to respond if one is negative. A negative result should be used as an entry point to enable the individual to remain negative – extensive support and counselling should be provided to enable her/him to remain negative, including promoting safe sex, partner testing and re-testing in 6 weeks (for the window period).

Deliberations at the conference, and good practice, again highlighted that 'Know Your Status' campaigns need to involve a number of core elements including:

- **Regular re-testing**

A programme reaching 100% 'know your status' can never be completed, it will always be ongoing - as individuals need to regularly re-test. The WHO recommends that individuals at higher risk re-test every 6-12 months. Similarly, when using prevalence data for programme design and review purposes regular campaigns need to be held as a core part of evaluation and refining programmes.

- **Testing as a part of a comprehensive package**

In order to reach 100% 'know your status', evidence shows that testing needs to be part of a comprehensive package, which is now commonly captured as 'Universal Access to Prevention, Treatment, Care and Support by 2010'. Testing and counselling alone will never provide sufficient incentive to test, employees and families need to know that if they test positive they will receive care, support and treatment when needed.

- **"Know the Status of Your Partner"**

Furthermore, these workplace campaigns need to go further and embrace, "Know the Status of Your Partner". This is crucial to ensure that appropriate prevention strategies are used, especially as we are seeing increasing numbers of discordant couples (where one sexual partner is positive and the other negative), indeed Uganda is now reporting around 50% discordance. Discordancy means testing both partners is crucial, otherwise an employee may test negative however his/her partner may be positive, placing the employee at risk, or vice versa. Therefore a 100% Know Your Status campaign must be extended to employees' sexual partners.

- **Ensure confidentiality, encourage 'shared confidentiality'**

Equally important, is knowing that ones result will remain confidential. Much emphasis is placed on ensuring this necessary confidentiality, especially to avoid discrimination in the workplace. However, while

[11] Negative, positive not needing ART, or positive needing ART.

guaranteeing confidentiality, it is also important to encourage people to share their status, both to assist the individual to cope and to reduce stigma that thrives in a climate of secrecy. We should strive to move from 'absolute confidentiality' to 'shared confidentiality'. However, no matter what choice people make, an individuals' right not to disclose must always be respected.

Provider Initiated Testing and Counselling (PITC)

There are increasing discussions about mandatory testing. However, there are a number of ethical concerns around individual's rights, with most organisations sharing these concerns. Nonetheless, recently there has been a shift to almost a 'half way' position, namely Provider Initiated Testing and Counselling (PITC). In this case a medical provider assesses a patient's risk and if s/he feels the patient is at risk, either due to symptoms, risk profile or because there is a generalised epidemic, s/he will recommend that the patient take a test. This then becomes a form of opt-out testing, where the patient may opt-out of testing. The World Health Organisation released Guidelines in May 2007 recommending this approach as a good balance between the individuals' right and a public health concern in a generalised epidemic. The Private sector should familiarise itself with the WHO guidelines and align their programmes to the nationally adapted guidelines.

Consider other testing opportunities

There are other testing opportunities that should also be encouraged that include: using family planning clinics to encourage women wishing to conceive or who are pregnant to test early; couple counselling and testing; 'outreach VCT' door-to-door testing campaigns have been very successful in some countries, with Uganda seeing a 95% acceptability rate in some programmes, and finally, supporting a shift towards enabling testing by lower cadres of health practitioners. The later falls under the WHO guidelines for task-shifting (as captured in *WHO: Treat, Train and Retain*), the idea is to enable lower cadres of health care workers to administer tests and medicines, thereby enabling a much larger number of tests to be conducted. The concept is gaining much support across Africa where the lack of health care workers is creating backlogs for testing and administering medicines.

Link testing to Performance Management

During the conference discussions about successes and hindrances of workplace programmes, it became evident that a 100% 'know your status' campaign in the workplace is a targeted model that would fit very well with performance management systems. Many success stories were shared about linking VCT uptake to key performance indicators and it seems a feasible model to use to stimulate a situation where encouraging testing becomes a performance related management issue.

'Know Your Status' practices suggested by the conference

- The delegates had lively discussion about 'beyond VCT' and how to achieve 100% 'know your status'. There were many innovative ideas about how programmes could be expanded to accommodate some of the ideas raised above including scaling up VCT to become comprehensive 'know your status' campaigns and creating conducive environments for testing.
- Delegates raised questions about compulsory testing in the context of such high prevalence. The meeting generally agreed that coercion is not an effective way to build support for an HIV and Aids programme or address sexual practices. Delegates were advised to consider the WHO guidelines on Provider-Initiated Testing and Counselling; this provides very helpful guidelines for countries with generalised and hyper-endemic epidemics (in other words recommending routine/diagnostic testing with opt-out.
- Make available, though not compulsory, on site testing, during working hours and linked to education programmes with external service providers to ensure the best quality services, this has also been shown to increase employees trust in confidentiality.
- Where appropriate utilise rapid testing, ensuring the method is in line with national guidelines.
- Be aware of baseline and changing prevalence levels among employees, through regular re-testing.
- Encourage 'shared confidentiality' among employees and families.
- Management should 'lead by example', and should preferably show that it has tested in public.
- 'Know your status' should be linked to incentives, such as support for people who test positive and advice to those who test negative (whatever state their health or their need for ART.

Summary of a Discussion about how to Achieve 100% 'Know Your Status' at the Workplace

- Prepare employees from the onset. Create awareness on what to expect about the programme and why.

- Engage external service providers, they were suggested to ensure absolute confidentiality and high quality of the VCT services. This builds confidence among the employees to test.

- Steering committees and peer educators should champion the programme at the workplace. They serve as examples and good role models. By providing leadership, there is increased VCT uptake.

- Involve people living with HIV and Aids , through sharing about their own experiences this may arrest fears that living with HIV and Aids is a death sentence

- Anonymous, linked, testing for purposes of prevalence surveys can offer the option for counselling and receiving the results afterwards, this often increases testing uptake.

- Regular testing in the company creates a culture of 'know your status'.

- Know your status' should be part of the induction programmes for new employees.

- Support and leadership from management and labour leaders came out as a unique and key factor in the success of 'know your status' uptake at the workplace. Senior managers should lead the way during 'know your status' days and encourage those working under them to do the same.

- Employees should be encouraged to freely and voluntarily disclose their status.

- The programmes should be tailored to meet specific needs that affects testing uptake such as knowledge, attitudes and practices. If there are misconceptions and myths about VCT, they must be addressed.

- Steering committee members should be trained about the programme and indicators for monitoring, enabling them to adjust the programme as appropriate, to ensure 100% 'know your status'.

- Integration of HIV and Aids into broader wellness programmes. Some companies have decided to treat HIV and Aids just like any other illness in order to minimise stigma and increases testing.

- Increased education about transmission and prevention of HIV and Aids is important to prepare employees to test; it can dispel fears that are based on misconceptions.

- Testing immediately after training reported high take up.

- Integrating testing uptake as a key performance indicator for managers was strongly recommended as a way to ensure the programme becomes a bottom line performance issue.

- Companies with different branches can compete in terms of testing uptake.

- The process to formulate the policy, its content and how it is shared has an impact on employees' response to it.

- Offering several options for employees after testing, especially if they are HIV positive is key.

- Use of 'significant others' in the company to champion VCT uptake. Some categories of employees have great respect from their colleagues, they should be encouraged to promote testing.

- Inclusion of sexual partners through couple counselling is key.

- Provider-Initiated testing and Counselling (PITC) or Opt-out options could be used during other medical examinations.

- *WHO Guidance On Provider-Initiated HIV Testing And Counselling In Health Facilities (May 2007) provides guidelines on when to use provider initiated testing (sometimes known as opt-out testing). It clearly states that it must respect individual rights and provide an environment where people can decline the test. It recommends that in countries with a generalised epidemic, such as all the SHWAP countries, that PITC should be used. It provides guidance on how to do so from a rights-based perspective. http://www.who.int/hiv/topics/vct/PITCguidelines.pdf*

- *WHO Treat, Train & Retain www.who.int This guideline offers an overview of WHO's proposed changes within the public health sector to enable countries to realise Universal Access despite weak public health systems. It is important to be aware of these in order to ensure coherence between private and public sector work.*

Henry's story

Henry's story epitomises what is needed to encourage an employee to disclose his/her status and how powerful it is to do so. Henry went for an HIV test after his wife passed away. His results returned positive. Fortunately for Henry he had a very supportive counsellor who helped him with the initial anguish. He disclosed to his family and pastor and they were all supportive.

Henry joined his current employer after he had learnt he was living with HIV, he did not reveal his status as he did not feel he could trust his employer. After a while he became very ill and went to a doctor outside of work, he felt safe disclosing to his doctor as he did not feel this could jeopardise his position at work.

Later Henry became very ill and needed ARVs, which he could not afford. Throughout this period of illness his managers were very understanding, despite not knowing his diagnosis. His doctor later suggested that he disclose to his manager. The combination of his doctor and counsellor encouraging him to disclose and the fact that he had begun to trust his managers, as they had been so supportive through his illness, lead him to take the brave step of disclosing to his manager. They were very supportive and the company has a comprehensive HIV and Aids mainstreamed programme that he can access, and given the high cost of ARVs it was a life-saver.

Henry eventually decided to disclose to his colleagues, he wanted to encourage friends and colleagues to test and to access the company HIV and Aids plan that he was benefiting from.

When asked why he finally chose to disclose Henry replied: "I began to think, why not share so that I can be an example to my friends at work, and maybe I can help one or two friends."

As told by Henry Chihana at the SWHAP conference, Johannesburg, July 2007

100% Treatment and Care

Clearly offering treatment is not enough – many delegates shared stories of employees and friends who had access to treatment and yet 'chose' not to take it. As one delegate said; "People die with lifelines available to them. Why?".

The conference discussed how to increase treatment uptake and support care in the home and community, below are the key issues that were raised.

Increasing adherence levels

Alex Coutinho explained that where there is high stigma, weak public health systems and low levels of support, adherence is often very low. It is very important to ensure adequate support structures and health care workers to assist with adherence and provide care, and the workplace provides an excellent opportunity to do this.

Low adherence rates point to the fact, which we have already discussed, that starting a person on treatment must be part of a comprehensive package that includes: medical care, psycho-social support, support to families and caregivers, financial and nutritional support and preferably openness to enable wider support. A positive workplace attitude towards dealing with HIV and Aids, and the benefits of treatment are key.

Providing treatment to sexual partners is key

As already mentioned, it is evident that providing treatment and care must go beyond the workplace and be a family based approach. It is important if one person is on treatment to attempt to get all his/her sexual partners on treatment and to ensure all partners practice positive prevention, in order to reduce co-infection and resistance. Furthermore family members tend to often share drugs if only one is on treatment. It is crucial to understand the family situation and respond to someone living with HIV and Aids as a part of a family, not a single entity.

Be aware of other responses

The delegates noted that while companies should embrace a holistic response, this response is often determined by the national response in their country. As mentioned earlier it is important to be aware of the public sector and NGO response and to ensure that the company programme compliments these, and avoids unnecessary duplication.

People living with HIV and Aids need more then ARV's

When designing programmes for people living with HIV and Aids it is important to think beyond providing ART. Especially in light of the fact that if 100 employees test positive, approximately 20 will need treatment. The programmes need to offer treatment for them, but it also needs to support the other 80 who do not need ARV treatment yet. This care and support includes providing information about: staying healthy, management of opportunistic infections, nutritional advice and positive prevention. In Uganda people living with HIV and Aids are provided with a basic care package that includes: ARV, malaria nets, safe water and condoms. Peer educators need regularly re-training to keep abreast of new developments

Furthermore as Alex Coutinho noted "ARV's give back life. What then?" When people living with HIV and Aids respond to treatment they become healthy again, they now have a very different set of needs as people living healthily with AIDS. Counsellors and peer educators need to be trained to assist with these changing needs, such as positive prevention.

Provide support to the caregivers

Care for people living with HIV and Aids and their children is crucial, and is desperately under-recognised, under-funded and under-staffed. Indeed, most care takes place in the home and communities, a report in 2004 showed that 90% of people sick with AIDS are cared for in their homes[12]. This home-based care places a great burden on the caregivers, who are overwhelmingly women and girls. Indeed, many women take time off from work, or eventually leave work in order to care for the sick and dying at home. A study in South Africa showed that of 312 households 40% had to take time off from work to care for the ill[13]. This has an obvious impact on both the caregiver and the employer. Both would benefit from comprehensive care and support programmes supported by the employer, for employees and their families. Comprehensive care programmes would also lead to better ARV adherence that again means healthier employees.

[12] UNAIDS, 2004, 4th Global AIDS Report, p118.

[13] Southern Africa Partnership Programme, 2005, Impact of Home Based Care on women & Girls in Southern Africa, p 26.

Treatment and care practices suggested by the conference

Offering broader programmes that include treatment and care is key, and these need, to be extended to families. However, the delegates noted that there are often financial constraints that limit broader programmes. However, as Lars G Malmer noted we need to find creative ways to overcome this and extend treatment and care to families and communities.

- In communities where roll out of treatment is limited, companies should consider extending their support beyond the period of employment, continuing to provide ARV's for a period after an employee leaves to assist in the transition from a workplace programme to public sector programme. This is crucial to ensure uninterrupted treatment to minimise resistance.
- Enrol employees on wellness programmes and disease management programmes.
- Train both employees and partners on adherence and home-based care.
- Provide information to employees about additional community services.
- Provide post-exposure prophylaxis (PEP) after rape, unprotected sex and needle –stick injuries to employees and communities
- Be compliant with international guidelines on prevention, care and treatment.
- Undertake ingoing monitoring of CD4 count and viral load where needed.
- Provide ongoing monitoring and care for opportunistic infections.
- Develop comprehensive workplace family planning clinics, that address sexual and reproductive health for men and women.
- Ensure that trade-unions and other worker representative bodies are actively engaged as important representatives of employees concerns and rights.

- *WHO Towards Universal Access by 2010 (2006) This provides guidance on the role that WHO will play in achieving universal access. It is important for programming purposes as it outlines key WHO activities towards universal access. www.who.int*

- *WHO Antiretroviral Therapy For HIV Infection In Adults And Adolescents: Recommendations for a public health approach. This provides useful guidance on treatment, and recommends beginning ARV's when the CD4 count drops below 350. http://www.who.int/hiv/pub/guidelines/artadultguidelines.pdf.*

8.Mainstreaming HIV and Aids programmes

> *"Mainstreaming HIV and Aids is a process that enables actors to address the causes and effects of HIV and Aids in an effective and sustained manner, both through their usual work and within their workplace."*[14]

This definition illustrates that mainstreaming goes beyond simply have an add-on HIV and Aids programme that might include awareness raising or VCT, or expanding health or human resource policies to include HIV and Aids . Effective mainstreaming means incorporating HIV and Aids into the core business of the organisation. Every time a key decision is made the company must reflect on two questions: what is the potential impact of this decision on HIV and Aids and what is the potential impact of HIV and Aids on this decision. Companies need to understand the impact of the epidemic on their company and employee, how their interventions has an impact on HIV and Aids and whether their goals are realistic and achievable in the context of HIV and Aids – applying the HIV and Aids lens to all decisions.

In support mainstreaming Clem Sunter shared a case from an Anglo American colliery where they have 100% up take of voluntary counselling and testing, repeated every six months. He believes this success is due to the fact that the manager at the Colliery has made testing one of his Key Performance Indicators. He has made responding to HIV and Aids as important as any other business bottom line and has made its management as normal as any other business management. This is the key to mainstreaming integration.

Why should companies mainstream HIV and Aids?

- Experience shows that when HIV and Aids is delegated to a Human Resources function without visible, high-level management involvement, the programme has low success;
- HIV affects every element of the organisation;
- Mainstreaming HIV makes it becomes a workplace-wide response, not delegated to just one individual;
- HIV and Aids programmes becomes a performance issue across the company; and
- The HIV and Aids policy then informs the Corporate Social Investment programmes

The conference reflected on what a good HIV and Aids programme would look like. A key element was that workplace policies need to ensure firstly that they are compatible with national policies and changing international developments, and secondly that they are complimenting the work of all players. Indeed, Alex Coutinho felt that we need to recognise that many of the new innovations are in the public sector, however, they are usually applicable to the private sector, and often partnerships are needed for implementation.

[14] UNAIDS working definition from, *UNAIDS: Mainstreaming HIV and AIDS in Sectors and programmes*.

HIV and Aids Programmes and Policies should

- Be shared and discussed during employee induction;
- Have the necessary resources (financial and human) made available by management;
- Include information about: nutritional supplements and post-test counselling;
- Be clear on referrals for treatment of opportunistic infections and AIDS;
- Include programmes to reduce stigma;
- Be continually monitored and evaluated, with clear indicators;
- Be based on regularly updated statistics;
- Include the provision of travel kits for employees who travel for work purposes;
- Address care and support as a holistic issue between the workplace and community;
- Enable employees to take necessary sick and caregiver leave;
- Have clear steps to ensure smooth hand over of patients from workplace clinics to community clinics when necessary;

Prevention

- Mainstreamed throughout the company and be linked to company goals and targets;
- The scope must be expanded beyond current traditional focus of VCT and sometimes treatment;
- User-friendly and brief, with separate implementation guidelines;
- Linked to Key Performance Indicators;
- Based on the use of peer educators
- Seen as a company bottom line in the same line as personal protective equipment (PPE) is viewed;

Testing

- Extend beyond VCT, to broader 'know your status' campaigns;
- Extend beyond one-off testing, it must be promoted as regular testing;
- Provider-initiated testing and counselling or opt-out testing should be considered;
- Be aligned to national policies on testing protocols;
- Have resources made available to ensure effective implementation;
- Guarantee confidentiality and non-discrimination;
- Link the Employment Assistance Programmes to external service providers;

- Not include everything in the policy, again it must be short with accompanying implementation guidelines;
- Must be actively disseminated to employees

Mainstreaming

- HIV and Aids becomes a part of all organisational core functions – planning, human resource management, marketing, service provision, budgeting, etc
- HIV and Aids becomes integrated into Key Performance Indicators across the organisation. The KPI's include: activities, outcomes, VCT uptake, support structures, treatment, behaviour change and impact assessments;
- The Programme must be driven by senior and middle-management;
- Reporting must occur at top level;
- A dedicated strategy, with clear objectives and monitoring, must be developed and implemented at all levels of the organisation; and
- The company must ensure adequate resources (financial and human) are made available.

In light of this discussion about effective mainstreaming Alex Coutinho challenged businesses to become more creative with their HIV and Aids mainstreaming. He mentioned innovative ways of including HIV and Aids into corporate social investment programmes, for instance he shared an example of a company that established a partnership with a school that needed a laboratory. The company negotiated that they would supply a laboratory if the school provided free education for 100 orphans. He also challenged the private sector more broadly to consider ideas to raise funds for HIV and Aids through their sales. He illustrated this with the example of 'Product Red', this is a concept developed by Bono in 2006, where a number of international companies joined together and provide a percentage of sales to the Global Fund for AIDS, TB, and Malaria[15].

The conference repeatedly stressed the importance of mainstreaming the HIV and Aids response using the key elements outlined above, equally there are a number of very useful tools to assist with.

- *UNAIDS: Mainstreaming HIV and AIDS in Sectors and programmes: An Implementation Guide for National Responses (2005). It discusses the six steps for mainstreaming. http://www.undp.org/hiv/docs/alldocs/MainstreamingB.pdf*
- *VSO: HIV&AIDS Mainstreaming Guide for VSO Offices, www.vso.org.uk*
- *Sue Holden, AIDS on the Agenda: Adapting Development and Humanitarian Programmes to Meet the Challenges of HIV/AIDS, Oxfam in association with ActionAid and Save the Children UK, 2003.*
- *Rose Smart, Mainstreaming HIV&AIDS, HEARD Training courses, www.heard.org.za*

[15] Product Red's primary objective is to engage the private sector in raising awareness and funds for the Global Fund to help fight AIDS in Africa. Companies whose products take on the (PRODUCT) RED mark contribute a significant percentage of the sales or portion of the profits from that product to the Global Fund to finance AIDS programs in Africa, with an emphasis on the health of women and children. www.data.org

Key challenges facing workplace HIV and Aids programmes

- Lack of, or inconsistent, management commitment;
- Declining motivation among committee members (employers and employees);
- Monitoring and managing the programmes;
- Lack of clarity around mechanisms for delivering post-VCT support including: treatment, care and support through the workplace;
- Failure to accommodate families and communities in HIV and Aids programmes;
- Mainstreaming often not effectively implemented;
- Capturing statistics and indicators;
- Lack of confidence from employees in the programme;
- Individuals fear knowing their status, which limits testing take up;
- Social cultural factors such as the influence of the some churches
- Lack of support from company international head quarters.

9. Reaching out: families and communities

The conference repeatedly emphasised the importance of families and communities, and the reality that the workplace is not an island, there was overwhelming commitment to extend programmes. As employees are sexually active, and programme effectiveness depends on accessing all sexual partners, reaching out to sexual partners must be a non-negotiable. While recognising the indivisible nature of working with sexual partners it is still important to ensure that structures are put in place to realise this. Additionally, the conference then went on to discuss how to reach the families and communities beyond the sexual partners.

The following are suggestions on expanding programmes to partners, families and communities. HIV and Aids workplace programmes should:

- Link to wellness programmes and should be holistic, and therefore be offered to the whole family, they must also be comprehensive from prevention through to palliative care
- Offer regular family and/or couple counselling and support groups for employees and families
- Undertake direct follow up with the families of employees who are living with HIV and Aids
- Companies should sponsor HIV and Aids service providers serving the communities
- Establish 'women's clubs', for female employees and female partners of employees, these create opportunities for women to discuss and address their particular vulnerabilities and burden
- Provide scholarships for families of employees living with HIV and Aids
- Provide support to deceased employees dependants, especially grandparent and child-headed households

- Encourage staff to volunteer in community programmes, ideally during work time and adopt and visit children's homes and hospices
- Link to community clinics, where they are effective, to facilitate families accessing information, testing, treatment and care at these clinics. Or where services are not available open company clinics to community members
- Provide a bridging period for patients moving from workplace clinics to community clinics if appropriate
- The workplace should link to broader service providers including: community hospices and children's homes; departments of health, social development and education to facilitate knowledge sharing and access
- Companies should support mobile 'know your status' clinics for the communities
- Offer testing at community events – family days, trade fairs etc. However, 'Know your status' campaigns in communities should not be offered in isolation and should preferably be part of a comprehensive package of prevention, treatment, care and support – probably not offered by the company but rather by Government.
- Engage with the community churches to reinforce the messages
- Develop community friendly materials that do not only speak 'company language'
- Identify other companies in the area that community programmes can link up with
- Encourage customers and suppliers to run 'know your status' campaigns at their places of work
- The company should support home-based care groups in the communities, through corporate social investment programmes

10. SWHAP Programme Considerations and Next Steps

Key challenges for SWHAP and respective country programmes

During the conference it was evident that despite the SWHAP programme being successful in many areas, there are challenges to be addressed, including:

- Setting up SWHAP networks where companies are geographically far apart
- Consolidating statistics and indicators to a level higher then the individual workplace, for programme review and reporting
- Insufficient networking and sharing, between companies and across countries, such sharing should be in a targeted way to address specific needs of members to avoid information overload
- Insufficient learning about successes and hindrances between members of SWHAP
- Uncertainty about the future of the programme
- Insufficient connectedness to national and international developments, not always keeping abreast of cutting edge developments
- As a regional structure it is important to recognise difference while looking for similarities and shared experience. SWHAP must not loose important local difference in favour of cross-country similarities and collaboration
- Call for global HIV and Aids strategies across the Swedish companies, it should not to be left to individual branches
- The Newsletter is not being accessed by everyone, it needs wider circulation
- More networking meetings at national level, they are very effective
- More exchange visits for members to learn from each other
- More use of IT to share good practice
- Companies have many regular meetings, get HIV and Aids placed on the agenda as a recurring item

It is clear that the programme has made a substantial difference in its workplaces. Practices have been reviewed, new ideas and ways of operating have been shared and lessons are beginning to drive new initiatives. The regional conference made a significant contribution to a feeling of collegiality between workplaces and mechanisms for continuing this (including the SWHAP website) will be strengthened.

Future work will focus on strengthening capacity in workplaces, reaching out more operationally and via example, and creating SWHAP workplaces as strong voices for diverse African responses to HIV and AIDS.

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