CGIAR GENDER AND DIVERSITY PROGRAM
WORKING PAPER NO. 38

HIV/AIDS Policy in the CGIAR Workplace: The Challenge of Implementation

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Draft for discussion

Table of Contents

Tables

Acknowledgements

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The process provides yet another example of cooperation in the CGIAR – and underscores the commitment that Future Harvest Centers make to their staff, as they seek to address the challenge of HIV/AIDS in the workplace.

Thanks, too, to consulting researcher Dr. Nancy Allen for her skills of investigation and analysis, helping us to come to grips with some of the most complex and rapidly changing issues facing our organizations today.

Vicki Wilde
Program Leader

Executive Summary

This study was designed to review the progress and on-going challenges of implementing HIV/AIDS policy in the CGIAR. The study rests on three foundations: (1) a survey of HIV/AIDS policy implementation at all 16 Future Harvest Centers; (2) a case study of HIV/AIDS policy implementation in Kenya; and, (3) an exploration of insurance coverage for HIV/AIDS medical care.

The study concludes that policy development has been sound. Half of all Future Harvest Centers have developed an HIV/AIDS Workplace Policy. There is strong commitment to the core principles of non-discrimination and non-disclosure with regard to HIV status throughout the system. Implementation has been slow in the fundamental areas of education and prevention, including such concerns as encouragement of Voluntary Counseling and Testing (VCT), development of peer counseling programs, distribution of condoms, and staff training. Most critically, Centers have made little progress in the urgent matter of medical coverage for HIV/AIDS treatment for nationally recruited staff (NRS).

Meanwhile, the global pandemic rages on with no region immune from the personal, social and economic ravages of HIV/AIDS. Although sub-Saharan Africa continues to lead the grim statistics, the virus is now spreading rapidly in Asia where there are now equally dire predictions.

On the positive front, the price of anti-retroviral drugs (ARVs) has dropped significantly in many developing countries, dramatically so in some countries in sub-Saharan Africa within the past year. The drop in cost of ARVs has made HIV/AIDS treatment an affordable option for Future Harvest Centers. Moreover, evidence is building from international studies that investments in HIV/AIDS education and prevention and ARV therapy offer clear financial benefits to organizations. Future Harvest Centers must consider what changes to medical schemes are necessary to make this option a reality for all nationally recruited staff.

The study presents evidence that insurers in Africa may be responding to the reduction in ARV prices by improving coverage for HIV/AIDS treatment. Centers are encouraged to explore those options locally, but if they are not successful in that regard, the study also presents

indicative costs for supplemental self-insurance for HIV/AIDS, as well as international insurance coverage secured on the basis of regional or inter-regional pooling. These latter options, while considerably more expensive than many medical plans now in place, offer HIV/AIDS coverage absent from many current plans.

Finally, the study recommends that all Centers continue to take an active interest in the continuing development of HIV/AIDS policy and practice, as the environment for HIV/AIDS prevention and care is changing rapidly, both locally and internationally. All Centers, regardless of location, must pay closer attention to the HIV/AIDS education and care being extended by host institutions to their Africa- and Asia-based staff as they cannot safely assume that HIV/AIDS care is being fully managed on their behalf. All Centers must engage in an accelerated and concentrated effort to implement HIV/AIDS policy, especially with regard to HIV/AIDS education and prevention in such areas as VCT. All Centers are encouraged to localize HIV/AIDS Policy in very concrete terms with specific information regarding availability and cost of ARVs, identification of vetted VCT Clinics, sources of post-exposure prophylaxis (PEP) kits and lists of locations for safe blood.

Introduction

Another one among us has died of AIDS.

In the course of this study, a confirmed case of AIDS resulted in the death of another Future Harvest colleague. It is almost certain that other employees have died of AIDS in the past year, but in the absence of consistent care for persons living with HIV/AIDS, Future Harvest Centers are unable or reluctant to say more than we 'suspect he or she died of AIDS' or 'medical claims suggest that we have five other HIV/AIDS cases, or maybe as many as ten.' For some, the uncertainty fuels heightened concern; for others the lack of certainty permits inattention.

Exactly one year ago, in October 2001, the CGIAR Gender & Diversity Program put forward model guidelines for HIV/AIDS policy and practice as a resource to Future Harvest Centers. Its goal was to encourage adoption of HIV/AIDS policies and programs, in order to:

- Prevent further HIV infection among all CGIAR employees and their family members;
- Preserve the lives of those employers and their family members currently infected with HIV/AIDS;
- Provide compassionate care for those employees and their family members suffering and dying from AIDS;
- Foster a workplace that does not discriminate on the basis of disease; and,
- Set an example of compassionate management of HIV/AIDS in the communities in which the CGIAR works.

Progress on HIV/AIDS policy formulation in the CGIAR has been generally sound, but implementation of policy remains a challenge.

Meanwhile, the global pandemic rages on with no region immune from the personal, social and economic ravages of HIV/AIDS. Sub-Saharan Africa continues to lead the grim statistics with more than 15 million deaths, more than 12 million orphans, and HIV prevalence rates greater than 15% in much of East Africa, more than 30% in some countries in Southern Africa, and approaching double digits in a number of West African countries.

But Asia, where the virus is spreading the fastest, is rapidly becoming the focus of equally dire predictions. Thailand has been on the HIV/AIDS map for a number of years already, with HIV/AIDS prevalence rates of about 2 percent, which equals one in 60 of all people, and one in 30 of all working people.[1] In China, if current infection rates hold steady, 10 million people will be HIV-positive by 2010. In Indonesia, explosive rates of HIV/AIDS prevalence in particular sub-populations and geographic regions are sparking fear of very rapid diffusion of HIV infection in the general population. [2] Indeed, patterns of HIV infection in Indonesia, Cambodia, and Vietnam are near textbook examples of HIV/AIDS epidemic diffusion. In India, the description of HIV disease must account for large geographic differences with some states such as Maharashtra, Andhra Pradesh and Tamil Nadu now registering HIV rates over three percent in pregnant women, far exceeding the national average. In the Philippines where HIV/AIDS prevalence remains fortunately very low, concern is focused on risky behaviors that are almost certain to contribute to the eventual spread of HIV.[3]

But there is some encouraging news. The price of anti-retroviral drugs (ARVs) has dropped significantly in many developing countries, dramatically so in sub-Saharan Africa. Efforts at education and prevention are thought to be having positive impact at the national level in some countries in Africa, notably Senegal and Uganda. Further investment by development agencies in surveillance and intervention systems in Asia hold a glimmer of hope that the spread of the disease can be arrested before it reaches the disastrous levels now prevalent in Africa. Finally, research into an HIV/AIDS vaccine continues.

The HIV/AIDS pandemic is a pressing challenge for the CGIAR. HIV/AIDS affects the health of friends and colleagues, the quality of work, and ultimately, prosperity and development throughout the world. In light of these challenges, the CGIAR has established a

[1] According to the Thailand Business Coalition on AIDS at http://europa.eu.int/comm/development/aids/html/n10305.htm, September 2002.
[2] In Bogor, Indonesia the home of CIFOR headquarters and a large ICRAF regional office, one study shows HIV infection rates among intravenous drug users (IDUs) at 25%. A typical pattern of diffusion for the HIV virus is from IDUs to sex workers to the clients of sex workers and then into the general population. (MAP, October 2001)
[3] Data drawn from UNAIDS and Map, October 2001.

"Systemwide Initiative on the Impact of HIV/AIDS on Agriculture, Agricultural Research and Development" (SWIHA). The CGIAR Gender & Diversity program was asked to take the lead to address the problem of HIV/AIDS in the CGIAR workplace. The Gender& Diversity (G&D) program welcomed this challenge, not only because it is an issue of enormous global significance, but also because HIV/AIDS is having a disproportionate impact on nationally recruited staff, which poses a direct threat to the diversity G&D seeks to foster.

In 2001, the G&D issued working paper 28 "HIV/AIDS in the CGIAR Workplace: Model Policies and Practices". Future Harvest Centers responded to the worldwide epidemic by establishing thoughtful and well-crafted policies on HIV/AIDS. This study was designed to review the progress in policy formulation, with a primary focus on the challenges of implementing HIV/AIDS policy. The study builds on three areas of investigation: (1) a survey of HIV/AIDS policy implementation at all 16 Future Harvest Centers; (2) a case study of HIV/AIDS policy implementation in Kenya; and, (3) an exploration of insurance options for HIV/AIDS medical care.

G&D HIV/AIDS Survey Results

As a foundation for this study, the CGIAR Gender & Diversity program conducted a survey of all 16 Future Harvest Centers. The survey sought information in three different areas: (1) the status of HIV/AIDS workplace policy and implementation in the CGIAR; (2) estimates of HIV/AIDS incidence and impact; and, (3) information on insurance policies for nationally recruited staff. Information on insurance was gathered to assess the existing circumstances for HIV/AIDS care and as a basis for further research on insurance options.

STATUS OF HIV/AIDS WORKPLACE POLICY AND IMPLEMENTATION

HIV/AIDS Workplace Policy
8 Centers have established or drafted HIV/AIDS policies that are committed to:

- No testing for HIV/AIDS
- Hiring without regard to HIV status
- Confidentiality with regard to HIV status

All Centers are honoring their commitments in these fundamental areas.

Most Future Harvest Centers located in developing countries, have established, or are in the process of developing, an HIV/AIDS workplace policy. Although most have been issued as stand-alone documents, a few Centers have incorporated them into human resources policy documents. Three Centers in developing countries appear to have no plans to issue an HIV/AIDS document, but they are notably headquartered in countries with relatively low HIV/AIDS prevalence, CIAT and CIP in Latin America and ICARDA in the Middle East. Nonetheless, CIP, for example, has expressed strong concerns about HIV/AIDS workplace issues for its project and program staff located in Africa and has taken the important step of

naming an HIV/AIDS focal person based in Africa. IFPRI, IPGRI and ISNAR have not instituted HIV/AIDS policies on the stated (or apparent) grounds that compliance with strong host country laws "obviates the need for a separate specific statement for HIV/AIDS." In summary, exactly one-half of all Centers have developed an HIV/AIDS workplace policy.

The process of policy formulation in many Centers has been highly participatory. Almost all Centers have made use of G&D working paper no. 28 "HIV/AIDS in the CIGAR Workplace: Model Policies and Practices," in drafting their policies.

Job Access, Job Security and Principles of Non-Disclosure

All of the Centers that have established an HIV/AIDS policy, as well as those who have submitted policies to their Boards, have made, or expect to make, strong policy commitments to non-discrimination and non-disclosure:

- Job Access – no pre-employment screening or testing for HIV/AIDS;
- Job Security – no employee will be terminated on the basis of his or her HIV status; and,
- Principles of Non-Disclosure -- knowledge of an employee's HIV status will be treated in complete confidence.

Table 1 summarizes these commitments.

Table 1: Policy Commitment to Job Access, Job Security, and Non-Disclosure

	HIV/AIDS Policy	Job Access	Job Security	Non-Disclosure
Africa				
IITA	February 1999	Yes	Yes	Yes
ICRAF	May 2001	Yes	Yes	Yes
ILRI	January 2002	Yes	Yes	Yes
WARDA	Submitted to Board	Yes	Yes	Yes
Asia				
IRRI	January 2001	Yes	Yes	Yes
IWMI	November 2001	Yes	Yes	Yes
ICLARM	Submitted to Board	Yes	Yes	Yes
Latin America				
CIMMYT	January 2002	Yes	Yes	Yes

Some Centers have had difficulty implementing the 'job access' clause, because they have been unable to find insurers who do not require HIV/AIDS testing. These Centers have, nonetheless, demonstrated their commitment to non-discrimination by not endorsing the practice of testing, by refusing to the greatest extent possible knowledge of the test results, and finally, of course, by employing staff regardless of their HIV status. Responses to questions regarding implementation of the

'job security' clause, as well as conversations at ICRAF and ILRI, indicate that CGIAR centers are honoring their commitment.

Some Centers have faced the painful reality of watching an employee become disabled by AIDS. WARDA reports, for example, on the discreet attempt to place ill employees in "less-tasking assignments." One respondent expressed concern that the commitments to 'job access' and 'job security' are, in effect, commitments to employing, or maintaining employment of people unable or unfit to perform their jobs. [4] It must be stressed that no HIV/AIDS policy document reviewed in the course of this study should be construed as making such a commitment.[5] The sad reality in the current environment, however, is -- that when disability insurance will not pay because a person has AIDS, when hospitalization benefits run out and medical insurance does not cover in-home care -- that Centers have allowed dying employees to continue working at low levels of productivity, in order that they can support their families for as long as possible. This is not a desirable outcome, either for the Center or for the employee. It is hoped that improved HIV/AIDS care in the future will allow a more dignified and less painful choice for individuals and Centers.

[4] In the HIV/AIDS literature this is labeled as a "fear of AIDS exceptionalism " and expresses the concern that people with HIV/AIDS will be treated better than employees with other diseases. This not the intent of HIV/AIDS policy, nor is there any evidence from this study that that is happening. The fact remains that organizations need to acknowledge that HIV may be different from other diseases because the stigma it carries can compromise care. Additionally, the sheer numbers of employees that have or may develop HIV/AIDS suggests a specific, concentrated response by employers worldwide.

[5] Many HIV/AIDS policies are careful to state that HIV/AIDS will be " treated like any other chronic disease" or "in the eventuality that an employee becomes disabled that he or she will be treated according to the usual standards and policies for disability" or, for example, that "no person who is unfit for work will be employed."

Education and Prevention, VCT, Equitable Insurance

HIV/AIDS Policy and Implementation

- 6 Centers have made education and prevention a central tenet of policy, but implementation has been modest.
- 8 Centers have made a firm policy commitment to VCT, but implementation remains spotty.
- No Center in Africa has been able to make a firm policy commitment to equitable insurance for NRS.

The remaining pillars of HIV/AIDS policy advocated by many international organizations: namely, investing in HIV/AIDS education and prevention; encouraging employees to consider Voluntary Counseling and Testing (VCT); and, providing equitable insurance for nationally recruited staff (NRS) have not been so easily adopted.

Table 2 provides a summary of those commitments.

Table 2: Policy Commitment to VCT, Education & Prevention, Equitable Insurance

	Education & Prevention	VCT	Equitable Insurance
Africa			
ICRAF	Yes	Yes	"No" -- "we are trying to evaluate how to develop this aspect of our policy"
IITA	Not as matter of policy, but in active practice	Yes	"No" -- 'NRS is entitled to equitable care but care is limited to poor level of in-country inpatient care'
ILRI	Yes	Yes	"We are "exploring opportunites"
WARDA	Yes	Sound Practice	"Complex issue"
Asia			
ICLARM	Yes, for employees and families	Yes	"No" -- 'unfortunately in Asia this poses a great challenge'
IRRI	Yes	Yes	"Yes"
IWMI	No	Yes	"Yes"
Latin America			
CIMMYT	Not as matter of policy, but in practice	Yes	"Yes" – 'policy assures that HIV/AIDS coverage will be available to IRS and NRS'

Table 2 shows quite clearly that many Centers feel that their ability to provide equitable insurance, or in some cases any coverage for HIV/AIDS treatment at all, is compromised by locally available insurance and care options.

IMPLEMENTATION: EDUCATION AND PREVENTION

HIV/AIDS Policy Implementation: Education and Prevention

- Education: Most Centers in developing countries have conducted one or more seminars on HIV/AIDS.
- Prevention: Two Centers provide condoms through lavatory dispensers. One Center makes condoms available through its on-site clinic, One Center includes condoms in travel kits.
- VCT: One Center provides VCT at its on-site Clinic. One Center has identified a VCT Clinic and disseminated that information.
- Training: Staff training for HIV/AIDS has been limited to a few efforts in the area of confidentiality.

Education

Most Centers have engaged in a modest measure of HIV/AIDS education and prevention regardless of formal policy commitments. A small number of centers are making a concerted effort. Providing basic HIV/AIDS awareness seminars is the most common educational activity. In a number of cases, seminars have been widely inclusive with invitations extended to casual laborers, on-site partner organizations, other partner organizations and family members. It is interesting to note that the level of attendance at seminars and workshops correlates very closely with HIV/AIDS prevalence in the region – seminars and workshops at Africa-based centers are said to be well or very well attended, while in Latin America, where HIV/AIDS prevalence remains relatively low, seminars have apparently been poorly attended.

Prevention

Condoms are not widely available to staff, but some progress is being made. Four Centers. CIFOR, ICRAF, ICRISAT, IITA, now make condoms available to staff, but only one of those centers, ICRAF, has made them available in both female and male lavatories. The survey indicates that a number of Centers have discussed placement of condom dispensers, but have not determined a course of action. It is clear that the issue of condom provision remains a difficult and culturally sensitive topic, requiring each Center to exercise its best judgment.

Voluntary Counseling and Testing (VCT)

Experience from Africa suggests that VCT is the perhaps the most important mechanism for successful, concentrated HIV/AIDS education and prevention. Only a few Centers have taken any significant action in this area. Studies also suggest that when people receive VCT, discussion of HIV/AIDS in the workplace becomes more open and more positive, enabling further education, prevention and compassionate intervention. HIV/AIDS workplace policy, therefore, increasingly stresses the importance of publicizing VCT clinic locations and providing referrals to qualified VCT Clinics. WARDA has established a relationship with a VCT Clinic and referral information has been widely disseminated at the Center. IITA states that the on-site clinic in Ibadan can provide VCT while IRRI's clinic at Los Banos can provide testing, but no counseling. Two other Centers advise that they can provide referrals to a VCT Clinic on request. One Center qualified its commitment to VCT expressing a concern about the impropriety of approaching a staff member regarding testing of any kind. It is precisely for this reason that referral information needs to be widely disseminated, making the choice be entirely voluntary and yet systematically encouraged.

Training

No Center has provided any staff training in the area of supervision of HIV/AIDS employees. Three centers, CIMMYT, ICLARM, WARDA, have provided some form of training in the confidential handling of medical information. This contrasts sharply with UN agencies and the World Bank that have instituted careful confidentiality procedures for the management of HIV/AIDS medical information. The need for training and procedures for the confidential management of HIV/AIDS medical information is likely to become more pronounced as more Centers begin to provide ARV therapy.

Appendix 2 (1) provides a comparative review of education and prevention implementation, focusing on seminar activities, VCT, condom distribution, and staff training.

IMPLEMENTATION: PEER COUNSELING, SAFE BLOOD, OCCUPATIONAL HEALTH AND SAFETY

HIV/AIDS Policy Implementation: Peer Counseling, Safe Blood, OHS

- One Center has initiated a peer counseling program.
- Two Centers provide a list of safe locations to obtain blood.
- Centers with Occupational Health and Safety Guidelines generally include references to HIV/AIDS.

Only one Center (WARDA) has initiated a peer counseling program, although a number of centers state that some form of peer counseling is under consideration. It is surprising that more of the Africa-based Centers have not considered or developed a peer counseling program. Successful peer counseling programs instituted at other organizations of similar size have been able to achieve an openness that enables improved HIV/AIDS care, even where financial constraints limit what the organization can offer.

Only two Centers have made available a list of locations where one might obtain safe blood, although the UNAIDS model policy considers this a standard element of medical information and HIV/AIDS prevention that should be provided to all employees.

Travel kits are currently provided by only one Center (CIFOR), and although they provide condoms CIFOR has not decided whether to include post-exposure prophylaxis (PEP) kits. PEP is a complex treatment for exposure to HIV, and is discussed in the next section of the paper.

Appendix 2 (2) provides a comparative review of HIV/AIDS policy implementation, with attention to peer counseling, safe blood location lists, occupational safety and health standards, including the provision of travel kits and PEP kits.

IMPACT AND INCIDENCE OF HIV/AIDS ON FUTURE HARVEST CENTERS

Impact and Incidence of HIV/AIDS

- 3 Centers, all in Africa, report "feeling the impact" of HIV/AIDS in the workplace.
- 6 Centers report that they are "concerned about the future".
- 7 Centers report that they are "not currently experiencing the impact".

The survey questionnaire asked whether a Center was "feeling the impact of HIV/AIDS in terms of ailing employees, death of employees, or other HIV/AIDS related family or work stress?" Three Centers, all located in Africa, reported they were "feeling the impact" currently, while another six Centers professed to be "concerned about the future." Another seven Centers responded that "no" they were not currently experiencing the impact of HIV/AIDS. Of course, these short answers cannot capture the intensity of the impact or the depth of the concern. Conversations with directors and other staff members at African Centers both before and during this study, often revealed intense concern, heightened by the uncertainty for the future.

The questionnaire went on to ask whether Centers were particularly concerned about staff in some regions or employment categories. As expected, Centers answered overwhelmingly that they were most concerned for staff posted in Africa, generating the following list of countries of concern across the various Centers: Ethiopia, Ghana, Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda, and Zimbabwe. Indeed, these are all countries with double-digit rates of HIV prevalence. This is a critical issue for further development of policy and implementation. It is not safe to assume that location in Africa puts a staff member in touch with best practice on HIV/AIDS policy and implementation. Concern for staff posted in Africa requires closer attention to HIV/AIDS policy implementation, especially to medical coverage being provided either by host institutions or through other field office, program and project arrangements. We recommend that Centers outside Africa name an HIV/AIDS focal person with the responsibility to review current education and prevention activities as well as medical coverage being provided to Africa-based staff.

Estimating the incidence of HIV/AIDS at Future Harvest Centers proved difficult as it does in all organizations that commit to no HIV/AIDS testing. In summary, most Centers based in Africa estimate variously that they have two-to-three, or five- to-10 HIV/AIDS cases among those insured by the Center. These numbers are based primarily on medical claims or center-based clinic information. In this manner, the total estimate of HIV/AIDS cases across all Centers ranges from eight-to- 25.[6] These are all relatively certain cases, and based on conversations at ICRAF and ILRI it is safe to assume that Centers recognize that there are certainly other AIDS cases still not identified through current mechanisms. The struggle to improve HIV/AIDS risk assessment is discussed in the next section.

Appendix 1 provides UNAIDS data on HIV prevalence for each country in which a Future Harvest Center is headquartered.

INSURANCE COVERAGE FOR NATIONALLY RECRUITED STAFF

Insurance for Nationally Recruited Staff

- Centers, in general, do not provide an enabling environment for HIV/AIDS care, in the form of medical, disability or life insurance.
- Only a few Centers in Asia and Africa provide medical schemes that are likely to cover the cost of HIV/AIDS treatment, even with greatly reduced ARV prices.

The survey included an extended series of questions on existing insurance coverage for nationally recruited staff (NRS) in order both to increase understanding of the current situation for HIV/AIDS care and to establish a baseline for assessing whether Centers should consider other insurance options that offer improved care for HIV-positive staff members.

NRS in developing countries are covered under a wide variety of plans, almost all of which are either locally procured and/or self-funded and many of which exclude HIV/AIDS care either explicitly or by virtue of plan limits. In short, only a few Centers in Asia and

[6] We did not include theoretical estimates based on national HIV/AIDS prevalence rates, although this is a useful starting point for risk assessment.

Africa provide insurance coverage that is likely to cover the cost of HIV/AIDS treatment, even at greatly reduced prices for ARVs.[7]

All NRS at all Centers receive some form of outpatient and inpatient coverage with internal distinctions occurring at only three of the Centers.[8] Patterns of coverage for employees of African and Asian Centers generally exhibit similarities with modest coverage limits, some amount of HIV/AIDS testing by local insurers and sometimes explicit exclusions and limitations for HIV/AIDS. Insurance coverage for NRS in Latin America appears to be in a class of its own, providing unlimited or very high coverage, including full coverage of HIV/AIDS care with much of the service being extended through the National Health Plans, in the case of CIAT and CIMMYT.

Appendix 3 (1) and C (2) contain comparative tables of outpatient and inpatient coverage of Centers located in developing countries.

[7] Internationally Recruited Staff (IRS) and many Regionally Recruited Staff (RRS) at Future Harvest Centers are currently covered under an AETNA medical insurance plan, administered by AIARC. As of 1 January 2003, this medical coverage will switch to J Van Breda, a leading global insurer based in Belgium. HIV/AIDS is treated as a pre-existing condition in the first year of employment during which time coverage is limited to US$4000, as is the case with other pre-existing conditions. After the first year of employment, HIV/AIDS is treated as any other medical condition and is subject to the standard limitations of the plan. ISNAR, IPGRI and IFPRI provide medical coverage to NRS that is either identical to or equivalent to that provided IRS throughout the system. Of the seven Centers employing staff in the RRS category, four covered RRS under the same AETNA plan as IRS, two Centers covered RRS under the same plan as NRS, while one Center provided separate coverage for RRS.

[8] Distinctions occurred in two cases on the basis of wage/salary levels and in one case between urban-based and other staff.

Outpatient Coverage

Outpatient Health Coverage

- Self-insurance – Approximately one-half of all Centers located in developing countries self-insure for outpatient coverage, providing Centers the freedom to determine appropriate HIV/AIDS coverage.
- On-site clinics – 7 Centers operate on-site clinics that, depending on capacity, could perform important functions in the area of HIV/AIDS education, prevention and care.

The distinguishing feature of outpatient coverage for NRS in the CGIAR is the number of Centers providing outpatient care on a self-insured basis. Approximately one-half of all centers located in developing countries self-insure. Additionally, almost one-half of the Centers operate a clinic on-site, managed either by a local health management firm under local insurance cover or by the Center itself, on a self-insured basis. These choices reflect the perceived inadequacies of local insurance coverage and/or medical care in many locations, a reality for which Centers have sought to compensate even before the additional concerns prompted by HIV/AIDS. Self-insurance, of course, gives the Center the freedom to provide HIV/AIDS care if medical services are available and they so choose[9].

Coverage limits for outpatient care vary from less than US$500 per year to "unlimited coverage," although, on closer examination, it is important to note that "unlimited coverage" involves qualifications and sometimes significant limitations. Even where the plan does not explicitly limit or even address HIV/AIDS, the median coverage limit for Asia and Africa-based Centers is unlikely to cover the cost of ARV treatment, except in those countries where generic ARVs are already available. Even in those latter countries, it is worth examining whether current coverage limits would extend to the management of opportunistic infections and other HIV/AIDS related care.[10]

[9] Only two of the Asia/Africa Centers (CIFOR and IITA) who self-insure stated that their "plan covers HIV/AIDS related expenses, including ARVs." CIFOR also advises that HIV/AIDS care is difficult to obtain in Indonesia due in great part to government regulations. IITA is the only Center that appears to have the capacity to provide HIV/AIDS care, although ARVs in Nigeria are currently costly at a reported US$250.00 per month.

[10] In two of the countries where generic ARVs are available, Sri Lanka and India, the outpatient coverage limits of the Centers are less than US$500.00 per year.

On-site clinics can perform important functions in the education, prevention, and care for HIV/AIDS. Four Centers reported that their on-site doctor would be able to extend medical services for HIV/AIDS patients, although only three of those advised that they had access to ARV drugs. Other Centers were more cautious about capacity in this area, stating "no" the clinic is not prepared to provide HIV/AIDS care. Confidence in the clinic's ability to provide HIV/AIDS care should be examined with caution. HIV/AIDS medical care is considered to be a special area of expertise and in some countries physicians must be specially licensed to provide anti-retroviral therapy. With regard to VTC, Centers need to ascertain whether the clinic can provide the requisite pre-test and post-test counseling that must accompany testing.

Inpatient Coverage

Inpatient Health Coverage

- More than half of all inpatient and hospitalization plans are subject to HIV/AIDS restrictions.
- Many local insurers require HIV/AIDS testing.

Like outpatient care, inpatient health plans are highly varied across Centers. Centers are less likely to self-insure for inpatient care, seeking external insurance to cover the less predictable risks associated with hospitalization. More than half of these plans are subject to restrictions for HIV/AIDS. Many local insurers require HIV/AIDS testing at th time of employment. The ability of many Centers to extend HIV/AIDS care in hospital is severely compromised.

Appendix 3 (2)) provides further details.

Cost of Medical Coverage

Costs of Health Care Coverage
Reported costs of medical coverage for Centers located in developing countries range from less than US$300 per NRS employee per year to US$1,250 per NRS employee per year.

The cost to the Centers of medical care provided to NRS was not easily determined using survey responses. Most Centers reported that data was not available or that it would be provided at a later date. This is understandable, as medical costs for NRS are often a complex combination of local insurance, self-insurance, on-campus clinic expenses and very different arrangements for inpatient and outpatient coverage. For those few Centers able to report the total cost of NRS medical care, the range ran from less than US$300 to approximately US$1,250 per employee per year, with African Centers generally at the low end of the range.[11] In this case, the contrast with the cost of medical insurance at IFPRI, ISNAR and IPGRI is instructive with IFPRI spending over US$1,000,000 on total health expenses, more than US$6,000 per employee[12], while IPGRI pays over US$2,000 per nationally recruited employee. The immediate implication is that international insurance coverage schemes for NRS modeled on that of IRS would almost certainly be considered prohibitively expensive by the Centers. Fortunately, there may be intermediate options that allow for improved HIV/AIDS care. These options will be discussed at greater length in the final section of the paper.

Disability and Life Insurance

Staff Disability and Life Insurance
Almost all Centers provide some disability and life insurance for nationally recruited staff.
About one-third of disability and life insurance providers require an HIV/AIDS test.
About one-third of disability and life insurance providers will not pay a claim if the individual is disabled by or dies of AIDS.

[11] We suspect, although no data was made available, that the current medical expenditures at some Asian Centers are also low as reflected in the very low coverage limits under self-insured plans.
[12] It was unclear whether the US$1,000,000 figure included IRS and NRS, or just NRS – therefore the US$6000 is an approximate figure.

Life insurance and disability insurance are essential components of HIV/AIDS employee care. As phrased by an AIDS insurance advocate:

> "Health insurance gets you access to medical treatment how and when you need it, disability insurance helps to cushion the devastating financial blows if you become unable to work and lose your income, and life insurance promises to help smooth the financial path of those you love in the event of your death."[13]

Almost all Centers, 78 percent, provide some form of disability insurance, and all Centers provide some life insurance. However, at a number of Centers neither life insurers nor disability insurers will pay benefits if the client is known or even presumed to have HIV/AIDS. Aside from any financial loss, this has other very negative effects. It acts as a major deterrent to improved HIV/AIDS care and communication. Employees fear that if they learn their HIV status and/or reveal their HIV positive status to medical insurers, that they will jeopardize payment under disability or life insurance plans. As there has been little hope of extended life through medical treatment, most HIV-positive employees choose to remain silent about their condition and work as long as possible, hoping to maintain access to disability benefits and life insurance payments.

Most insurers requiring an HIVAIDS test report those results to Centers and some, not all, insurers refuse to extend a contract if the test is positive. Most organizations as well as many doctors conspire with patients to avoid noting the cause of death or disability as HIV/AIDS on insurance documentation. Even if a life insurer pays a claim, some organizations now attach the payment to reduce outstanding hospital bills so often associated with an AIDS death, thereby further compromising the capacity of the family to carry on after his or her death.

The concerns about medical coverage for HIV/AIDS have overshadowed concern for life and disability insurance coverage. Many Centers responded that that they did not know if an insurer

[13] See Paul Hampton Crockett. "Your Insurers are Not Necessarily Your Friends." Retrieved from http://www.thebody.com/crocektt/insurers.html. 9 September 2002.

would pay a claim in the event of an AIDS death or disability. These Centers are strongly encouraged to investigate this issue. If it is determined that an insurer would not pay, alternatives should be explored. Development NGOs working in refugee and war zones, for example, must already self-insure for death and disability benefits and are able to extend those benefits in the case of HIV/AIDS. The study did not undertake an extended investigation of alternative options.

Appendix 4 offers a comparative review of life and disability insurance issues at Future Harvest Centers.

Lessons from the Kenya Case Study

At the time the CGIAR Gender & Diversity Program began this study in April 2002, Future Harvest Centers in Kenya, ICRAF and ILRI, were wrestling with a number of immediate HIV/AIDS concerns. Indeed, the experience of ILRI and ICRAF were formative in the design of the survey. It was decided that undertaking a case study in Kenya would help us bring to light the realities of adapting HIV/AIDS policy to local circumstances. The goal was to find answers to practical questions of implementation -- How might ILRI and ICRAF gain access to ARVs? Would it be possible to get logistical assistance from the World Bank or the UN? Is it true that no local insurers provide HIV/AIDS coverage? Are there other methods for insurance coverage that could be tested in the Kenya context? Is there good local HIV/AIDS data, or are there local consultants that can help assess risk for HIV/AIDS?

Additionally, Kenya is host to a large number of donor agencies and development NGOs. It is headquarters for the United Nations Environment Program (UNEP) and Habitat, home of a World Bank mission, and the regional base for many other UN agencies. Thus, Kenya offers an opportunity to learn how other organizations are dealing with these same issues. It is the combination of visits to other organizations, local insurance agents, doctors' offices, and interviews at ILRI and ICRAF that constitute the "Kenya case study."

The Kenya case study prompted discoveries in a number of areas. An important lesson from the study is that the world of HIV/AIDS workplace policy is evolving very rapidly. Organizations that were just beginning to look at HIV/AIDS issues at the onset of this study in April 2002 are now considering HIV/AIDS treatment programs. Some insurance firms are responding, albeit modestly, to the reality of HIV/AIDS in their marketplace. International research organizations are building evidence for pro-active care. The pace of change is palpable.

Some of the case study details are unique to Kenya and East Africa, but in the process links have been made to critical issues of HIV/AIDS care with implications far outside the region. Undertaking this case

study provided a valuable opportunity to investigate the implementation of the World Bank and UN models for HIV/AIDS care that have been upheld as models of best practice.

The case study focuses on several issues of importance to the Future Harvest Centers: costs and access to ARVs, the costs and benefits of investment in ARV therapy, assessment of HIV/AIDS risk in organizations, and the response of other organizations to the inadequacies of local insurance coverage for HIV/AIDS. In addition during the course of the study, interesting information emerged about issues of confidentiality and post-exposure prophylaxis.

ANTI-RETROVIRAL THERAPY: OPPORTUNITY, OPTION, OBLIGATION

HIV/AIDS Treatment

- Anti-retroviral therapy for HIV/AIDS employees is now a very real option for Future Harvest Centers.
- Many Centers as well as field offices are located in countries with reduced-cost and/or generic ARVs.
- Centers must decide what changes to medical schemes are required to make ARV therapy a reality for NRS.

In 2001, when the G&D Program presented a model for workplace policy, the cost of treatment for people living with HIV/AIDS was perceived by many organizations as prohibitive. Since that time, the costs of anti-retroviral drugs (ARVs) -- the chief component of effective HIV/AIDS treatment – have fallen dramatically. In Kenya, a "triple cocktail" of ARVs now costs approximately US$85 per month, which is less than one-quarter of what it cost one year ago. Similar reductions have occurred in other low and middle-income countries through the reduced price offers of leading pharmaceutical companies.[14]

The greatest reduction in prices, however, has occurred in those countries that are producing or importing generics. Thus, in Uganda where generics are available, ARVs can be purchased at about one-half or less of the price of the equivalent non-generic ("originator") drugs in neighboring Kenya. *Medecins Sans Frontieres* one of the chief advocates for access to essential medicines in developing countries, recently published a paper trying to provide organizations with updated information on sample prices for low- and middle- income countries.[15] They conclude, along with a number of other advocacy groups, that the lack of transparency continues to hinder access to

[14] Global public pressure led to a partnership between the UN and five pharmaceuticals in May 2000 called the "Accelerating Access Initiative." Following the announcement of the partnership, these five companies announced their intention to cut the prices of ARVs, although the price cuts were not clearly specified. The result has been a series of bilateral negotiations and a wide range of reduced prices around the world. Other pharmaceuticals have since joined the inititative.

[15] Medecins Sans Frontieres (June 2002). *Untangling the web of Price Reductions: a Pricing Guide for the Purchase of ARVs for Developing Countries*. Retrieved from http://www.acccessmed-msg.org.

essential medicines.[16] Still, it is safe to say that many of the countries in which Future Harvest Centers operate in the developing world now have access to reduced-price ARVs and some countries, India and Sri Lanka, have access to locally or regionally-produced generics.

HIV/AIDS treatment has three primary components: (1) prophylactic treatment of some opportunistic infections with antibiotics and other drugs, (2) the direct treatment of opportunistic infections, and (3) anti-retroviral therapy as well as the associated lab tests, check-ups and medical management of side-effects. Anti-retroviral therapy or, more precisely, highly active anti-retroviral therapy (HAART) [17] consists of the administration of a "triple cocktail" of life-extending drugs. To date HAART remains the only treatment that can lead to a substantial extension of life for people living with HIV/AIDS (PLWHA). In the absence of ARVs, their disease progresses rapidly. With HAART, they can lead productive lives for 10 to 15 years, or perhaps many more.

The sample costs for HAART in Kenya provided through a full service HIV/AIDS clinic are currently as follows:

[16] Few Centers were able to provide much information on the availability or cost of ARVs in their respective countries, with the qualified exception of centers in South Asia who are aware of the availability of generics in the region and therefore can assume that the prices are among the lowest in the world.
[17] HAART refers to a regimen of multiple ARVs, consisting of precise combinations of protease inhibitors (PI), non-nucleoside reverse transcriptase inhibitors (NNRI) and nucleoside analogue reverse transcriptase inhibitors (NRTI) that make up the so-called "triple cocktail."

Table 3: Costs of Anti-retroviral Therapy (HAART) at a Clinic in Nairobi

	Units	Cost Per Unit Ksh.	Cost Per Unit US$	Costs per Year US$
Stage 1: HIV+ CD4>200				
Program Consultation Sessions	4	3,000.00	38.46	153.85
Lab Test – CD4 Count	4	2,500.00	32.05	128.21
Lab Test – Viral Load	2	8,000.00	102.56	205.13
Total Stage 1 Costs[18]:				**$ 487.18**
Stage 2: HIV+ CD4<200				
Program Consultation Sessions	8	4,000.00	51.28	410.26
Lab Test - CD4 Count	4	2,000.00	25.64	102.56
Lab Test - Viral Load	3	8,000.00	102.56	307.69
Lab Test - Amylase	4	800.00	10.26	41.03
Lab Test - Serum Creatinine	4	350.00	4.49	17.95
Lab – Hemogram	4	670.00	8.59	34.36
CXR	1	700.00	8.97	8.97
Stage 2: Diagnostic & Monitoring				**$ 922.82**
Stage 2a: First Line Antiretroviral	Month	6,500.00	83.33	*1,000.00*
Stage2b: approx. 50% require Combvir	Month	7,700.00	98.72	*1,184.62*
Avg. of those requiring Combvir and not				**$ 1,092.31**
Total Average Stage 2 Costs:				**$ 2,015.13**

[18]This does not include the cost of antibiotics or other drugs used in Stage 1 to treat or prevent opportunistic infections. As ARV therapy is introduced in Stage 2 the cost of other drugs usually declines as opportunistic infections decline.

Although the ARVs, lab tests and consultation costs are based on Kenya prices, the example in Table 8 illustrates the size of a healthcare package required to provide HAART. ARVs in Kenya are now available for between US$80 and US$100 per month, but the accompanying lab tests, check-ups and medical treatment of side-effects approximately doubles the monthly costs of Stage 2 HIV/AIDS care.[19]

Specialized HIV/AIDS medical care also requires associated services such as psychological and nutritional counseling, and systematic efforts by practitioners to ensure compliance. Compliance is essential for patient health, but also to reduce the threat of drug resistance. As ARVs are more widely administered around the world, many observers and researchers fear increasing HIV resistance to common ARVs. Fear of drug resistance is not widely accepted as an excuse for not offering HAART, but fear of drug resistance is a good reason to search for the best local medical services.

Because of recent reductions in price, a number of organizations in Kenya are just starting to pay for ARVs.[20] Some are proceeding on an *ad hoc* basis, but some have established careful policy guidelines. As these organizations sort out the rapidly changing options in Kenya and in the other countries in which they operate, the pattern of coverage still varies considerably. One organization will pay for staff members only; one pays for staff and spouse, but not other dependents; one pays only in countries where generic drugs are available, thus excluding Kenyan staff, and so on. Some organizations specify minimum laboratory facilities or minimum care standards that must be in place before a HAART program is initiated. Such statements are sometimes attached to other "minimum standards of care" that more centralized NGOs and donor agencies specify for country program insurance and medical schemes.

Appendix 5 contains a statement that accompanied the introduction of ARV therapy in one development NGO.

[19] We explored with a local doctor what the cost of ARVs would be if a patient appeared independently requesting ARV care. In that case if accessed by prescription through private physician and purchased at one of the only four or five pharmacies now providing ARVs the cost could be as much as 30% to 40% higher. We assume, but did not ascertain that lab costs would also be substantially higher if individually procured.

[20] We did not extend the Kenya case study to private sector firms. From secondary sources, we learned that a number of private firms in Kenya are now also beginning to provide HAART. Some firms such as Tetrapak have actively publicized the fact that they now provide HAART.

Among donors, DFID[21], for example, provides HIV/AIDS care to nationally recruited staff around the world subject to the following broad provisos:

- That coverage is limited to those countries where there is no local state scheme to which staff could turn for treatment;
- That the necessary medical infrastructure is available to enable full treatment to be administered effectively;
- That treatment is limited to employee and long term partner only; dependants are not covered;
- That the right to treatment lasts only as long as employment does (though with special provision for those who leave through retirement/retrenchment rather than as a result of their own actions);
- That all new recruits be required to show that they are medically fit for work (DFID does not permit or require HIV/AIDS testing for employees at the time of employment or at any other time)

Many organizations currently are piloting HIV/AIDS treatment programs and policies and expect to make revisions and add countries to their coverage lists in the near future. As would be expected, most organizations limit coverage to the period of employment. Only one organization in this study has put forward a guarantee of ARV treatment for life. This generous offer is being piloted by that development NGO in Burundi where the government has recently made important strides in the HIV/AIDS policy area including the provision of generic ARVs and careful licensing of HIV/AIDS practitioners. It is increasingly common to find employers now providing ARVs to HIV-positive pregnant women in the effort to prevent mother-to-child transmission[22]. This last is a low-cost

[21]The US State Department, in contrast, has been a latecomer to HIV/AIDS workplace policy putting forward a minimalist workplace policy for "national employees and U.S. citizen resident local hires" only in August 2001. The US State Department does not cover ARVs for national staff living with HIV/AIDS. The policy "allows" overseas missions to negotiate with local insurance carriers for long-term medications for the suppression of opportunistic infections and brief course of anti-retroviral drugs only to prevent mother-to-child transmission. See "New Policy on HIV in the Workplace" retrieved, September 2002, from http://www.state.gov/r/pa/prs/ps/2001/4603.htm

[22] Nevirapene, an ARV, has been found to be effective in blocking mother-to-child transmission of HIV in at least 60 percent of the cases in African studies. The mother receives a dose just prior to giving birth and the newborn a syrup of the medicine soon after birth. This regimen of Nevirapene is now available for as little as US$4.00 in many countries in sub-Saharan Africa.

commitment that can make a significant impact on the next generation.

In contrast to the UN and the World Bank, many NGOs have allocated considerable staff time to a careful search for the least expensive sources for ARVs and other HIV/AIDS services in the area. Indeed, one of the sad realities of HIV/AIDS care in Kenya is the pressing need to manage the costs for the terminally ill. One NGO insists that those employees accessing the recently established HIV/AIDS reserve fund seek terminal care at less expensive hospitals rather than the leading hospitals covered under regular insurance.

In conclusion, HIV/AIDS treatment is now readily and professionally available in Kenya at a cost of approximately US$500 (Stage 1) and US$2000 (Stage 2) per employee per year, with the expectation that these costs will continue to decline.[23] Although, we cannot provide similar information for other countries, many countries in which Future Harvest Centers operate have also been the recipients of reduced-price drug offers from pharmaceuticals. At these prices, this can no longer be easily dismissed as "unaffordable." HAART is now a real option in many countries and Centers must consider what changes to medical schemes will be required to make this option a reality.[24]

INVESTING IN HIV/AIDS TREATMENT: COSTS AND BENEFITS

HIV/AIDS Treatment as an Investment

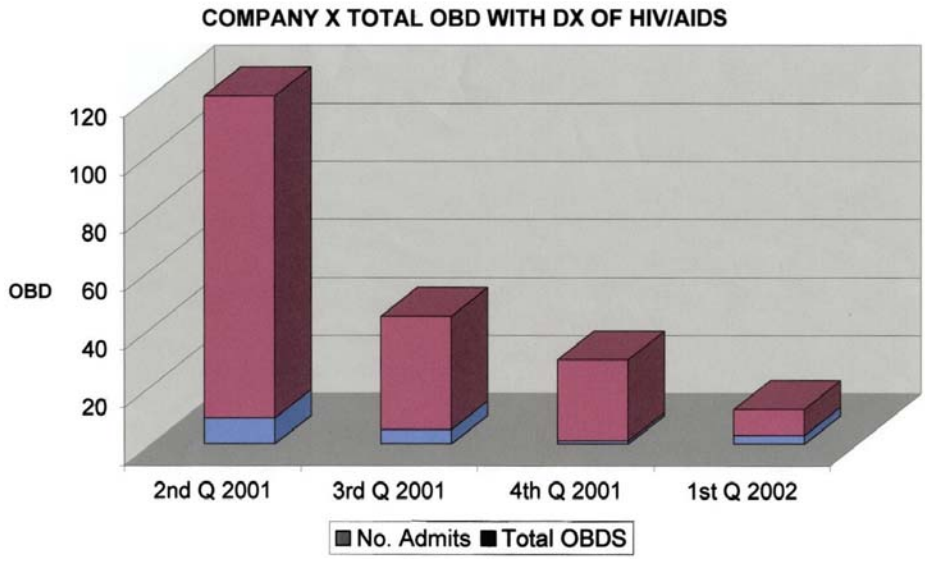
Financial benefits in reduced absenteeism, employee retention, and productivity are gained as the health of employees improves. Investment in ARV therapy is immediately beneficial for organizations already paying for other medical care, including hospitalization, of HIV/AIDS patients. Human benefits of improved and extended life for PLWHA are incalculable.

[23] These estimates do not include the cost of drugs for opportunistic infections, which are likely to remain high in Stage 1 before ARVs are introduced.

[24] Such care may already be a reality at IITA where self-insurance is designed to allow for full HIV/AIDS treatment and where the clinic appears to be aware of the number of HIV/AIDS patients being served.

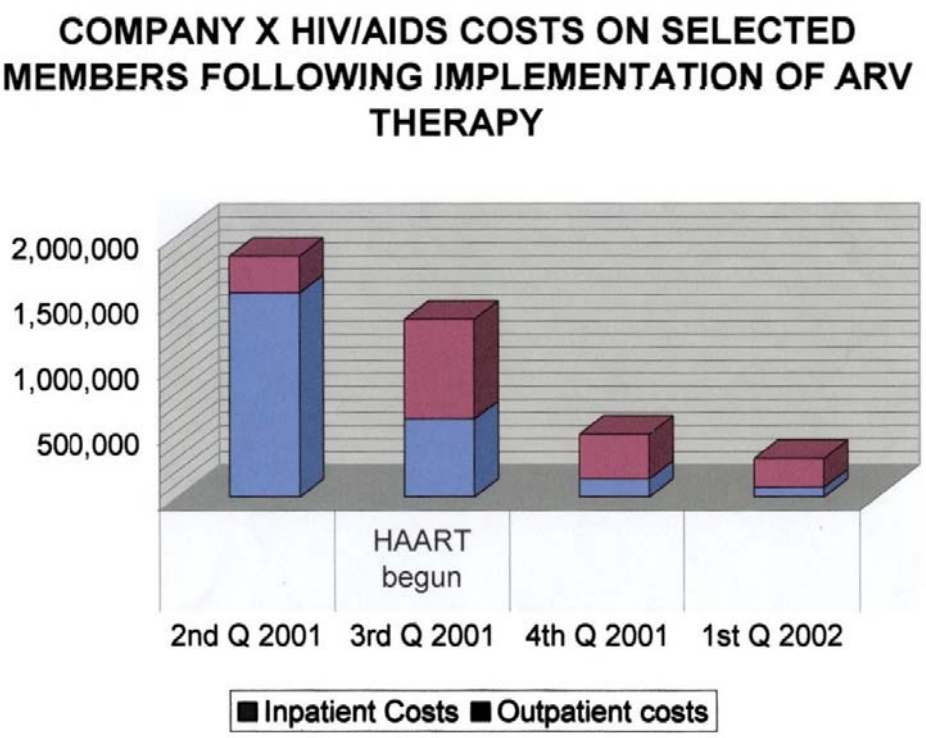
There is no longer serious doubt that some investment in HIV/AIDS prevention, education and care has not only ethical and moral value, but also financial benefits in the workplace. The greater the impact of HIV/AIDS in a region or an industry, the more compelling the case becomes for action.

Our interest in this topic was encouraged by very compelling data obtained from a health management firm in Kenya.[25] This health management firm with operations in Kenya, Zimbabwe, and Malawi offered the following data from a client file.



As chronicled in the diagram above, the number of occupied bed days (OBD) in hospital fell dramatically from approximately 120 days/quarter to less than 10 days/quarter for those patients diagnosed (DX) with HIV/AIDS, following active intervention in HIV/AIDS care, including HAART begun in the third quarter of 2001. The second diagram below also provides an impressive record of the associated drop in inpatient costs (as well as outpatient costs) following the introduction of HAART.

[25] The firm, in this case, is Strategis Health. The managing director in Kenya, Dr. Len Heffner, provided enormous insight into HIV/AIDS treatment. While this data must be treated with caution as it reflects the experience of only one firm, it is still instructive.



Various questions were asked to ascertain whether the dramatic drop in costs (in Kenyan Shillings) and OBD were not an artifact of a move from hospitalization to in-home care in the terminal stages of AIDS, and that the reduction in cost could indeed be credited to HAART. Follow-up discussions confirmed that the reduction in cost could, in large part, be attributed to HAART.[26]

This information goes beyond the issue of cost. The diagrams tell the story of 12 people dying of AIDS. In the third quarter of last year, they began to receive HAART. Eleven of the original 12 continue on ARVs and are fully functional, living well with HIV/AIDS.[27] One very senior member of staff in this company well into Stage 2 AIDS at the time HAART began, is reported to be traveling again on a regular basis. An additional seven members of this medical scheme are being carefully monitored and will begin on HAART as necessary. They too

[26] Occupied Bed Days (OBD) in the third quarter are attributable to the death of a HIV/AIDS baby whose parents did not seek care for the infant under the HIV program. One of the original 12 was "non-compliant despite intense counseling and resorted to traditional healing, dying at home without benefit of in-home care.

[27] UN clinic staff in Nairobi report similar stories of remarkable recovery and generally improved health and self-care as employees begin a regimen of HAART.

are living with a hope of healing, not available to them a short while ago.

This health management firm concludes that if an organization is already picking up the costs of medications and hospitalization associated with opportunistic infections and AIDS death, then the organization is likely to be immediately, better off financially with an introduction of HAART. If the insurance provider and/or the firm have been denying claims and care on the basis of HIV status, silently allowing or encouraging employees to leave the firm as they fall increasingly ill from HIV/AIDS then beginning an assertive HIV/AIDS care program with HAART will likely raise the organization's immediate medical costs. Neither of these calculations takes into account the substantial financial benefits of reduced absenteeism, employee retention and productivity gained as the health of employees is restored.

Many studies are seeking to verify the financial costs and benefits of HAART and other HIV/AIDS interventions. International research has depended heavily on the data emerging from very large mining companies in South Africa and Botswana, which allow for easier statistical verification. One of the leading studies emerging from that data set is being conducted at the Center for International Health at Boston University. The authors conclude in a recent paper that:

> "Under reasonable assumptions about the costs and effectiveness of specific interventions, these firms will be better off financially with interventions than without. However better information on the effectiveness of interventions is urgently need to strengthen the analysis."[28]

[28] J L Simon, S B Rosen et al. from Research of the AIDS Economic Team, Center for International Health, Boston University. This statement retrieved from http://www.brook.edu/dybdocroot/comm/ConferenceReport/cr09.htm

A number of smaller studies have depended more heavily on single case studies or case study comparisons of smaller firms. These studies too are developing evidence that organizations are financially better off by engaging in active HIV/AIDS education and prevention and care, including provision of HAART.[29,30]

Improved financial calculation of both direct and indirect costs and benefits are being developed in a number of studies. An early and very frequently cited study in this area (AIDSCAP/Family Health International 1996) concluded that health care costs were a relatively small share, only 12% of AIDS-related costs while HIV absenteeism (37%), AIDS Absenteeism (15%), Recruitment Costs (10%), Training (7%), Labor Turnover (5%), Funeral Attendance (3%), Burial/Death Benefits Costs (10%) and Productivity Loss after Training (1%) accounted for the far larger share of AIDS-related costs. Although this calculation requires updating to account for the greater use of reduced price ARVs since 1996, it continues to be cited regularly because it is assumed that the broad parameters of the conclusion still hold: i.e., the cost of medical care is low in comparison to the total of indirect costs associated with HIV/AIDS, at least when HIV prevalence rates begin to approach double digits.

In summary, the evidence is building strongly in favor of the financial benefits of intervention in HIV/AIDS, through education, prevention and HAART. The vital benefits in terms of improved and extended human life are incalculable.

[29] See Forsythe, Steven, Charlotte Laurence, John Stover, Jill Bausch, Joe Deering, Karen Foreit (July 2002). "Cost Saving and affordability of antiretroviral therapy for private sector employees in developing countries" AIDS 2002 Barcelona XIV International AIDS Conference. Abstract (TuORG1245) and presentation retrieved from http://www.aids2002.com/Program.

[30] See, also, SP Eholie, E Bissagnene, A Gaumon, J Mambo, J Guiza, A Kakou, A Kadia (July 2002). "The Socio-economic impact of HIV/AIDS infection and of investment in antiretroviral therapies (ARVs) on a private company of Abidjan, Cote d'Ivoire. AIDS 2002 Barcelona XIV International AIDS Conference. Abstract (MoOrB1096) and presentation retrieved from http://www.aids2002.com/Program.

ASSESSING RISK: LOOKING FOR NUMBERS NOT NAMES

Risk Assessment for HIV/AIDS
No Centers have formally assessed future AIDS risk.
Centers need to assess HIV/AIDS risk more carefully, through improved internal analysis and attention to the issue.
Centers without scientific risk assessment data available must accept crude estimates in order to move forward on treatment and insurance decisions.

Only one Future Harvest Center reported on an assessment of HIV/AIDS risk that appears to have been a cursory estimate of HIV prevalence at the Center, not future AIDS risk. No other Centers reported formal mechanisms for HIV/AIDS risk assessment nor did any of the NGOs visited in Kenya in the course of this study. Indeed, assessing risk is very difficult in all organizations that make a commitment not to test for HIV/AIDS[31].

Various international organizations engaged in similar studies were contacted and asked if they had developed risk assessment methods. They had not. No other development NGOs or development consultancy firms reported undertaking a formal risk assessment. The World Bank and the United Nations in Nairobi were not aware of any such models used by headquarters, nor had they done such an assessment locally. In exploring whether any local firms offered HIV/AIDS risk assessment, medical insurers reported that "yes" such firms existed but that none to date had developed a sound reputation. As to how most medical insurers assess HIV/AIDS risk, most appear to assume that national prevalence rates are sufficiently high to exclude HIV/AIDS coverage without further analysis. Finally, by tracking the phrase "HIV/AIDS risk assessment in the workplace" [32] and multiple

[31] Some HIV/AIDS consultants in Kenya have advocated use of voluntary anonymous prevalence surveys using saliva tests that while not sufficiently accurate for clinical purposes, are reasonably robust across large groups. This is the method that has been used in mining and other large companies in southern Africa. This requires that employees trust that results would indeed be anonymous.
[32] We did learn of an epidemiological method called "back calculation" that allows one to estimate from the number of AIDS deaths in a population "back" to the rate of HIV prevalence in that population and then in

variations, thereof, on the WWW, it was found primarily, and not surprisingly, that ***the inability to assess risk is a major deterrent to provision of HIV/AIDS medical care***.

How then to proceed? National statistics on HIV/AIDS in Kenya are readily available and widely disseminated. HIV/AIDS data in Kenya, as in most of sub-Saharan Africa, is based primarily on tests performed among pregnant women attending antenatal clinics that have been selected as sentinel surveillance sites. While these methods are thought to provide highly reliable figures at the national level and have proved remarkably robust in predicting the gender distribution of HIV/AIDS, these data do not allow characterization of HIV/AIDS across socio-economic classes. Socio-economic data, if available, might allow organizations to estimate the rate of HIV/AIDS among different education classes or employment groupings. No such data proved to be readily available or reliable. [33]

Most organizations rely, therefore, on a crude assessment of risk assuming that the organization shares the same HIV prevalence profile as the nation. On this basis, most organizations in Kenya assume that 15 percent of their employees are HIV-positive and some smaller number of those employees will have AIDS. How these numbers will grow over time is generally not calculated, most organizations assume simply that these numbers will grow. [34] Additionally, a number of organizations seem to have chosen a simpler course of action, reducing financial risk rather than trying to estimate it more closely. These organizations reduce risk by limiting newer treatment programs (HAART) to immediate employees only or to employees in particular countries. As information develops, they may choose to extend HAART coverage.

Anecdotal evidence on the number of HIV/AIDS cases proved remarkably consistent across organizations. Those organizations that

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turn predict the number of future HIV/AIDS illnesses, or *if HIV prevalence rates are known the same method allows the prediction of the number of HIV/AIDS illnesses anticipated over a given time period*. The data required for this method proved too extensive at the organizational level and we found no other evidence that these formulas have been adjusted for risk estimation at the firm or organizational level.

[33] Suggestions at set-up for the study that the medical association in Kenya or various employers associations had developed socio-economic based statistics proved false.

[34] Knowledgeable HR personnel are aware that the incubation period is approximately seven years from infection to onset of AIDS-related diseases and without ARV treatment eight-to-12 years from infection to death. However, at the organizational level no one appears to have modeled rates of disease development.

do not test for HIV/AIDS and have not provided permanent or consistent HIV/AIDS care become aware of AIDS cases as employees fall ill in Stage 1 HIV/AIDS. In those organizations, the number of identified HIV/AIDS cases in the total insured population appears to be about 1 to 2 percent of the employee population. Where there is an active program for treatment of HIV/AIDS including ARVs and/or a strong peer counseling program, as is the case at the United Nations, the number of known cases among staff and dependents appears to approach 5 percent of the employee population.

The experience of Strategis Health[35] in Kenya is broadly consistent with those organizational estimates. Across their current client base, they find that they seem to be providing ARV treatment to about 5 to 6 percent of the insured population presumed to be HIV-positive. The rough calculation emerging from that experience suggests the following method:

> Assume that the insured population shares the national HIV/AIDS profile, which in Kenya implies that 15% of the insured population is HIV-positive. Assume then that approximately 5 to 6 percent of that number will come forward for HAART, while another 3 percent of that number will be in Stage 1 AIDS, not yet requiring HAART.

The medical claims officer or HR person most closely involved with medical claims processing proved repeatedly to be the person most likely to have a handle on the number of HIV/AIDS cases in an organization. These individuals have learned to detect when a case is likely to be an HIV/AIDS case even before insurers begin to reject the claims, or in the case of self-insurance before the individual begins to exceed plan limits. This information was often not shared with HR management. It was surprising that human resource managers were not in closer contact with these individuals, who proved to be very savvy about HIV/AIDS in the organization. HR staff members are privy to other indications of HIV/AIDS status in the rejections of life insurance and disability insurance contracts in some cases. No confidentiality needs to be breached if HR managers explore these estimates on the basis of numbers not names.

[35] Strategis Health is the health management firm discussed earlier, now providing a full HIV/AIDS care package for self-insured clients. As one of the very few firms engaged in active HIV/AIDS care across a growing client base, they proved to be a valuable source for estimating HIV/AIDS risk.

In the absence of well-developed methods for HIV/AIDS risk assessment at the organizational level, Centers may have to accept rough, even crude, estimates in order to move forward on HIV/AIDS treatment and insurance decisions. Fear and uncertainty of the financial risk should not be allowed to delay action any longer. For purposes, of further risk analysis we recommend close examination of internal medical records with the HR staff member most closely linked to the medical claims process and the use of a formula similar to the one presented above. Iteration between these two efforts should allow a better estimate of HIV/AIDS risk than is currently being used at most Centers.

CONFIDENTIALITY MANAGEMENT

Confidentiality Management

- Centers should continue to commit to the highest standards of confidentiality and develop systematic procedures that protect the identity and dignity of PLWHA.
- Centers should invest further in VCT, peer counseling and HIV/AIDS treatment in a manner that will encourage PLWHA to come forward.

Virtually all organizations that make a commitment to HIV/AIDS management uphold confidentiality as a central tenet of HIV/AIDS workplace policy. Future Harvest Centers, UN agencies, the World Bank and NGOs in Kenya all voiced strong commitments to confidentiality. At the UN, strict procedures on the confidential handling of medical information have been issued and disseminated. In other organizations, commitment to confidentiality protection is not always matched by systems development and training.

With or without good systems, most organizations and HR managers have interpreted confidentiality very strictly and are deeply reluctant to approach an employee regarding his or her HIV status. This remains the case even when the individual is obviously suffering and when the HR manager or clinic nurse is aware or deeply concerned that the individual has AIDS. This type of story was repeated frequently and the commitment to silence was, for the most part, not challenged. Still

as the study proceeded we began to hear some subtle shifts. Compassionate employers who have confidentiality procedures in place, substantive and consistent care to offer HIV-positive employees and who have no intent to discriminate, were beginning to wonder if employees might be better off if they could be approached more directly regarding their HIV status. It is thought by other observers that as HAART is made available, more individuals will come forward and such direct approaches will become less necessary. This is a complex issue, but one that Centers should remain aware of as they balance confidentiality with the need to encourage increased voluntary testing and counseling.

POST-EXPOSURE PROPHYLAXIS (PEP)

Post-Exposure Prophylaxis

- Centers and all field offices should identify a local source of PEP and a medical professional qualified to administer it.

Post-exposure Prophylaxis (PEP) treatment is an emergency treatment for individuals who may have been accidentally or violently exposed to HIV through contact with infected blood or rape. The treatment consists of a regimen of high-dosage antiviral medications, laboratory tests and counseling.[36] The United Nations and the World Bank are committed to the provision of PEP kits as a part of an active HIV/AIDS workplace policy. UNAIDS and the World Bank jointly produced a lengthy protocol for the importation and provision of such kits at UN stations around the world[37]. On the ground in Kenya, UN clinic staff report that to date none of these kits have been used in Nairobi, and are regularly replaced as they expire. Indeed, UN clinic staff report that they would advise employees to access PEP through either Nairobi Hospital or Aga Khan Hospital where such kits are also

[36] Treatment ideally starts 1 to 2 hours after exposure, but may start as late as 72 hours, and normally lasts 4 weeks. It must be administered under careful medical supervision as the high dosage of prophylactic ARVs can cause very serious side effects. Approximately 40% of health care workers that begin PEP (following an accidental exposure) discontinue use due to side effects according to "Post Exposure Prophylaxis" 2000 AIDS.ORG INC. retrieved from http://immunet.org/FactSheeets/154-pep.html.

[37] This protocol is published at the UNAIDS website under "PEP Kits." Retrieved from http://www.unaids.org/hivaidsinfo/UNWorkplace/Web%20version/Improving-pep.html

readily available and the full counseling and medical services that must accompany it can be provided.

Other organizations have been more reluctant to make a policy commitment on the provision of PEP kits. One development NGO concerned about staff exposure to HIV in the refugee camps and war zones in which they operate, examined the issue carefully. After a lengthy study of the issue this organization extended the following recommendations:

- We do not advocate for or against this treatment (PEP) in cases of exposure to HIV. The appropriateness of any treatment should be discussed between the affected individual and their doctor. The physician is the one qualified to make a recommendation in specific cases. However, if the use of PEP is indicated and the treatment agreed upon by the employee and their physician, it is important to begin treatment as soon as possible. Therefore, we are asking country programs to identify a source of PEP and a medical professional qualified to treat it.
- (The organization) discourages country programs from purchasing PEP to ensure its availability due to its limited shelf life. While the country program may purchase PEP only when the availability of the drugs in an emergency is in question. In these cases it must be held in a local hospital, clinic or doctor's office. Under no circumstance should it be held in the office or private residence of an employee.
- PEP must only be used on the advice and under the supervision of a qualified medical professional.

This recommendation that "country programs identify a source of PEP" and qualified medical professionals for its administration would seem to be good practice for Future Harvest Centers as well. This example is also included to illustrate the manner in which other highly decentralized organizations suggest action at the country level.

APPROACHES TO MEDICAL COVERAGE IN OTHER ORGANIZATIONS

HIV/AIDS Medical Coverage

- United Nations and World Bank provide country staff with medical insurance that covers the cost of ARV therapy and other HIV/AIDS care.
- Like Future Harvest Centers, development NGOs and some donors usually rely on local insurance coverage and self-insured mechanisms to deliver acceptable, but not always high, standards of care to country staff.
- Development NGOs and donors have begun to develop HIV/AIDS reserve funds to assist PLWHA and to begin covering ARV costs.

The United Nations and the World Bank are regularly upheld as international standard-bearers on HIV/AIDS workplace policy. The particular feature of these policies that is applauded is the "provision of medical insurance for national staff equivalent to that of international staff." While precise equivalence was difficult to determine, it is indeed true in Kenya that the World Bank provides its "country staff"[38] with insurance that covers the cost of anti-retroviral therapy and other HIV/AIDS care. Likewise it is true that the United Nations provides medical coverage for HIV/AIDS care to its national and/or general service staff.

The World Bank through its Medical Benefits Plan (MBP) offers insurance to country staff through a contributory scheme based on salary and family size, resulting anywhere from a premium contribution of 0.6% to 1.6% of salary depending on the number of dependents covered. All insurance claims from the field are processed through the World Bank in Washington, D.C. with special precautions to protect the confidentiality of HIV/AIDS patients. A similar plan is provided to a number of UN agencies, including UNEP, Habitat, UNICEF, and UNON in Nairobi via a self-insured mechanism called the Medical Insurance Plan (MIP) that is administered from the United Nations in New York[39]. Both of these plans require a 20% co-

[38] Country staff is essentially equivalent to NRS in the CGIAR.

[39] In this UN plan, employees also make a premium contribution between 1.0% and 2.25% of salary; as well as a 20% co-payment on outpatient services. Plan ceilings are determined by formula based on UN salary structure.

payment as is usual for all international insurance coverage. Both of these schemes permit staff to access ARVs through private physicians in Nairobi and offer support through medical advisory services – an HIV/AIDS medical specialist at the World Bank and through the on-site clinic services at the UN. We were unable to determine from either of these organizations the precise cost of these programs, but were able to very roughly estimate costs for the institution and the employee at sample salary levels.

Appendix 7 provides a rough estimate of the institutional and employee contributions at particular salary levels under these two plans.

The patterns of medical coverage for national staff of NGOs in Kenya as well as many commercial firms were much closer to the medical schemes currently being provided by ICRAF and ILRI. These are systems based on the norms of local insurance and with small exceptions are schemes with a very large number of exclusions, relatively low coverage limits and based on full reimbursement to the employee. Many organizations, like ICRAF self-insure for outpatient coverage to compensate for the high level of exclusions that is common to local insurance[40].

Notably, within the past year almost every NGO that we had visited had established or was considering the creation of a special reserve fund to cover HIV/AIDS expenses. The calculations for establishing such funds were almost entirely *ad hoc* and included such simple mechanisms as a quick build-up of funds through a corporate contribution of approximately US$6.00 per employee per month for a period of three months, an additional 10% overheard charge to programs and projects, and a reserve fund calculated as 10% of the regular medical budget. The adequacy of these reserve funds to cover future HIV/AIDS expenses was calculated only in a very rough fashion and at least one of them appeared patently inadequate. These efforts, nonetheless, act as a strong foundation for a program of on-going support in an environment of continuing risk assessment.

[40] ILRI partially self-insures.

Insurance Options

HIV/AIDS Insurance Options: Rough Estimations of Cost
-- Local Self-Insurance designed to cover HIV/AIDS treatment is the least expensive option for Centers, but does not otherwise improve overall medical care for NRS.
-- Regional Pooling through an international insurance firm is likely to cost from US$82 to US$124 per employee per month for a family of four.
-- International insurance coverage modeled on the UN and World Bank medical plans is likely to cost from US$75 to US$115 per employee per month.

Medical coverage continues to be the single greatest HIV/AIDS implementation challenge experienced by Future Harvest Centers. Centers were asked in the survey if they would be interested in hearing about other insurance options and most Centers responded that they would "assuming prices are not prohibitive."

As with virtually all issues in HIV/AIDS care, rapid change and development are underway in some parts of the insurance industry. Six months ago in Kenya, local organizations insisted with absolute certainty that no medical insurance firm in Kenya provided insurance coverage for HIV/AIDS. But during the completion of this report in the last weeks of September 2002, one leading insurance agency in East Africa, AAR, agreed to extend HIV/AIDS coverage, including provision of ARVs to employees at one organization for an additional US$40 per employee per year.[41] Similarly, Strategis Health, has entered the market with full health management services including intensive HIV/AIDS care for self-insured clients. A number of newer regional providers based out of South Africa have been entering the market aggressively. J. Van Breda, a major international insurance company, offers insurance for East African clients that limits HIV/AIDS coverage to US$3,000 per person per year for a five-year period, an amount sufficient to cover HAART but not a lengthy AIDS hospitalization. In contrast, an international insurance broker based in

[41] This may or may not be readily extended to other clients. This was made possible, the informant felt because the account while covering only 270 people in Kenya, covers many more in Uganda and Tanzania. The cost of ARVs in Uganda where generic ARVs are readily available is considerably lower than in Kenya. The additional US$40 premium for full HIV/AIDS care had already been successfully piloted in Uganda.

the United States reports that most international insurance firms still "do not want to look at HIV/AIDS in the developing world" that they are "quite frankly frightened of the numbers." The first order of business for Centers in Asia and Africa is to review the current insurance market to see if, in fact, insurance providers have not already responded to reduced cost of ARVs with new policies for HIV/AIDS treatment.

There is sobering evidence of the urgent need to make decisions in this matter. For example, ICRAF experienced a medical budget overrun of almost US$18,000 in this budget year associated with the care of one or two HIV/AIDS patients. As is the case with HIV/AIDS, any attempt to seek reimbursement from the patient ends abruptly with the patient's death. This approach to HIV/AIDS, while deeply compassionate is not sustainable. Had affordable ARVs been made available a year ago, one of those patients might be living well with HIV/AIDS today. This latter option is now abundantly possible in Kenya.

In light of the need for Centers to have more information to make decisions, this study offers information on various insurance options from improved local coverage to international insurance on a system-wide basis.

First, a pool of 6,606 NRS (all Centers excluding IFPRI, IPGRI, ISNAR), or 4,736 NRS (Asia/Africa Centers) or even 3,589 NRS in African Centers alone, is a very large insurance pool and brokers are interested in talking. However, it is difficult to get even rough quotes from insurance brokers without providing substantial information on the insured population in terms of age, gender and recent medical claims history. Second, quotes from major multinational insurance firms for "fully insured" coverage are stratospheric in cost even if medical care in the United States and Canada is eliminated from the plan, higher even than what is currently provided to IRS of the CGIAR. Moreover, many international insurance firms are unwilling to consider covering HIV/AIDS care in Africa.

Eventually, three options were found worthy of further consideration within the CGIAR. For ease of presentation, these options are referred to as: Local Plus, Regional Basic, and International Standard. Please note that these are extremely rough indications of cost and are

provided as a basis for further review, not as completed analysis. Details of plan coverage and limits are described and compared only in broad terms. Any of these options would have to be pursued in far greater detail and with substantially more information from the Centers.

Local Plus

This is the simplest and least costly of the three options. In short, Centers maintain their local medical scheme and supplement it with self-insurance designed specifically to cover the local costs of HIV/AIDS treatment.[42]

For Kenya, we calculate roughly that this would amount to an additional US$28/per insured/per year for a five-year scenario, or just over $2.30 per month for each insured individual. Of course, this self-insured amount will differ from Center to Center, based on local HIV/AIDS prevalence rates and associated risk as well as the local cost of HAART and other HIV/AIDS care. The Center would, of course, need to choose an appropriate method for building up the self-insured fund and many models are available. On this basis, Centers in many countries should be able to make a firm and immediate policy commitment to NRS that HIV/AIDS treatment will now be covered.

Appendix 6 presents the HIV/AIDS risk assessment and HIV/AIDS costs that guided these calculations in the Kenya example.

The primary advantage of this approach, after low cost, is that local staff will continue to file claims and receive benefits as they are accustomed to doing. In Kenya, for example, staff members are accustomed to 100% reimbursement, and the concept of co-payments or even methods for co-payments have been hard to introduce. For those Centers who already self-insure it would be easy to blend this into the current medical scheme. On the negative side, this does little to improve overall medical coverage for NRS in the system.

[42] In an alternative scenario, supplementary coverage might be pooled through system-wide self-insurance for HIV/AIDS. See Appendix 8, for a solution based on central pooling for HIV/AIDS coverage across countries. Supplementary insurance in that case is provided at the central level. This was the alternative devised by Development Alternatives Inc. (DAI) after a review of local insurance policies revealed generally poor coverage as well as lack of coverage for HIV/AIDS. DAI is a development consulting firm with 500 local employees in 49 countries

Regional Plus

J. Van Breda, a leading global insurance firm headquartered in Belgium, proved to be one of the few international insurance firms able to talk easily about local medical costs across a wide range of countries and most importantly about HIV/AIDS coverage in Africa. J. Van Breda was not willing to provide a quote on a regional or inter-regional basis without further information on the insured pool and medical claims histories of different Centers, although they remain interested in further discussion.

Fortunately, however, J. Van Breda had recently prepared a full proposal for ICRAF for the year 2003, in which premium costs were clearly spelled out. We asked them if we might safely assume that further pooling of CGIAR employees in the Africa region or across Africa/Asia would serve to reduce the premium costs. They answered somewhat equivocally that "the advantage of pooling does not so much play on the technical premium setting, but it can be important for premium stability as peak files can more easily be absorbed." They emphasized also that medical costs differ greatly from one country to another, even in Africa. On this basis, we have assumed that J. Van Breda would be able to offer medical insurance on a regional or inter-regional basis in a range 20% lower to 20% higher than what they have currently proposed to ICRAF. On that basis, insurance premiums might be obtained in the range between:

US$28.00 to $42.00 per adult per month;
US$13.00 toUS$20.00 per child per month.

or, restated

US$82.00 to US$124.00 per employee per month for a family of four

Importantly, this plan generally provides better medical coverage than is currently provided at many Centers. Plan cover limits, in the ICRAF proposal, are US$8,000.00 per family for outpatient expenses and US$12,000.00 per family for inpatient expenses, with very few other limitations. Most importantly for the purposes of this study, van Breda has set an HIV/AIDS limit at US$3,000 per person per year for a period of five consecutive years. While this is not as desirable as

unlimited HIV/AIDS coverage, this amount would cover HAART in a number of countries at recently reduced cost of ARVs, although it would not cover an expensive AIDS hospitalization. Such terms may be negotiable with greater regional pooling. This plan like virtually all international insurance plans sets a 20% co-payment for outpatient expenses. Disadvantages will emerge around the greater complexity of administration and the J. Van Breda's greater distance from the local market.

International Standard

This last option is modeled on the Medical Insurance Plan (MIP) of the United Nations and the Medical Benefits Plan (MBP) of the World Bank[43]. We were not able to obtain as much as information as we would have liked about the cost of these plans directly from the respective organizations, but have learned something about that style of plan from discussions with international brokers. Fundamentally these are self-insured plans (most likely with added reinsurance to cap risk) and therefore HIV/AIDS coverage can be established at the level or within the limits the client desires. The large insurance firms that typically manage such plans as "administrative services only" contracts bear large up-front costs in the development of the plan and as such are likely to be workable only on the basis of a fairly large pool of employees and dependents. Such plans are likely to cost, on average, anywhere in the range of:

US$75.00 – US$115.00 per employee per month for a family of four

The averages above were suggested as a range by an international insurance broker, but are roughly confirmed by calculations presented in *Appendix 7.* In fact, rough calculations suggest that the UN and World Bank though self-administered schemes are offering coverage at the low end of the range, or perhaps even lower depending on assumptions about salary structure in the respective organizations.

[43] As stated in the introduction to the MBP: "The Medical Benefits Plan (MBP) is a health plan operated by the World Bank Group for the benefit of its country office active staff members (and their eligible family members) serving at designated country offices away from Headquarters. The purpose of the MBP is to assist staff members and their eligible family members in meeting the cost of certain health services, facilities and supplies." A copy of this document has been forwarded to AIARC.

Appendix 7 presents a sample contribution to monthly premiums by the employee and the institution at various salary levels according to information gathered by interview at UNON and as described by the World Bank in its MBP documentation.

These medical plans are almost certainly an improvement over most current outpatient medical schemes at the Center level in terms of plan coverage.[44]

The disadvantages will emerge around the greater complexity of administration and the administrator's greater distance from the local market. Both the UN and the World Bank provide substantial back-stopping in-house for the efficient processing of claims from country staff to headquarters. These administrative details as well as the costs would require careful examination. Both the United Nations and the World Bank plans involve a contribution to premium by staff members based on salary and the number of dependents as well as a co-payment of 20% for most outpatient care. The capacity of NRS to make contributions in the amount of 1.0% to 2.25% of salary (UN) and 0.6% to 1.5% of salary (World Bank) towards medical coverage would also require consideration at the Center level.

Our analysis of current medical coverage in the CGIAR concludes that only a few Centers provide medical schemes that are likely to cover the cost of HIV/AIDS treatment, even at greatly reduced prices for ARVs. Centers in Latin America appear to be an exception to this conclusion and are therefore not likely to be interested in substantive change to current medical coverage schemes. Centers in Africa, however, need to urgently consider these or other insurance options in order to improve coverage for HIV/AIDS treatment. Centers in Asia need to seriously review current medical plans in light of local HIV/AIDS care options and the growing threat of HIV/AIDS in that region. All Centers must pay close attention to the coverage being extended by host institutions to their Africa-based staff as they cannot

[44] Coverage limits at both the World Bank and the UN are tied to a specific "reference salary," and in the case of the World Bank is limited to three times that monthly reference salary amount in a given plan year, yielding plan limits higher than many Center outpatient medical schemes.

safely assume that HIV/AIDS care is being fully managed on their behalf. [45]

The choice must, of course, be mediated both by cost and conscience. HIV/AIDS treatment is available at substantially reduced cost. Evidence is growing that that expenditure has financial benefits to the organization. The insurance options presented above, while more costly than most current medical schemes are not prohibitively expensive at the lower end of those ranges. The time has come to make this option a reality for staff living with HIV/AIDS.

[45] IRRI and IITA may be among the exceptions. IITA appears to have the capacity to provide HIV/AIDS treatment and no obvious restrictions in the self-insured plan appear to restrict that possibility. IRRI's medical plan also permits at least some level of HIV/AIDS treatment. IRRI staff may benefit in this matter from their location in the Philippines. The Philippines has been cited by UNAIDS as an example of "best practice." Among other thing the AIDS Law mandates the provision of insurance to persons with HIV/AIDS. Good laws are not a guarantee that the rights of persons with HIV/AIDS are protected, and like good policy, implementation in the Philippines has not been without challenges. CIFOR's outpatient plan does not appear to limit HAART but commentary in the survey suggests that such medical care is problematic nonetheless.

Summary of Recommendations

All Centers must engage in an accelerated and concentrated effort at implementation of HIV/AIDS policy, especially with regard to HIV/AIDS education and prevention.

- Education and prevention must remain the cornerstone of all HIV/AIDS workplace policy. Preventing a single case of HIV infection through education is the simplest and most cost-effective investment that a Center can make.
- Efforts at implementation must be renewed with increased emphasis on VCT.
- Further consideration should be given to developing peer-counseling programs.
- Commitment to confidentiality must be matched with development of systems to protect the dignity of PLWHA.

All Centers are encouraged to localize HIV/AIDS Policy in very concrete terms with specific information provided to staff on:

- Location and services of vetted VCT Clinics.
- Identification of sources of ARVs and approximate current prices of HAART.
- Source of PEP and qualified medical practitioner to treat and counsel.
- Locations for safe blood.

Centers in Africa urgently need to implement new medical schemes or supplement current plans to improve coverage for HIV/AIDS treatment including HAART.

- Make the option of HAART a reality for all NRS.
- Review the current insurance market to see if, in fact, insurance providers have not already responded to reduced cost of ARVs with new policies for HIV/AIDS treatment.
- Consider a self-insurance scheme to cover the cost of HAART.
- Consider cooperation with other Centers for improved medical coverage through regional pooling or international insurance along the lines of the World Bank and the United Nations medical schemes.

Centers in Asia need to review current medical plans in light of local HIV/AIDS care options and the growing threat of HIV/AIDS in that region.

- Make the option of HAART a reality for all NRS, before a crisis emerges.
- Review the current insurance market to see if, in fact, insurance providers have not already responded to reduced cost of ARVs with new policies for HIV/AIDS treatment.
- Consider a self-insurance scheme to cover the cost of HAART.
- Consider cooperation with other Centers for improved medical coverage through regional pooling or international insurance along the lines of the World Bank and the United Nations medical schemes.

All Centers must pay close attention to the HIV/AIDS education and care being extended by host institutions to their Africa- and Asia-based staff as they cannot safely assume that HIV/AIDS care is being fully managed on their behalf.

- Name an HIV/AIDS focal person for Africa- and/or Asia-based staff with the responsibility to review current education and prevention activities as well as medical coverage being provided to Africa-based staff.

All Centers are encouraged to review and improve life and disability insurance for PLWHA.

All Centers are reminded that HIV/AIDS policy development and implementation must remain an on-going process in light of the continuing changes in the environment for HIV/AIDS.

Appendix 1. Future Harvest Centers Host Country HIV/AIDS Adult Prevalence Rates

CIAT	Colombia	0.31%	
CIFOR	Indonesia	0.05%	*(Note)*
CIMMYT	Mexico	0.29%	
CIP	Peru	0.35%	
ICARDA	Syria	0.01%	
ICRISAT	India	0.70%	
ICLARM	Malaysia	0.42%	
ICRAF	Kenya	13.95%	
IFPRI	United States	0.61%	
IITA	Nigeria	5.06%	
ILRI	Kenya	13.95%	
	Ethiopia	10.63%	
IPGRI	Italy	0.35%	
ISNAR	Netherlands	0.19%	
IRRI	Philippines	0.07%	
IWMI	Sri Lanka	0.07%	
WARDA	Cote d'Ivoire	10.76%	

Source: UNAIDS, June 2000 reporting data from end 1999.

(Note: Other sources suggest much higher rates of HIV/AIDS prevalence in Indonesia. In particular, rapid spread of HIV among certain subpopulations and increasing reports of mother-to-child transmission is fueling fears of very rapid spread in the general population.)

Appendix 2 (1). HIV/AIDS Education and Prevention Activities

	Seminar(s)/ Workshop(s)	Condom Dispensers	VCT Referral	Confidentiality Procedures
Africa				
ICRAF	Yes Multiple Well attended	Kenya Free of charge. Male & female lavatories.	Not currently provided	No staff training.
IITA	Yes Multiple Very well attended Widely inclusive	Nigeria Free at clinic, no dispensers.	VCT available at on-site clinic.	
ILRI	Yes.	-	-	-
WARDA	Yes Multiple Countries Multiple Topics Well attended Widely inclusive	Policy not finalized.	Relationship established and information is widely disseminated.	Managers trained.
Asia				
ICRISAT	Yes Multiple Countries Well attended Widely inclusive	Zimbabwe Free of charge In male lavatories	Not currently provided	No staff training.
ICLARM	-	-	Referral information available	Head of HRU
CIFOR	Yes Multiple Countries Some well attended	Dispensers not discussed. Condoms supplied in travel kits.	Prepared to develop if need arises	No staff training.
IRRI	-	Not discussed.	No plans.	-
Latin America				
CIAT	Yes Colombia Poorly attended. Widely inclusive.	Not discussed.	No plans.	No staff training.
CIMMYT	Yes Mexico Poorly attended.	Discussed, but chose not to place condom dispensers	Referral info. available ; Relationship established	Yes staff training.
CIP	-	-	-	No staff training

Appendix 2 (2). HIV/AIDS Education and Prevention Activities

	Peer Counseling	List Safe Blood Locations	Occupational Health and Safety (OHS)	Travel Kits
Africa				
ICRAF	No plans.	No.	No.	Not discussed.
IITA	No plans	Yes and Institute is enrolled in Blood Care Foundation	OHS manual is currently being produced.	No.
ILRI				
WARDA	Peer counselor identified.	-	-	-
Asia				
CIFOR	No plans	No 100% safe blood available	HIV/AIDS discussed in OHS guidelines.	Condoms and malarial prophylaxis included. PEP not decided.
ICRISAT	Under consideration.	Yes	HIV/AIDS discussed in OHS guidelines.	Not discussed
ICLARM	-	No.	No OHS guidelines.	Not discussed
IRRI	No plans.	No.	No.	Not discussed.
Latin America				
CIAT	Under consideration.	No	HIV/AIDS discussed in OHS guidelines.	Not discussed.
CIMMYT	Under consideration.	Available, not circulated.	No OHS guidelines or first aid manuals	Discussed, not decided.
CIP	-	No.	No.	-

Appendix 3 (1). Outpatient (OP) Coverage for Nationally Recruited Staff

	Type of Outpatient Coverage	Outpatient Plan Limits	HIV/AIDS Testing by insurance agent	HIV/AIDS Coverage
Africa				
ICRAF	Center self-insures, administered by HRU and health firm	Between US$ 1001 to US$2500 (for staff and 3-5 dependents0	No (self-insurance)	Plan does not explicitly address HIV/AIDS
IITA	Center self-insures, administered by HRU	Unlimited Coverage	No (self-insures)	Center assumes expenses for HIV/AIDS related illnesses, but not ARVs
ILRI	Combination of local and self-insurance	Unlimited Coverage in Nairobi	No	Phase 1 and 2, but not full-blown AIDS, no ARVs.. ARVs covered up to US$260 under self-insured portion
WARDA	National Health Plan, plus supplemental local insurance	–	–	–
Asia				
CIFOR	Center self-insures, claims administered by health firm	Unlimited Coverage	No (self-insurance)	All HIV/AIDS related expenses, including ARVs
ICRISAT	Center self-insures, administered by HRU	Less than US$500 per year	No (self-insures)	Plan does not explicitly address HIV/AIDS
ICLARM	International Insurance	Between US$ 1001 to US$2500	Yes, at time of employment	Specifically excluded
IRRI	Local Insurance/HMO	Between US$ 1001 to US$2500	No	Up to limit of Ph.P 150,000
IWMI	Center self-insures, administered by HRU	Less than US$500 per year	No (self-insures)	Plan does not explicitly address HIV/AIDS
Latin America				
CIMMYT	National Health Plan, plus supplemental local insurance	Up to US$35,000	No	All HIV/AIDS related expenses, including ARVs
CIAT	National Health Plan of the host country	Unlimited Coverage	No	All HIV/AIDS related expenses, including ARVs

CIP	Local Insurance/HMO	In combination with inpatient plan, up to US$23,000	Unsure	Specifically excluded.
Middle East				
ICARDA	Local Insurance/HMO	Between US$501 to US$1000	No	Up to US$5,000 for HIV/AIDS, including drugs

Appendix 3 (2). Inpatient (IP) Coverage for Nationally Recruited Staff

	Type of Inpatient Coverage	Inpatient Plan Limits (per year)	HIV/AIDS Testing by insurance agent	HIV/AIDS Coverage
Africa				
ICRAF	Local Insurance/HMO	US$25,000	Yes, at time of employment	Plan specifically excludes all HIV/AIDS related expenses
IITA	Center self-insures, administered by HRU	Unlimited Coverage	No (self-insures)	Center assumes expenses for HIV/AIDS related illnesses, but not ARVs
ILRI	Local Insurance/HMO and self-insurance	Limit approximately US$6,400 per person. Fist US$2,565 covered by plan, remaining 50% ILRI, 50% staff	No	Phase 1 and 2, but not full-blown AIDS
WARDA	National Health Plan, plus supplemental local insurance	–	–	–
Asia				
CIFOR	International Insurance Provider	Between US$ 1,001 to US$2,500	Yes, at time of employment	Plan specifically excludes all HIV/AIDS related expenses
ICRISAT	Center self-insures, administered by HRU	Between US$ 1,001 to US$2,500	No (self-insures)	Plan does not explicitly address HIV/AIDS
ICLARM	International Insurance Provider	Between US$ 2,501 to US$5,000	Yes, at time of employment	Plan specifically excludes all HIV/AIDS related expenses
IRRI	Local Insurance/HMO	Between US$ 2,501 to US$5,000	No	Up to limit of Ph.P 150,000
IWMI	Center self-insures, admin-istered by HRU	Between US$ 1,001 to US$2,500	No (self-insures)	Plan does not explicitly address HIV/AIDS
Latin America				
CIAT	National Health Plan of the host country	Unlimited Coverage	No	All HIV/AIDS related expenses, including ARVs
CIMMYT	National Health Plan, plus supplemental local insurance	Up to US$35,000 per person per illness	No	Center assumes HIV/AIDS related expenses, including ARVs
CIP	Local Insurance/HMO	In combination with inpatient plan, up to US$23,000	Unsure	Plan specifically excludes all HIV/AIDS related expenses
Middle East				
ICARDA	-	US$35,000	No	All HIV/AIDS related expenses, including ARVs

Appendix 4. Disability and Life Insurance for Nationally Recruited Staff[46]

	Disability Insurance Provided?	HIV/AIDS Test Required?	Benefit paid if disabled due to HIV/AIDS?	Life Insurance Provided?	HIV/AIDS Test Required?	Benefit paid if death due to HIV/AIDS?
Africa						
ICRAF	Yes	Yes	No	Yes, all	Yes	No
IITA	Special cases	No	-	Yes, all	No	Yes
ILRI	Yes	No	Don't know.	Yes, some	At certain salary levels	No
Asia						
CIFOR	Yes	No	Don't know	Yes, all	Yes	No
ICRISAT	Special cases	No	No	Yes	No	-
ICLARM	Yes	Yes	No (unless acquired by blood transfusion)	Yes, all	Yes	Yes
IRRI	Yes	Yes	Yes	Yes, all	Yes, case-by-case	Yes
IWMI	Yes	No	Don't know	Yes, all	No	No
Latin America						
CIAT	Yes	No	Yes	Yes, all	No	-
CIMMYT	Yes	No	Yes	Yes, all	No	Yes
CIP	No	Don't know	Don't know	Yes, all	No	Don't know
Middle East						
ICARDA	Yes	No	Yes	Yes	No	-

[46] We extend our apologies to WARDA for absence of data here. The electronic survey instrument appears to have pre-empted or scrambled responses to a series of questions on NRS insurance coverage in the middle of the survey.

Appendix 5. Example Pre-requisites for Provision of ARV

The regional management office of a development NGO in East Africa issued the following pre-requisites for country programs considering the provision of ARV therapy. These stipulated:

> **Prevention program be in place.** It is essential that prevention remain the mainstay of efforts to address HIV/AIDS. All country programs should develop an active sensitization and education program for staff members and their families. The nature of such a program may vary from country program to country program in order to take into consideration country specific culture and the status of the epidemic. Voluntary Counselling and Testing facilities must be available.
>
> **ARV Availability**. A variety of generic and branded ARVs are regularly available. … ARV treatment must be only available to those with a positive HIV test who fulfil the criteria for treatment.
>
> **Laboratory Facilities**. The minimum laboratory tests required are Haemoglobin and Total White Cell Count. Liver function tests and kidney function tests are desirable. More accurate assessment of disease progression and when to start treatment can be made with a CD$ count. If this is unavailable it means that it is likely that treatment will be started based on more clinical criteria. The results of later treatment are not as good but still markedly improve quality of life for PLWHAs. The WHO has new guidelines for ARV treatment in resource poor settings, which address the issue of minimum/desirable laboratory backup facilities.
>
> **Physicians trained in ARV therapy**. The administration of an ARV regime is complex and does have side effects, requires monthly physician follow-up and good patient compliance. It must be carried out by someone who is adequately trained.
>
> **Within Government Policy**. ARVs should be within the policy of the respective governments.

Various assumptions are made in the background paper, including the claim that ARV treatment may actually reduce medical bills as fewer opportunistic infections will require treatment and that in East Africa HAART treatment will cost approximately US$400 per year per employee based on the presumption that generics are or will soon be available.

Appendix 6. Cost of Additional Self-Insurance Sufficient to Cover HAART

Example:: ICRAF

Number of insured at Center, including hosted institutions:	728
Adult HIV Prevalence in Kenya:	15%
Estimated HIV+ among insured:	109
Percent of HIV+ likely to come forward for HAART in Year 1 or 2:	5%
Number of HIV+ individuals who are likely to enroll for HAART in Year 1 or 2:	5

Scenario 1:

Not all who are eligible come forward in the first year.

Year	Number enrolled in HIV/AIDS Program	Cost per person per year	Total Additional Costs	Additional Cost Per Insured
2003	3	$ 2,200.00	$ 6,600.00	$ 9.07
2004	5	$ 2,200.00	$ 11,000.00	$ 15.11
2005	7	$ 2,200.00	$ 15,400.00	$ 21.15
2006	9	$ 2,200.00	$ 19,800.00	$ 27.20
2007	10	$ 2,200.00	$ 22,000.00	$ 30.22

Scenario 2:

Enrollment in program begins fast.

Year	Number enrolled in HIV/AIDS Program	Cost per person per year	Total Additional Costs	Additional Cost Per Insured
2003	5	$ 2,200.00	$ 11,000.00	$ 15.11
2004	7	$ 2,200.00	$ 15,400.00	$ 21.15
2005	9	$ 2,200.00	$ 19,800.00	$ 27.20
2006	11	$ 2,200.00	$ 24,200.00	$ 33.24
2007	12	$ 2,200.00	$ 26,400.00	$ 36.26

Scenario 3:
Worst Case. Enrollment in program begins fast and builds fast.

Year	Number enrolled in HIV/AIDS Program	Cost per person per year	Total Additional Costs	Additional Cost Per Insured
2003	5	$ 2,200.00	$ 11,000.00	$ 15.11
2004	8	$ 2,200.00	$ 17,600.00	$ 24.18
2005	12	$ 2,200.00	$ 26,400.00	$ 36.26
2006	17	$ 2,200.00	$ 37,400.00	$ 51.37
2007	20	$ 2,200.00	$ 44,000.00	$ 60.44

Additional Cost per insured averaged across five years, across all three scenarios:

Comments and Assumptions:

(1) Costs for persons enrolled for Stage 1 HIV/AIDS management not included as many of those costs already being paid for. Better management at Stage 1 HIV/AIDS may even serve to reduce medications costs.

(2) Costs may well continue to decline as HAART provider is currently negotiating for reduced cost of lab reagents and some ARVs. Expected introduction of generics in the Kenyan market will further reduce costs.

(3) Staff turnover not included as conservative measure against possible underestimation of new enrollees.

(4) Compatability between outpatient and inpatient plan must be secured but HAART is expected to reduce hospital costs to the extent that some HIV/AIDS hospitalization is already being paid for.

(5) Not all additional costs will accrue to ICRAF, depending on arrangements with hosted institutions.

(6) US$2,200 covers HAART plus some other costs, it would not cover an expensive AIDS hospitalization, but it is presumed that such costs will not be as common as the benefits of HAART begin to accrue.

Appendix 7. Sample Contributions by UN/World Bank and Employees Under MIP (UN) and MBP (WB)

UNON:

	Monthly Salary *$500.00*		**Monthly Salary *$1,000.00***		**Monthly Salary *$1,500.00***	
	Employee	UN	Employee	UN	Employee	UN
Percent Contribution:	1%	9%	1.50%	9%	2.00%	9%
Total Monthly Contribution:	$5.00	$45.00	$15.00	$90.00	$30.00	$135.00

UN Average contribution across three salary ranges assuming staff evenly distributed in these three salary classes: $ 90.00 per employee/per month

World Bank:

	Monthly Salary *$500.00*		**Monthly Salary *$1,000.00***		**Monthly Salary *$1,500.00***	
	Employee Employee	UN WB	Employee Employee	UN WB	Employee Employee	UN WB
Percent Contribution:	1.30%	3.90%	1.30%	3.90%	1.30%	3.90%
Total Monthly Contribution:	$6.50	$19.50	$13.00	$39.00	$19.50	$58.50

WB Average contribution across three salary ranges assuming staff evenly distributed in these three salary classes: $ 39.00 per employee/per month

Comments/Assumptions:
UN: Employee contribution can vary from 1.0% to 2.25% of salary depending on the number of dependents as well as salary. World Bank: Employee contribution can vary from 0.6% to 1.5% of salary depending on the number of dependents.UN Contribution of 9% is the approximate contribution according to UNON, proabably overstated here at lower levels of salary.World Bank contribution of 3.9% is as documented for employees plus three to five dependents.

The accuracy of the average contribution will depend greatly on improved information on salary structure and numbers of personnel at different salary levels.

Appendix 8. DAI's Catastrophic Health Assistance and Education Policy

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DAI'S
Catastrophic Health Assistance and Education Policy
Summary Sheet

This policy complements the DAI HIV/AIDS Workplace Policy, released February 2002, which requires non-discrimination of employees affected by HIV/AIDS. This policy outlines HIV/AIDS care and support services which will be available for local DAI employees worldwide. It also provides resources for DAI field projects to launch HIV/AIDS education and prevention programs for local staff.

- The Catastrophic Health Assistance Policy is activated when the employee's local insurance and medical care coverage does not cover a catastrophic health condition such as (but not limited to) HIV/AIDS and related illnesses. The above financial assistance does not apply to routine health maintenance.
- The policy does not require an HIV/AIDS test to qualify. Rather, it requires at least two of four conditions are met: (1) inpatient hospital care; (2) a five-day absence plus treatment; (3) chronic condition requiring treatment; or (4) permanent or long-term conditions requiring supervision.
- The policy identifies a per-incident financial cap for medical treatments, services, or medications that are not covered through health coverage already provided by DAI.
- Employees with life-threatening illnesses may request a leave of absence (without pay) if other leave has been used to pursue medical care or recuperate from the effects of a life-threatening medical condition.
- All medical information obtained from the employee remains confidential and is handled in accordance with existing legal, medical, and ethical management practices.
- The policy guarantees employees' right to work as long as they can meet acceptable performance standards, and as long as continued employment does not present a health or safety risk to themselves or to others.
- The Catastrophic Health Assistance Policy applies to actively employed DAI local employees. Employee spouses, children, or siblings are not eligible for financial assistance.
- DAI provides its field projects with an annual budget for a Health Education and Prevention Program for all staff. In addition, DAI is providing guidance to field staff for the effective use of these resources.

For more information on this policy, please contact DAI's Office of Human Resources.

Glossary

AIDS. AIDS stands for *Acquired Immunodeficiency Syndrome*, a disease in which the body's immune system breaks down due to an infection with a virus called the *Human Immunodeficiency Virus* (HIV).

ARV. Anti-retroviral drugs. ARVs are drugs prescribed for the treatment of AIDS.

CD4 count. CD4 count is the number of CD4 cells in a cubic millimeter of blood. CD4 cells help to protect people from getting infections. HIV attacks and destroys CD4 cells. A CD4 count in a healthy, HIV-negative adult is usually 600-1200 CD4 cells oer cubic millimeter of blood. The CD4 count of most people with HIV usually falls over time. If the CD4 count drops below 200, there is a high risk of serious infection and death. For many developing countries, HAART is administered only when CD$ count falls below 200.

Generic Drug. According to the WHO, a pharmaceutical product usually intended to be interchangeable with the innovator (or originator) product, and which is usually manufactured without a license from the innovator or original patent-holder.

HAART. Highly Active Antiretroviral Therapy**.** HAART refers to a regimen of multiple ARVs, consisting of precise combinations of protease inhibitors (PI), non-nucleoside reverse transcriptase inhibitors (NNRI) and nucleoside analogue reverse transcriptase inhibitors (NRTI) that make up the so-called "triple cocktail" currently deemed the most effective treatment for HIV/AIDS.

HIV. HIV stands for the *Human Immunodeficiency Virus* (HIV) that leads to AIDS.

OHS. Occupational, Health and Safety

PEP. Post-exposure prophylaxis treatment is an emergency medical response to individuals who may have been exposed to the HIV. The PEP treatment consists of ARV medication, laboratory tests and counseling.

PLWHA. People living with HIV/AIDS. This is now the preferred term to use when discussing people who "have" HIV/AIDS. It substitutes for earlier phrases that typically referred to people "suffering from HIV/AIDS" or "victims of AIDS." The newer term emphasizes the reality that with treatment people can <u>live</u> with HIV/AIDS.

Stage 1 AIDS. Stage 1 AIDS refers to the phase of HIV/AIDS in which the individual begins to succumb to illness and opportunistic infections, but is not yet thought to be a candidate for HAART.

Stage 2 AIDS. Stage 2 AIDS refers to the phase of HIV/AIDS in which the individual more frequently succumbs to serious illness and debilitating opportunistic infections.

Stage 2 AIDS is often identified with a CD4 count of less than 200 and where possible HAART is immediately indicated**.**

UNAIDS. United Nations joint co-sponsored program on HIV/AIDS, created in 1996 to lead, strengthen and support an expanded response to the HIV/AIDS epidemic. The six original co-sponsors are UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. UNAIDS is the leading source for official HIV/AIDS data.

Viral load. Viral load is the amount of HIV that can be measured in the blood. If the person has not developed symptoms, a viral load higher than 100,000 per milliliter of plasma is considered high, and below 10,000 is considered low. A viral load assay gives approximately two to three months advance notice on the progress of HIV/AIDS in comparison to the CD4 count. Wherever available, viral load tests are considered an essential part of HAART laboratory testing. In resource poor settings, this expensive and often unavailable laboratory test is not considered essential.

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We have listed only those references directly cited or used in the paper. Many other resources and references, including in-house documents, were consulted in the process of developing the study and the report.

About The Author

Dr. Nancy J. Allen is an organizational sociologist, specializing in formal organization and institutional development. She received her Ph.D. from Harvard University, in a joint degree of the Harvard Business School and the Department of Sociology. She also holds an M.B.A. from the University of Santa Clara and a B.S. in Arabic and Middle East Studies from Georgetown University. She is currently working as an independent consultant, based in Nairobi, Kenya specializing in organizational and institutional development, international human resources management and strategic planning. Dr. Allen has worked in the private sector, and more recently in the public sector. From 1994 to 2000, she worked for the Harvard Institute for International Development as an economic advisor at the Ministry of Finance in Indonesia. In Indonesia, she specialized in foreign direct investment, trade and industrial policy, and export manufacturing, always maintaining a broad focus on issues of institutional development. In the period after the East Asian economic crisis, she developed additional expertise in areas of competition policy, bankruptcy law, civil service reform, as well as corporate and public governance.