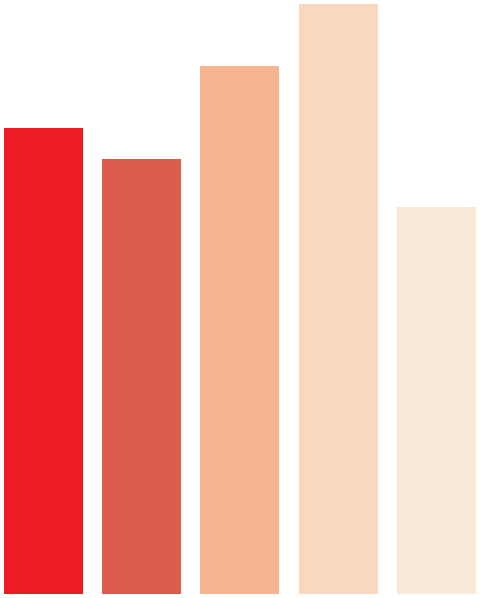
Framework Report

September 2011



THE AIDS ACCOUNTABILITY

Workplace Scorecard

AIDS Accountability international

Framework Report

The AIDS Accountability Workplace Scorecard

September, 2011

For questions regarding this
report, please contact:

Johanna Löfgren
Head of Workplace Initiative
AIDS Accountability International
Eriksbergsgatan 46
SE- 114 30 Stockholm
Sweden
johanna@aidsaccountability.org
Phone: +46 (8) 700 4612
Mobile: + 46 (7) 3051 4798

Framework Report

The AIDS Accountability Workplace Scorecard

Content

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Ramnik Ahuja, Health Advisor at Confederation of Indian Industry (CII), India
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Pamela Bolton, Associate Vice President, Knowledge, Evaluation & Performance at GBCHealth, USA
Murray Coombs, Dr. at Elixir & Health Advisor at Dow Southern Africa and Unilever Central Africa, South Africa
Charles Dalton, Executive at EOH Health, South Africa
Valentine Engoudou Douala-Mouteng, CEO at Pan African Business Coalition on HIV/AIDS (PABC)
Susana Frazao Pinheiro, Founder & President at Local Insight Global Impact**,** Portugal
Gavin George, Senior Researcher at Health, Economics and HIV/AIDS Research Division, University of KwaZulu-Natal, South Africa
Celina Gorre Managing Director at Foundation for the Global Compact, USA
Toby Heaps, President, editor and co-founder at Corporate Knights, Canada
Lee-Nah Hsu, Technical Specialist at ILO/AIDS, Geneva
Ludvig Hubendick, Programme Coordinator at Swedish Workplace HIV/Aids Programme (SWHAP), Sweden
Julian Hussey, Independent Consultant, United Kingdom
Magdalena Kettis, Head of Social and Environmental Issues, Ownership Policy at Norges Bank Investment Management, Norway
Alan Leather, Advisor to Global Unions AIDS Programme, Geneva
Charmaine McCue, General Manager at Reality Training Concepts, South Africa
Brad Mears, CEO at South African Business Coalition on HIV/AIDS (SABCOHA), South Africa
Zuzanna Muskat-Gorska, Global Trade Union HIV/AIDS Coordinator at International Trade Union Confederation (ITUC), Brussels
Carol O'Brien, Executive Director at The American Chamber of Commerce, South Africa
Sara C. Page-Mtongwiza, Deputy Director, at Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), South Africa
Nick Rouse, Managing Director at Frontier Markets Fund Managers, United Kingdom
Alyson Slater, Former Strategy and Communications Director at Global Reporting Initiative (GRI), The Netherlands
Linzi Smith, Managing Director at Education, Training and Counselling (ETC), South Africa

Glossary

AIDS	The acquired immunodeficiency syndrome which results from advanced stages of HIV infection, and is characterized by opportunistic infections or HIV-related cancers, or both.
Antiretroviral Therapy	Treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs. When several such drugs, typically three or four, are taken in combination, the approach is known as Highly Active Antiretroviral Therapy, or HAART.
Employee	Any person(s) performing work for monetary compensation.
HIV	The human immunodeficiency virus, a virus that damages the human immune system.
Human rights	The rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status.
Reasonable accommodation	Any modification or adjustment to a job or to the workplace that is reasonably practicable and enables a person living with HIV or AIDS to have access to, or participate or advance in, employment
Stigma	The social mark that, when associated with a person, usually causes marginalization or presents an obstacle to the full enjoyment of social life by the person infected or affected by HIV.
Tuberculosis	An infectious bacterial disease caused by Mycobacterium Tuberculosis, which most commonly affects the lungs.
Workplace	The physical location where employment and associated activities take place.
Workplace-related Discrimination	Any distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation, as referred to in the ILO Discrimination (Employment and Occupation) Convention, 1958, and Recommendation, 1958.

Acronyms

ART	Antiretroviral therapy
ARVs	Antiretroviral drugs (see Antiretroviral therapy)
HTC	HIV Testing and Counselling
IFC	International Finance Corporation
ILO	International Labour Organization
KABP	Knowledge, Attitude, Practice and Behaviour
M&E	Monitoring and Evaluation
MNC	Multi National Corporation
N/A	Not Applicable
PLHIV	Persons living with HIV
PITC	Provider Initiated Testing and Counselling

SWHAP	Swedish Workplace HIV/AIDS Programme
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS

Introduction

The aim of the AIDS Accountability Workplace Scorecard is to improve HIV and AIDS workplace programmes in the countries and sectors most affected by the disease, and improve the health of employees, their families and communities. Through this initiative we will:

1. Provide tools for HIV and AIDS workplace programme monitoring and evaluation

AAI has developed scorecard tools for small, medium and large workplaces, which can be used to assess a global, regional or national HIV and AIDS programme or interventions at a specific workplace site. The scorecards can serve as both internal monitoring and evaluation tools and as assessments to present to stakeholders within and outside the organization.

2. Publish annual Rankings of HIV and AIDS Workplace Programmes

Scorecard users who wish to receive a ranking analysis and recommendations for how to improve their programmes can submit their scorecards to AAI. AAI 's ranking analysis will allow users to compare their performance with others and over time also measure their own progress. Respondents will be encouraged to publish their ranking in AAI's yearly Ranking Reports.

3. Share good practice

The knowledge and good practices generated through the published rankings will be used to stimulate improved HIV and AIDS Workplace Programmes worldwide. Large networks of companies, trade union confederations, and national and international organizations can use the scorecard as a common framework for monitoring and evaluation of workplace programmes.

HIV and AIDS Affecting Workplaces

Even though a lot of progress has been made since the first cases of HIV were identified in the mid-1980s, the epidemic continues to pose huge challenges. Many developing countries and especially countries in sub-Saharan Africa, as seen in Table 1 below, are facing a generalized epidemic, meaning that more than 1% of the adult population is HIV infected. Other countries have non-generalized epidemics, but still very large populations of persons living with HIV (PLHIV), as seen in Table 2.

HIV is mainly transmitted through sexual intercourse, meaning young and middle-aged adults are the most vulnerable to contracting the virus. The HIV epidemic is affecting the size, growth rate, age and skills composition of labour forces and the productivity of workplaces in the most affected regions and sectors. In this way, the epidemic is limiting the profitability of businesses and diminishing their competitiveness. Workplaces affected by HIV and AIDS face direct, out-of-pocket costs such as increased benefit premiums and costs of recruitment and training as well as indirect costs from reductions in labour productivity through increased absenteeism, increased senior management time to deal with HIV matters, loss of workforce morale and experience and, ultimately the loss of workers who die from AIDS.

Small and medium size workplaces are particularly vulnerable to HIV and AIDS. They have small workforces and the loss or prolonged absenteeism of one or more key employees can even result in the collapse of the business.

Labour intensive industries in countries with large numbers of PLHIV are most likely to experience the impact of HIV on productivity. These industries include: mining; oil and gas; construction and transportation; agribusiness; and manufacturing. The health sector is also especially vulnerable to HIV and AIDS.

Table 1. Countries with generalized HIV epidemics

Countries with adult (15-49 years) HIV prevalence of 1% and above (UNAIDS, 2010)

Sub-Saharan Africa		**Asia and the Pacific**		**Europe and Central Asia**		**Middle East and North Africa**		**North America, Caribbean and South America**	
Angola	2.0%	Thailand	1.3%	Russian Federation	1.0%	Djibouti	2.5%	Bahamas	3.1%
Benin	1.2%			Ukraine	1.1%	Sudan	1.1%	Barbados	1.4%
Botswana	24.8%			Estonia	1.2%			Haiti	1.9%
Burkina Faso	1.2%							Jamaica	1.7%
Burundi	3.3%							Trinidad and Tobago	1.5%
Cameroon	5.3%							Belize	2.3%
Central African Republic	4.7%							Guyana	1.2%
Chad	3.4%							Suriname	1.0%
Congo	3.4%								
Côte d'Ivoire	3.4%								
Equatorial Guinea	5.0%								
Gabon	5.2%								
Gambia	2.0%								
Ghana	1.8%								
Guinea	1.3%								
Guinea-Bissau	2.5%								
Kenya	6.3%								
Lesotho	23.6%								
Liberia	1.5%								
Malawi	11.0%								
Mali	1.0%								
Mauritius	1.0%								
Mozambique	11.5%								
Namibia	13.1%								
Nigeria	3.6%								
Rwanda	2.9%								
Sierra Leone	1.6%								
South Africa	17.8%								
Swaziland	25.9%								
Togo	3.2%								
Uganda	6.5%								
United Republic of Tanzania	5.6%								
Zambia	13.5%								
Zimbabwe	14.3%								

Table 2. Countries with non-generalized HIV epidemics and large populations of PLHIV

Countries with non-generalized HIV epidemics and an estimated adult (15+) population living with HIV above 500 000 (UNAIDS, 2010)			
Asia and the Pacific	*Number of adults living with HIV (HIV prevalence)*	**North America, Caribbean and South America**	*Number of adults living with HIV (HIV prevalence)*
China	730 000 (0.1%)	United States	1 200 000 (0.6%)
India	2 300 000 (0.3%)		

HIV and AIDS Workplace Programmes

"*Heineken decided several years ago that a comprehensive policy for HIV/AIDS, including all aspects of prevention, non-discrimination and treatment, is both a sound business decision and a clear way forward for our company. We can only hope that our example inspires other leaders, be they in business or government, to actually deliver on the things that have been promised over and over again."*
Dr. Stefaan Van der Borght, Director of the Health Affairs Department at international brewer, Heineken.

Fighting stigma and discrimination

The relationship between human rights and HIV is profound. Violations of human rights, such as discrimination against women or men who have sex with men, lead to increased risks of HIV infection and in turn, HIV causes further human rights violations. Punitive policies, practices and stigma and discrimination are hindering access to HIV prevention, care and support services.

The 2010 *ILO Recommendation on HIV and AIDS and the World of Work* (No.200) sets the international human rights standard for the response to HIV and AIDS in the workplace. The Recommendation No. 200 is cited in the 2011 Political Declaration adopted by United Nations member States during the high level meeting on AIDS in New York, which calls for

" […] employers, trade and labour unions, employees and volunteers to eliminate stigma and discrimination, protect human rights and facilitate access to HIV prevention, treatment, care and support." (United Nations General Assembly, 2011).

Box 1. Examples of discrimination and stigmatization in the workplace

- Job termination due to real or perceived HIV status.
- Temporary absence from work because of illness or care giving duties related to HIV or AIDS is treated differently than absences for other health reasons.
- Employees and/or their dependents affected by HIV and AIDS are discriminated against in access to social security systems and occupational insurance schemes.
- Mandatory or forced HIV testing of employees and/or jobseekers and job applicants.
- Lacking procedures to protect employees' medical and personal data confidentiality.

Keeping employees healthy

In addition to respecting internationally proclaimed human rights, good practice workplace responses to HIV and AIDS should include cost efficient investments in a healthy workforce.

1. Prevention

An HIV and AIDS Workplace programme should include behaviour change communication interventions to raise awareness and educate employees at all levels on HIV and AIDS. Peer education is an evidence-based and cost efficient approach to HIV and AIDS education (UNAIDS 1999 Best practice collection: Peer education-Concepts, Uses and Challenges).

Moreover, the workplace should provide training on prevention of occupational risks of HIV and tuberculosis and access to prevention and treatment of some HIV related infectious diseases such as sexually transmitted infections and tuberculosis.

2. Treatment, Care and Support

The workplace should also facilitate access to voluntary counselling and testing for HIV, through referral or onsite provision. HIV treatment provision to eligible employees has proved to have positive financial returns for most companies. Studies conducted in countries in Sub Saharan African countries by the Boston University School of Public Health have shown that providing treatment to HIV infected employees produced positive returns on investment for the vast majority of companies (Rosen et al, 2004 & Rosen et al. 2007). For example, a study from 2004 shows that six corporations in South Africa and Botswana would have earned positive returns on their investments if they had provided employees with free HIV treatment. In addition, a number of unmeasured and/or non-financial benefits such as reductions in the time managers spend coping with employee deaths and turnover and mitigation of the impact of AIDS on workforce morale, motivation and discipline were identified (Rosen et al, 2004).

Support to employees affected by HIV and AIDS cover a wide range of interventions. For example the workplace should offer employees living with HIV reasonable accommodation and time off for medical visits, ensure that the workplace is an environment free from stigma and discrimination and provide psychosocial support to employees affected by HIV and AIDS.

Box 2. Case Study: Cost-benefit analysis of treatment for companies in South Africa

In 2008 the Swedish Workplace HIV and AIDS Programme (SWHAP) conducted an HIV and AIDS impact assessment of ten of its partner companies in South Africa.

Methodology

The SWHAP HIV/AIDS impact assessment consisted of three parts: i) estimating HIV prevalence in the workplace, ii) estimating the financial impact in a non-intervention scenario and iii) assessing the impact of three different intervention strategies against the baseline financial case. The assessed intervention strategies were:

Scenario 1: employee wellness management and treatment for sexually transmitted infections (STIs).
Scenario 2: scenario 1 + anti-retroviral treatment at an eligible CD4 count of 200. The CD4 count is a measure of how much the immune system has been weakened by HIV. The higher the number the stronger your immune system.
Scenario 3: scenario 1 + anti-retroviral treatment starting earlier at a CD4 count of 350.

The estimated HIV prevalence among the employees of the ten workplaces was estimated at 12.9%. The study projected that, in a non- intervention scenario, the aggregated additional costs of HIV and AIDS for the companies involved could exceed 450 million ZAR (64 million USD) during 2008-2012.

Early treatment - the most beneficial intervention

The cost-benefit analysis of the three scenarios revealed mainly positive results – while the results for the third scenario, showed by far the greatest impact. As companies' treatment costs were deducted from the gross savings realized by the third intervention strategy, the potential savings were 47% of the additional costs of HIV/AIDS for the non- intervention scenario, compared to 0.7% and 4% for the other two scenarios respectively.

Provision of anti-retroviral treatment at a CD4 count of 350 thus yields a much greater return on investment, even though the cost related to this intervention is markedly higher than those of the other strategies. The savings were related to a decreased number of exits due to death or ill-health retirement caused by HIV and AIDS, which resulted in lower costs for recruitment, overtime and supervision, as well as maintenance of productivity levels. An estimated 48% of total savings were also due to the decreased premiums for death and ill-health retirement benefits.

Source: Adapted from the Swedish Workplace HIV and AIDS Workplace Programme, 2008.

Programme Extension

An HIV and AIDS workplace programme needs to account for the fact that the families and dependants of employees are equally affected by HIV and AIDS, and to an appropriate extent seek to include families and dependants in programme activities. The workplace should also consider covering suppliers, subcontractors and the extended community where it operates.

Partnerships

In order to establish a sustainable HIV and AIDS programme it is recommended that the workplace partners with National health authorities or AIDS Committees, NGOs, medical organisations or other local service providers in the implementation of the prevention, care and support services.

Benefits of the Workplace Scorecard

The Workplace Scorecard is designed to serve individual companies and organizations both as a monitoring and evaluation tool and as an objective assessment to present to stakeholders. AAI's ranking analysis will enable companies and organizations to benchmark their workplace programmes against their peers and, over time against themselves, and to gain knowledge about how their programmes can be improved.

Large networks of companies, trade union confederations, and national and international organizations can use the scorecard as a common framework for monitoring and evaluation of workplace programmes.

Questionnaires

The Workplace Scorecard questionnaires can be ordered for free and can serve as self-assessment or guidance tools for companies and organizations that wish to set up a workplace programme or monitor progress of their interventions.

Ranking analysis

For those requesting a benchmarked analysis and ranking of their workplace programme to present to their board, investors and other stakeholders, it will be possible to report the scorecard results to AAI and receive a ranking analysis, information about the strengths and weaknesses identified in the analysis and recommendations for how the programme can be improved.

Publication of rankings

Scorecard respondents will be encouraged, but not required, to publish their results on AAI's website and be part of the annual Ranking that AAI will launch globally.

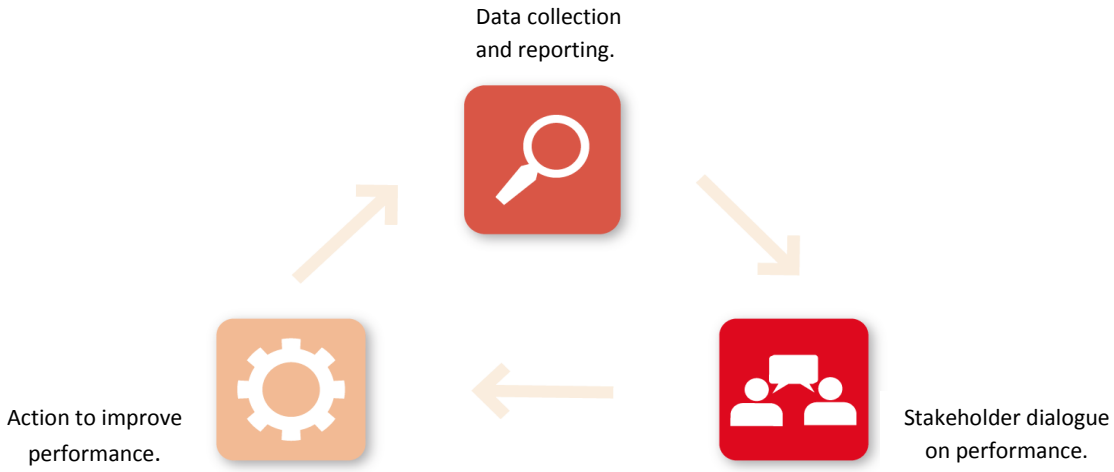
In 2011, AAI and South African Business Coalition on HIV and AIDS (SABCOHA) have formalized a partnership to establish the *South African Business AIDS Awards (SABAA*), which aims to incentivize SABCOHA's member companies to report on their HIV and AIDS programmes by recognizing excellent workplace interventions by category and business sector/industry. The assessment of award candidates will made based on the AIDS Accountability Workplace Scorecard methodology and SABCOHA's Bizwell M&E framework. The award will be jointly managed by SABCOHA and AAI, with AAI conducting the independent ranking analysis of the candidate companies and compiling the award report.

Workplace Accountability Framework

AIDS Accountability International (AAI) was established in 2006 and is an independent non-profit organization working to accelerate progress in the response to AIDS by developing tools with which leaders in society can be held accountable.

Building on AAI's framework for government accountability, our previous research, consultations with experts on HIV and AIDS Workplace Programmes and the findings from AAI's country scorecard projects, the AIDS Accountability Workplace Scorecard is guided by a workplace accountability framework, presented in Figure 1. It is important to note that all three steps of the framework are necessary for an adequate workplace response to HIV and AIDS and that the steps are performed in a circular process where interventions and performance are continuously monitored, reported, discussed and improved.

Figure 1. Workplace Accountability Framework



Data collection and reporting

In order to assess whether a company or organization is responding adequately to the HIV and AIDS challenge, data on activities and performance is needed. This information should be evaluated by a programme committee consisting of management and employee representatives.

Considering the fact that monitoring an HIV and AIDS workplace programme involves managing personal and medical information, the existence of workplace policies and practices to ensure *confidentiality* and *data protection* are of critical importance. All scorecard respondents will be requested to provide information on such policies and practices before submitting data through the scorecard questionnaire, as presented in Box 3.

Information about the workplace HIV and AIDS programme should be made available in an accessible manner to other relevant stakeholders and reported on in annual reports and sustainability reports. The organization should aim to achieve the highest possible level of transparency, while at the same time not violating the employees' right to confidentiality in personal and medical data.

Box 3. Assessing confidentiality and data protection

Does the workplace have policies on confidentiality and data protection principles such as:

1. Purpose—data should only be used for the purpose stated and not for any other purposes;
2. Consent—data should not be disclosed without the data subject's consent;
3. Notice—data subjects should be given notice when, by whom and for what purpose their data is being collected, processed or disclosed'
4. Security—collected data should be kept secure from any potential abuses;
5. Access—data subjects should be allowed to access their data and make corrections to any inaccurate data;
6. De-identification – data should not be kept longer than is necessary for the purposes for which the data were collected
7. Accountability—data subjects should have a method available to them to hold data collectors accountable for following the above principles.

Source: The International Trade Union Confederation

Stakeholder dialogue on performance

Monitoring and evaluation of a workplace programme is not worth much if it does not include a constructive dialogue on what can be learnt from the data and how the programme can be improved. This dialogue should include stakeholders who have been identified as important to the workplace HIV and AIDS Programme. These should be allowed to review relevant data, ask questions and be part of an open discussion about priorities, actions and performance.

This type of stakeholder engagement is increasingly recognized as a fundamental accountability mechanism in the private sector as it encourages explaining and answering for actions. Moreover, if performed well, stakeholder dialogues will increase the company's knowledge on the complex issues influencing the success of a workplace response to HIV and AIDS and contribute to their license to operate.

For the purpose of the Workplace Scorecard, we have chosen to focus on a limited number of aspects pertinent to stakeholder dialogue. In the planning of the workplace HIV and AIDS programme a key activity is to map the stakeholders that affect and/or could be affected by the workplace programme. While some stakeholder groups will vary depending on the programme type and the context in which the workplace is operating, all workplaces have employees. The employees, and their families and dependants, will be the primary target group for the workplace HIV and AIDS interventions and thus be directly affected by the interventions. The Workplace Scorecard will assess the degree to which employee representatives are invited to discuss the performance of the workplace programme.

In addition, we will capture whether PLHIV, represented by HIV positive employees or organizations representing PLHIV, have been consulted in the management of the workplace programme.

Other potential stakeholders include shareholders, suppliers, public and private service providers and NGOs. Companies and organizations that engage in community interventions should involve relevant community members in the dialogue on the performance of those interventions. It is however not within the current scope of the Workplace Scorecard to assess the extent to which these stakeholders are invited in this type of dialogue.

Action to improve performance

The last but critical step is the endeavouring to improve on the poor performance that has been identified by stakeholders in the monitoring and evaluation of its HIV and AIDS programme.

Proof of improved performance can of course only be tracked over time. The annual AIDS Accountability Workplace Rankings will showcase companies and organizations that have achieved extraordinary improvements in their workplace programmes.

Moreover, AAI is of the view that companies and organizations with well-functioning workplace programmes should be encouraged to share knowledge and good examples with other workplaces and organizations, as well as within national, regional and international networks. The dissemination of successful approaches will help improve the overall performance of the HIV response.

Three Guiding Principles

In addition to the accountability framework, the Workplace Scorecard will be guided by three additional principles, which have been identified through AAI's research and consultations as critical to the HIV and AIDS response. These are human rights, gender equality and evidence informed approaches.

Human rights

Human rights based HIV and AIDS workplace policies and programmes are aligned with the general principles of the ILO Recommendation No. 200. These are provided in Appendix 1. One key principle is that no employee should be required to undertake an HIV test or disclose their HIV status. Box 4 below explains how the Scorecard is guided by this principle. Voluntarism is also closely linked to the principle of employees' right to privacy and confidentiality in personal and medical data, which are described in the section "Data collection nd reporting" above.

Further, the workplace should be a supporting environment for HIV infected employees, and free from stigma and discrimination based on sex, gender, sexual orientation, real or perceived HIV status. One way to ensure that the workplace policy and programme is fulfilling the rights of people living with HIV is to ensure that representatives of this group are engaged in the planning and management of the programme.

Box 4. Human rights based HIV testing

A major challenge in the global response to HIV is the fact that a majority of people still are unaware of their HIV status. It is therefore of great importance that workplace programmes seek to encourage HIV testing of employees, their families and dependants. Of equal importance is the condition that the HIV testing offered should be *voluntary*, *confidential* and that it involves pre- and post-test *counselling*.

AAI fully supports the position of the UNAIDS Reference Group on Human rights and HIV (2007), that all HIV testing- whether initiated by provider or client- requires informed and truly voluntary consent by the person tested, post-test counselling and confidentiality of test results and of the fact of seeking a test. These conditions are sometimes referred to as the "three Cs":

- Consent
- Counselling
- Confidentiality

The term VCT which is used in the Workplace Scorecard and the ILO Recommendation No. 200 stands for voluntary counselling and testing. In our view VCT better captures the human rights relevant to HIV testing than other commonly used terms such as HIV testing and counselling (HTC) or Provider-initiated HIV testing and counselling (PITC).

Gender equality

Women and girls are more vulnerable to HIV infection and are disproportionately affected by the HIV pandemic compared to men as a result of gender inequality. While there are biological reasons that make women more vulnerable to HIV infection, the major factors of increased risk for women are social and cultural, in particular the inequality and disempowerment that come from being female in different contexts. Women are often vulnerable as a result of the behaviour of others, or because they lack the tools, information and resources needed to protect themselves.

In the context of the workplace, gender based discrimination of women can take many forms. Some companies do not hire women because they do not want to deal with maternal leave. Others do not provide time off for child births or maternity benefits. Women are also often disadvantaged in terms of wages, benefits and promotion possibilities. Sexual harassment and physical abuse in the workplace and the prevention of women from organizing in trade unions or participating in decision-making processes are other examples of gender based discrimination.

The Workplace Scorecard will assess the extent to which the workplace HIV and AIDS programme is gender mainstreamed through four types of questions. We acknowledge that there are several other ways to assess whether a particular programme is addressing gender inequalities, but these four strategies were chosen based on consultations with the Workplace Scorecard Development Team (see Appendix 2) and our previous research on the AIDS Accountability Scorecard on Women (2009).

1. Workplace responses to HIV should include interventions to *empower women and promote the active participation of both women and men* in the response to HIV and AIDS. For example, workplaces should make sure that women are not excluded from HIV and AIDS education and training due to family related responsibilities, and they should ensure gender balance in the composition of HIV and AIDS committees and peer educator teams.

2. Moreover, the workplace HIV and AIDS education and training should include *awareness raising and discussion on the gender dimensions of the epidemic* such as gender norms in relation to HIV risk factors and health seeking behaviours as well as the links between HIV and gender based violence.

3. Finally, the monitoring and evaluation of the workplace programme should include *sex disaggregated data.* This information is critical in order to assess whether women and men are getting their fair shares of attention and support. The quantitative data should be complemented with a discussion on how gender factors are influencing the process and results of the programme, and suggest how gender equality can be improved.

4. Other dimensions of gender such as norms that define masculinity, or the human rights and public health needs of people with different sexual orientations, are also central to an effective response to AIDS. The workplace should *promote the involvement and empowerment of all employees regardless their sexual orientation and whether or not they belong to a vulnerable group.*

Box 5. Getting the terms right- Sex and Gender

> The term ‘sex’ refers to biologically determined differences, whereas ‘gender’ refers to differences in social roles and relations. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity, and religion, as well as by geographical, economic, and political environments
>
> *The AIDS Accountability Scorecard on LGBT (2011)*

Evidence-informed approaches

The third guiding principle for the Workplace Scorecard is evidence-informed approaches. In line with UNAIDS' terminology, AAI rather uses the term evidence-informed than evidence based to acknowledge the importance of other inputs, such as human rights concerns, in policy making and programme design.

AAI will follow the ongoing research and policy discussion on workplace HIV and AIDS and make sure the Workplace Scorecard stays attuned with the most up to data findings and recommendations.

Scorecard Overview

The Workplace Scorecard is divided into four thematic sections, or *elements*:

1. Governance
2. Prevention
3. Treatment, Care and Support
4. Programme Extension

Each element consists of five indicators, which gather essential information on programme activities or results. Box 6 presents the Scorecard elements and themes of the indicators.

Box 6. The Scorecard Elements

Scorecard Elements	
1. GOVERNANCE	**2. PREVENTION**
1.1 Risk Assessment	2.1 Education and Training
1.2 HIV and AIDS Policy	2.2 Occupational Health and Safety
1.3 Programme Management	2.3 Peer Education
1.4 Monitoring and Evaluation	2.4 Condom Promotion
1.5 Fighting Stigma and Discrimination	2.5 HIV Related Diseases
3. TREATMENT, CARE AND SUPPORT	4. **PROGRAMME EXTENSION**
3.1 Voluntary Counselling and Testing (VCT)	4.1 Community Outreach
3.2 VCT Uptake	4.2 Families and Dependents
3.3 ARV Treatment	4.3 Family Coverage
3.4 ARV Uptake	4.4 Supply Chain
3.5 Treatment Adherence	4.5 Partnerships

Ranking Methodology

The ranking methodology is based on three criteria:

1. *Taking the workplace context into account.*

The Workplace Scorecard is designed to be applicable to any workplace programme in a country with a generalized HIV epidemic. However, when ranking the scorecard results it is critical to avoid a situation where we 'compare apples with pears'.

Evidence has shown that small and medium size workplaces, for various reasons, are less likely to address HIV in the workplace than large workplaces or multinational companies. Small, medium and large workplaces will therefore be ranked separately.

Companies and organizations that wish to rank their global or regional programmes will also be ranked separately. Since these programmes often cover countries with very different HIV epidemics, a prevalence weighting will account for the workforce rate that is located in a generalized epidemic context. The higher the rate of the workforce in countries with generalized epidemics, the more will be expected from the workplace programme.

We thus have four different rankings:

- Small workplaces: 1-50 employees
- Medium sized workplaces: 51-250 employees
- Large workplaces: >250 employees
- Global/regional programmes covering workplaces in more than one country

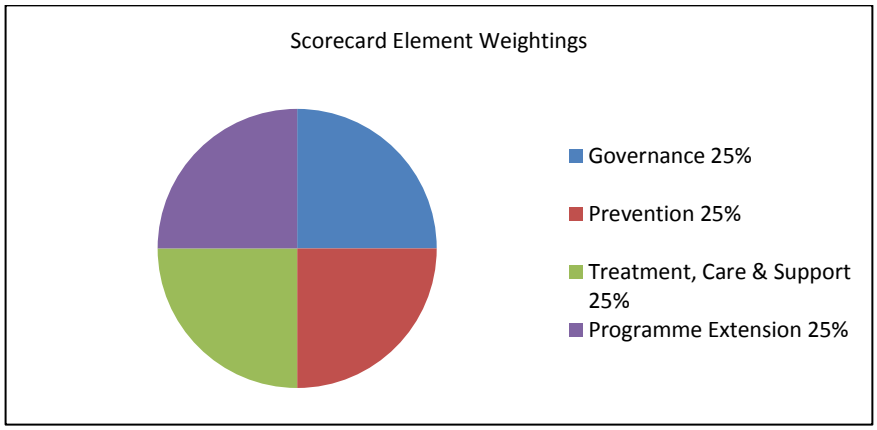
2. *In line with the new ILO standard on HIV and AIDS and the Workplace.*

One key principle of the ILO Recommendation No. 200 is that HIV and AIDS should be recognized and treated as a workplace issue. For this reason, three out of four scorecard elements are solely looking at workplace related interventions. This is not to say that community outreach is less important, but it rather a natural consequence of the decision to base the Workplace Scorecard on the ILO Recommendation No. 200.

3. *Simple to understand.*

As illustrated in Figure 2, the four elements of the Workplace Scorecard are weighted equally, as are the twenty indicators that shape the elements. In this way, it is easy for respondents and readers to understand how the ranking has been calculated, and consequently how the results can be improved.

Figure 2. Weightings of Scorecard Elements



Methodological considerations and limitations

The Workplace Scorecard is designed to suit all industries, sectors and programmatic approaches in high prevalence contexts. For example it will not favour any treatment service scheme over another. However, it should be noted that data availability varies from country to country. For example, M&E capacity in South Africa is better than other countries in Sub Saharan Africa. Also, workplaces with employer provided treatment or wellness programmes monitored their HIV treatment services while companies that refer employees to external service providers typically do not have access to the same level of information on ARV uptake and adherence. In order to make general claims on reporting differences and their relation to programmatic approach or country context, we will need to gather data from a larger number of workplaces.

The dual aim of the Scorecard is to identify programme innovations and effective practices and generate quantifiable results that can be scored and ranked. This requires a balance between quantitative and qualitative indicators. The Scorecard does not attempt to cover *all* the possible information pertinent to the monitoring and evaluation of a workplace programme, but is a summary of the most essential, comparable HIV and AIDS workplace programme indicators. Even if it would be possible to cover everything, it would not be desirable considering the reporting time and effort that could reasonably be expected from scorecard respondents.

One key consideration in developing the Scorecard was to find indicators that can be monitored and reported by workplaces without disrespecting the confidentiality of employees or other beneficiaries (see more above under *Data collection and Reporting*). The Scorecard does therefore not include indicators that could violate employees' right to confidentiality in medical and personal data.

Reporting and Validation

Participating companies and organizations will submit workplace information through scorecard questionnaires, available on AAI's website. To ensure high quality data, these questionnaires should be signed by management, appointed worker representative and the staff member responsible for the HIV programme. Moreover, AAI will use interviews and onsite visits as means to verify the data provided by respondents.

Collaborative Research Process

The Workplace Scorecard has been developed based on extensive consultation with the experts and specialists in the Workplace Scorecard Development Team. The team has met in regular telephone conferences and participated in online consultations. Two physical workshops were also held in 2010, one in Johannesburg and one in London. Development members are listed in Appendix 2.

The initial scorecard draft was developed by Gavin George from the Health, Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, South Africa and presented in a working paper "Ranking Companies in their response to HIV/AIDS" (George, 2010).

Pilot Studies

In order to test the feasibility of the Workplace Scorecard at an early stage, in 2009 AAI piloted a version of the Scorecard together with the Swedish Workplace HIV/AIDS Programme's (SWHAP) member companies in seven countries in Eastern and Southern Africa.

During spring 2011, a new pilot was conducted with seven multinational corporations (MNCs) that provided data through a pilot questionnaire and a follow-up telephone interview. The pilot companies were selected through purposive sampling. Only companies with operations in countries with generalized HIV epidemics were selected. Also, in order to access data in a relatively short time period we chose only MNCs, which were expected to have staff appointed for sustainability reporting. The global workforces represented in the pilot ranged from 20,000 to 90,000 employees. Thirdly, we selected companies that already report on their HIV and AIDS workplace programmes, in their annual reports or sustainability reports and on their company websites. Finally, to gather information on the added value of the Scorecard from a private sector employer's perspective, we targeted companies that have been recognized internationally for their HIV and AIDS workplace programmes. All participating companies have either won or been "commanded" by the Global Business Coalition on Health's Excellence Awards. Several have also been recognized by the ILO or the World Economic Forum for their work on HIV and AIDS.

The seven companies that agreed to participate in the pilot study are presented in greater detail in Table 3. As seen in the table, two companies reported on their global HIV and AIDS programmes; two on specific workplaces; two on national operations and one on regional operations.

Table 3. Companies participating in 2011 pilot study

2011 Pilot Companies							
	COMPANY 1	COMPANY 2	COMPANY 3	COMPANY 4	COMPANY 5	COMPANY 6	COMPANY 7
INDUSTRY	Manu-facturing	Wholesale and retail trade	Financial inter-mediation	Mining and quarrying	Mining and quarrying	Manu-facturing	Manu-facturing
REPORTING UNIT	One plant in Rwanda	Global programme	Global programme	All plants in South Africa	One plant in South Africa	Regional: Africa	South Africa
# OF EMPLOYEES AT UNIT	508	18,228	88,000	~ 72,000 full time employees	9500 (incl. contractors)	13,500	2983

Outcomes

The data from the two pilot studies have not been published. Instead the studies were used to strengthen the scorecard questionnaire and ranking methodology. An earlier version of the scorecard questionnaire turned out to be too policy oriented. As a consequence, the new questionnaire has a better balance between policy indicators and activity- output- and outcome indicators. Another pilot finding was that respondents as well as reviewers benefitted from indicators with multiple choice alternatives. The alternatives serve as benchmarks and enable a comparison of the progress level, frequency and quality of the HIV and AIDS activities.

It should be noted that the pilot studies included private sector workplaces only. In 2011/12 it is our aim to test the methodology with public and non-for-profit workplaces. We also wish to further test the scorecard outside Sub Saharan Africa, first and foremost in the Caribbean and Asia.

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Appendix 1: ILO Recommendation No. 200 General Principles

From the Authentic Recommendation Text:

> *III. General principles*
>
> *3. The following general principles should apply to all action involved in the national response to HIV and AIDS in the world of work:*
>
> *(a) the response to HIV and AIDS should be recognized as contributing to the realization of human rights and fundamental freedoms and gender equality for all, including workers, their families and their dependants;*
>
> *(b) HIV and AIDS should be recognized and treated as a workplace issue, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of organizations of employers and workers;*
>
> *(c) there should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection;*
>
> *(d) prevention of all means of HIV transmission should be a fundamental priority;*
>
> *(e) workers, their families and their dependants should have access to and benefit from prevention, treatment, care and support in relation to HIV and AIDS, and the workplace should play a role in facilitating access to these services;*
>
> *(f) workers' participation and engagement in the design, implementation and evaluation of national and workplace programmes should be recognized and reinforced;*
>
> *(g) workers should benefit from programmes to prevent specific risks of occupational transmission of HIV and related transmissible diseases, such as tuberculosis;*
>
> *(h) workers, their families and their dependants should enjoy protection of their privacy, including confidentiality related to HIV and AIDS, in particular with regard to their own HIV status;*
>
> *(i) no workers should be required to undertake an HIV test or disclose their HIV status;*
>
> *(j) measures to address HIV and AIDS in the world of work should be part of national development policies and programmes, including those related to labour, education, social protection and health; and*
>
> *(k) the protection of workers in occupations that are particularly exposed to the risk of HIV transmission.*

Appendix 2: Scorecard Development Team Members

The Workplace Scorecard has been developed through consultations with a Development Team of experts and specialists in workplace HIV and AIDS programmes.

Ramnik Ahuja, Health Advisor at Confederation of Indian Industry (CII), India
Asif Altaf, Global HIV/AIDS Coordinator at International Transport Workers' Federation (ITF), United Kingdom
Pamela Bolton, Associate Vice President, Knowledge, Evaluation & Performance at GBCHealth, USA
Charles Dalton, Executive at EOH Health, South Africa
Susana Frazao Pinheiro, Founder & President at Local Insight Global Impact**,** Portugal
Gavin George, Senior Researcher at Health, Economics and HIV/AIDS Research Division, University of KwaZulu-Natal, South Africa
Celina Gorre Managing Director at Foundation for the Global Compact, USA
Toby Heaps, President, editor and co-founder at Corporate Knights, Canada
Lee-Nah Hsu, Technical Specialist at ILO/AIDS, Geneva
Ludvig Hubendick, Programme Coordinator at Swedish Workplace HIV/Aids Programme (SWHAP), Sweden
Julian Hussey, Independent Consultant, United Kingdom
Magdalena Kettis, Head of Social and Environmental Issues, Ownership Policy at Norges Bank Investment Management, Norway
Alan Leather, Advisor to Global Unions AIDS Programme, Geneva
Charmaine McCue, General Manager at Reality Training Concepts, South Africa
Brad Mears, CEO at South African Business Coalition on HIV/AIDS (SABCOHA), South Africa
Zuzanna Muskat-Gorska, Global Trade Union HIV/AIDS Coordinator at International Trade Union Confederation (ITUC), Brussels
Sara C. Page-Mtongwiza, Deputy Director, at Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), South Africa
Nick Rouse, Managing Director at Frontier Markets Fund Managers, United Kingdom
Alyson Slater, Former Strategy and Communications Director at Global Reporting Initiative (GRI), The Netherlands
Linzi Smith, Managing Director at Education, Training and Counselling (ETC), South Africa

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- Learn more about the Workplace Scorecard
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- Be informed of developments

For further information or queries please contact:

Johanna Löfgren, Head of Workplace Initiative
johanna@aidsaccountability.org

Danga Mughogho, Liaison Officer
danga@aidsaccountability.org

AIDS Accountability International
Rating Centre
Plein Park Building
69-83 Plein Street
Cape Town
South Africa 8001
Telephone: +27 21 466 79 56

Secretariat
Eriksbergsgatan 46
114 30 Stockholm
Sweden
Telephone: +46 8 700 46 14

info@aidsaccountability.org
www.aidsaccountability.org