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GLOBAL HEALTH INITIATIVE

Private Sector Intervention Case Example

Rapidly assess needs, establish a programme with an experienced partner, then analyse and refine the programme

Case categories

Company: **DaimlerChrysler** Industry: **Automotive** Location: **South Africa** Programme: **HIV/AIDS**

Key questions

- **What level of prevalence and business impact analysis is required to fiscally justify offering comprehensive treatment including Highly Active Anti-Retroviral Treatment (HAART)?**
- **What level of internal project management and technical expertise is necessary to ensure that the programme is sustainable after the initial public-private partnership ends?**
- **How can the impact and effectiveness of community interventions be assessed?**

Overview

Company

DaimlerChrysler has the third largest automotive revenues worldwide.

- DaimlerChrysler is one of the world's largest automotive, transportation and services companies. It has manufacturing operations in 37 countries and distribution operations in more than 200 countries. In 2001, it employed 372,000 people, its revenues were US$ 136 billion and its net income was US$ 590 million.
- DaimlerChrysler South Africa (DCSA) has three main plants that manufacture, market, import and export motor vehicles and automotive parts. East London is their largest facility with 79% of the workforce. They also provide financial and fleet management services. In 2001, DCSA had 4,500 employees and 3,000 suppliers and contractors working at these three facilities. Although not part of the workplace and community projects, DCSA indirectly impacts 2,900 other workers who are members of other DaimlerChrysler affiliates or employed as part of the dealer network. DCSA's estimated 2001 revenues were US$ 1.4 billion and its 2001 net income was US$ 79 million.

Business Case

DCSA established its workplace and community HIV/AIDS project in 2001 to address the increasing financial burden associated with HIV/AIDS. DCSA also decided to provide prevention, care, support and treatment services to employees, their dependants and the community as part of DCSA's obligation to these stakeholders based on the principles of corporate social responsibility (CSR). This is also an extension of DaimlerChrysler's signing of the UN Global Compact on CSR.

- DCSA established a programme objective to reduce further spread of HIV infections and Sexually Transmitted Infections (STIs) and ensure access to treatment, care and support for people living with HIV/AIDS among the workforce of DCSA, their families and their immediate communities and to effectively manage the impact of HIV/AIDS on DCSA.
- DCSA estimated a 2001 HIV prevalence of 9% in 2001. Further, DCSA had observed an increase in the proportion of employee deaths attributable to HIV/AIDS since 1997; although no increase in the death rate has been detected. In 2002, DCSA estimated that the average present value cost per HIV infection is US$ 31,000. In the forecasted peak year for HIV/AIDS related expenditures, DCSA forecasted expenses equivalent to 4% of DCSA's salaries.
- In order to determine whether or not the project was effective, German Technical Cooperation (GTZ) and DCSA established project process and outcome indicators aligned with project objectives and interventions.
- DCSA's 2002 HIV/AIDS project budget is US$ 44 per employee per year or 0.5% of payroll.

Project Description

DCSA formed a partnership with labour, represented by the National Union of Metalworkers of South Africa, management and GTZ to prevent new infections, to provide care, support and treatment for HIV+ employees and dependants and to play an advocacy role regarding HIV/AIDS interventions at the workplace, in the community and at provincial and national levels.

- DCSA first codified its HIV/AIDS workforce policies in 1996. The policy is updated annually in the first quarter of every year and the most recent version was written in April 2002. Each version is signed and approved by the union and management.
- **Workplace prevention** programmes focus on behaviour change through intensive employee and management education, utilization of a peer educator approach, services of nurse practitioner counsellors, condom promotion and distribution, and Voluntary Counselling and Testing (VCT).
- Every employee is required to belong to the Corporate Health Plan, which ensures funding for HIV/AIDS treatment for employees and dependants (Aid for AIDS (AFA) disease management programme) including **Highly Active Anti-Retroviral Treatment (HAART)**. Each business unit also provides wellness programmes, which can include general health promotion, nutritional support and counselling, Syndromic STI management, tuberculosis (TB) treatment through Directly Observed Therapy Short course (DOTS) and health status monitoring.

Project Evaluation

DCSA and GTZ regularly review project performance.

- GTZ and DCSA are contractually obligated to submit regularly scheduled activity and outcome reports. The reports measure and analyse specific processes, outcomes and interventions dictated by the co-authored project strategy and operational plan documents.
- Upon completion of the project, DCSA will conduct an HIV seroprevalence survey and a Knowledge, Attitude, Perceptions and Behaviour (KAPB) profile assessment.

DCSA and GTZ will continue to focus on project interventions dictated by the project operational plans but will also focus on community interventions, assessing the cost-benefit impact of prevention and treatment, and institutionalization of the project.

Private Sector Intervention Case Example

Company: DaimlerChrysler Industry: Automotive Location: South Africa Programme: HIV/AIDS

Business Case

Vision

To improve the general health status of DCSA's employees. In particular, to reduce further spread of HIV infection and STIs and ensure access to treatment, care and support for people living with HIV/AIDS among the workforce of DCSA, their families and their immediate communities, and to effectively manage the impact of HIV/AIDS on DCSA.

- Increased effectiveness of **DCSA Health Services** related to HIV/AIDS prevention and care;
- Ensured adequate and cost-effective benefits in order to meet employees' needs in the HIV prevalent environment while minimizing the cost of HIV/AIDS impact on DCSA business operations;
- Increased information, education and communication about HIV/AIDS and the new DCSA services among employees in order to decrease stigma and increase preventive and care-seeking behaviours.

Case for Action

DCSA demonstrated a sizeable employee HIV prevalence, an increase in proportion of deaths attributable to HIV/AIDS and increases in forecasted HIV/AIDS expenses.

- In April 2000, the South African Ministry of Health estimated the prevalence rate in South African antenatal clinics to be 22.8%. In October 2001, DCSA conducted a **semi-linked** (to job bands) **cross-sectional anonymous seroprevalence survey** covering all three locations with the Medical Research Council (MRC). The sample consisted of approximately 1,400 employees selected using a stratified, random sampling technique with an average **response rate of 79%**. The response rate varied by location from 77% to 88%. **The adjusted overall DCSA prevalence rate was estimated to be 9%, which corresponds to approximately 400 people living with HIV/AIDS.** The prevalence varied by location with 6% in Pretoria, 9% in East London and 13% in Pine Town. Utilizing epidemiological modelling, the MRC estimated HIV prevalence, incidence and mortality in DCSA from 1985 to 2010.
- In May 2001, the University of South Africa (UNISA) conducted a **KAPB assessment** to establish a baseline for future impact evaluation. The survey was available in English, Xhosa and Zulu. The survey linked to job bands and queried a stratified random cross-section of 680 employees of whom 73% responded. The survey outcomes indicated several areas of need: (1) 20% of employees in East London believe that traditional medicine can cure HIV/AIDS; (2) 18% of operators in East London believe that sex with a virgin can cure HIV/AIDS; (3) 84% believe that people do not discuss HIV/AIDS because of fear of rejection; (4) 49% have never used a condom; (5) 28% use a condom during every sexual encounter.
- Although the number of deaths per 1,000 workers has not increased substantially, **the percentage that could be attributed to HIV/AIDS has risen from 15% of 7.3/1,000 in 1997 to 40% of 8.2/1,000 in 2001**. There has been no parallel increase in the number of ill-health retirements associated with HIV/AIDS.
- In April 2002, in conjunction with the University of Natal in Durban, Boston University and the WHO, DCSA conducted an economic impact analysis for HIV/AIDS. The average **present value (discounted cash flow) cost of an infection** was US$ 31,000 but ranged from **US$ 17,000 for hourly employees to US$ 126,000 for employees in the highest pay bands**. These costs, as reported, are comprised: death and disability (40%), productivity loss (41%), recruitment and training (6%), supervisory time (5%), health care (4%) and sick leave (4%).[1]
- In 2001, it was estimated that HIV/AIDS costs from infections acquired during that year posed present value future expenses of US$ 934,000, which equals 2.1% of DCSA South Africa's 2001 salary expenses. In 2006, the expected peak year of DCSA's HIV/AIDS costs, it forecasted US$ 1.6 million in expenses or 3.7% of DCSA South Africa's 2001 salary expense.

Expected Outcomes

In order to determine project effectiveness, GTZ and DCSA established project-specific process and outcome indicators that are aligned with project objectives and interventions.

- **Improved DCSA health services:** (1) within three years 40% of employees will obtain Voluntary Counselling and Testing (VCT), including 80% of all patients seeking treatment for STIs or TB; (2) within two years TB cure rate at all three plants and at East London will increase to 80%; (3) within three years the number of new STI treatments will decrease by 50% and the number of recurrent STI treatments by 50%.
- **Human resources and planning:** (1) DCSA will ensure insured benefit increases are equivalent in quality but their costs will remain in the bottom quartile in the industry; (2) DCSA will ensure appropriate re-modelling of payment methods of death benefit allocations; (3) DCSA will maintain medical aid premium increases below 20% per annum; (4) DCSA will maintain operational productivity at 2000 levels for the next three years.
- **Education and awareness:** (1) DCSA will ensure that 90% of employees have access to HIV/AIDS information, 40% have access to intranet resources, and 40% will utilize the national Department of Health hotline within three years; (2) DCSA will reach 80% of employees with peer education and will enrol 50% of HIV+ patients in AFA within three years; (3) DCSA will improve knowledge, attitudes, behaviour and perceptions across high need areas by 50% within five years.

Financing

DCSA's 2002 HIV/AIDS budget is US$ 44 per employee per year or 0.5% of salary expense.

- DCSA and GTZ signed a cooperation agreement to establish a projected **four-year budget** totalling **US$ 600,000. DCSA (80%) and GTZ (20%)** fund the public-private partnership's interventions through contractually guaranteed minimum expenditures.
- In **2002**, the combined GTZ and DCSA budget is approximately US$ 200,000, i.e. **US$ 44 per employee per year**, i.e. 0.5% of salary expense. These funds are spent on administration, monitoring and evaluation, workplace and community prevention and awareness projects, and advocacy and external communication. DCSA exceeded its budgeted annual contribution for 2002 by June and is expected to expand its contribution to ensure that the project continues to meet its objectives.
- The average 2001 **direct medical costs** (including non-HIV-related expenditures) for HIV+ patients enrolled in AFA disease management programme are **US$ 124 per enrolled employee per month**.
- In addition to its HIV/AIDS project budget, in 2002 DCSA Corporate Social Responsibility initiatives contributed **US$ 101,000 to community-based HIV/AIDS initiatives**.

Project Description

Policy

DCSA first codified its HIV/AIDS workforce policy in 1996. The policy is updated in the first quarter of every year and the most recent version was written in April 2002. Each version is signed and approved by the union and management.

- **Non-discrimination:** (1) employees will not be dismissed on the ground of their HIV status; (2) employees will undergo a medical exam before starting employment, but the exam does not include an HIV test and hiring decisions and will not utilize an HIV assessment.
- **Confidentially and disclosure:** (1) employees are not required to disclose status; (2) if status is disclosed, it cannot be disclosed to others without written consent.
- **Benefits:** (1) all employees are required to participate in DCSA's closed health insurance plan; (2) DCSA supplies 50% to 55% of the cost of the insurance premiums for each participant; (3) all of the health plan's options provide coverage for HIV/AIDS treatment, including HAART, up to US$ 2,000 per registered participant per year; (4) DCSA has set up US$ 1.5 million fund to pay for individuals that may in future exceed this allowance and will approve such expenditure on a case by case basis; (5) DCSA's health, retirement and other insurances do not discriminate against HIV/AIDS status.
- **Ill-health retirement:** (1) the employee or management can initiate an ill-health retirement; (2) the medical practitioner on the site makes an initial assessment, which is subsequently reviewed by the insurance provider; (3) depending on the retirement plan selected during employment, the employee gains access to a fraction of regular wages and potentially a lump sum payment after two years; (4) two employees took advantage of this option in 2001 for reasons related to HIV/AIDS.
- **Contractors and on-site suppliers:** (1) on-site contractors and suppliers are not required to adhere to DCSA's HIV policy; (2) although not contractually required, any contractor that works on a DCSA site has access to DCSA prevention, wellness and on-site treatment projects. However, this excludes access to the AFA disease management programme.

Prevention and Awareness

The prevention strategy utilizes campaigns and a coordinated communications intervention combining training, peer educators, condom promotion and distribution, and community activities.

- In conjunction with GTZ, DCSA created "**info-islands**", computer touch screen kiosks, supplemented with permanent poster displays and pamphlet dispensers in recreational environments at each of its three locations to engage employees in HIV/AIDS awareness and knowledge-building activities. The kiosks' multimedia content is available in Afrikaans, English, Xhosa and Zulu. DCSA and GTZ have developed a project website which is mirrored on the company **intranet, are in the process of developing an interactive Wellness Information** intranet site and have provided employees access to the **national employee helpline** to handle inquiries from all locations. These communication tools are integrated with the campaigns and focus on messages targeting needs identified by the KAPB profile assessment.
- DCSA used an event and campaign focused communication project: (1) policy launch in July 2001; (2) awareness messages, workplace prayer meetings and candle-light vigils on World AIDS day in December 2001; (3) TB awareness in March 2002; (4) VCT campaign in May 2002.
- All new employees, shop stewards and apprentices undergo **training**. Since the project launch in 2001, 150 new employees, 98 apprentices and 21 shop stewards were trained in basic knowledge of HIV/AIDS and the DCSA HIV/AIDS programme.
- **98 peer educators 1:46 ratio** were trained since the project launch by GTZ to provide basic HIV/AIDS knowledge to employees, participate in campaigns and engage the community. The goal peer educator ratio is 1:30 but it is adjusted for specific clusters of employees based on demographic differences. Peer educator selection is based on peer **nominations** to ensure that educators command the respect of the target audience. Approximately 75% of the peer educators take part in active outreach activities including (1) training during regular team meetings; (2) informal sessions at lunch; (3) ad hoc promotion of campaigns; (4) ad hoc community outreach. Peer educators will undergo refresher training annually. It is estimated that there is 65% attendance at the monthly support meetings in East London. 30% of the peer educators in East London turn in regular activity reports.

Project Description (continued…)

Prevention and Awareness (continued…)

- Free government **male condoms** have been available at 200 workplace dispensers, at workplace health facilities and through peer educators since 2001. DCSA is installing vending machines that will distribute free government condoms as well as sell branded male and female condoms at reduced rates. In 2001, in East London DCSA distributed 1.2 condoms per employee per month.
- **Syndromic Treatment of STIs** is available at company clinics and through external providers (e.g. private or government institutions). The KAPB survey indicated that 70% of employees prefer to use external providers for STI treatment. In 2001, the company clinics in East London treated 76 STIs per 1,000 employees. DCSA medical practitioners use the STI treatment process as an opportunity to suggest for VCT but the uptake levels are not currently tracked.

Voluntary Counselling and Testing

The VCT project was launched in 2001 and subsequently publicized through events.

- The service is available to employees and dependants for free both through company clinics and external providers whose services are reimbursed through the medical aid. It is estimated that 70% of employees regularly utilize services from the company medical facilities.
- **Eight nurse practitioner counsellors (563:1 ratio)** provide one-on-one counselling for employees who would like to learn more about their risk and potentially seek VCT services. These are all DCSA nurse practitioners and were trained in HIV/AIDS counselling skills by the national Department of Health.
- Since 2001, DCSA has provided VCT services **for 1,750 employees, which corresponds to 39% of the workforce.** 1,212 of the VCT applicants were tested during the VCT campaign started in May 2002. During this campaign the company emphasized the benefits to employees for learning their status, including access to the AFA programme, but DCSA also offered incentives in the form of cash prizes in a raffle to increase participation.

Care, Support and Treatment

HIV+ employees gain access to DCSA's comprehensive care, support and treatment outreach project, which provides support for those affected by HIV/AIDS.

- Employees and dependants can confidentially join a treatment programme called **Aids for AIDS (AFA)**, which is offered by DCSA's third party health plan administrator, Medscheme. Since its launch in 1999, the programme has enrolled 150 health plan members of whom 130 are currently participants. **The 102 participating employees represent 26% of the estimated HIV+ employees at DCSA**.
- The project includes authorization for coverage of antiretroviral therapy (ART). Of the 130 currently active patients in the AFA programme, 72 are on ART. 75% are on **Highly Active Anti-Retroviral Treatment (HAART)**, 20% are on **Dual Therapy** and four are on **Mother to Child Transmission Prevention (MTCTP)**.
- DCSA monitors and evaluates how effective it is in attracting employees in the early stages of the disease by tracking their state upon entry into the programme. Of the 150 people who have entered the AFA programme to date, 20% had a minimally impaired immune system, 18% had a moderately impaired immune system, 30% had symptoms and a moderately impaired immune system, while 32% had AIDS.
- In addition to the AFA programme, employees have access to DCSA's **comprehensive on-site wellness project** and their regular medical insurance benefits. Of the 130 active participants, 40 receive their medical treatment from DCSA's East London Health Centre, while external medical practitioners provide services for the remainder. Both groups of medical practitioners provide treatments that adhere to the AFA treatment guidelines.

Programme Evaluation

Key Success Factors

Since DCSA and GTZ signed their public-private partnership agreement in December 2000, they have compiled the following key lessons:

- Partnering in a public-private partnership with GTZ provided DCSA with project management, technical expertise and financial support from a partner with a proven track record of operating successful projects.
- Partnering with the trade union to both design and operate the project provided the project with the mandate and input necessary to engage the workforce. The president of the National Union of Metalworkers of South Africa and the chairman of DCSA are co-sponsors of the project.
- Implementing the project in parallel with conducting in-depth assessments allowed the project to meet the objectives more rapidly than if the implementation followed the assessments.
- Relying heavily on a structured peer educator programme with supervision and monitoring allowed DCSA greater access to the workers than other communication and educational methods.
- Continual external visibility increased DCSA's and GTZ's drive to meet the high standard built into the external expectations.

Self-evaluation Process

DCSA and GTZ regularly review project performance.

- The public-private partnership cooperation agreement specifically mandates GTZ to evaluate the project interventions and outcomes every six months with project status reports. DCSA tracks each location's outcome and activity goals every six months.
- DCSA Group HIV/AIDS committee holds bimonthly meetings to evaluate programme effectiveness and adapt programme activities. The committee has representation from management, human resources, medical, labour, the non-unionized staff committee and GTZ.
- The project will be regularly monitored, evaluated and adapted to ensure that it will be able to achieve the outcomes established in the preparation phase of the project. In addition to regular tracking of key processes and activity metrics, at the completion of the three-year project, DCSA will conduct a follow-up HIV seroprevalence linked with a KAPB profile assessment.

Future Goals

DCSA and GTZ will continue to focus on project interventions dictated by the project operational plan but will also focus on the following areas:

- In 2002, DCSA will examine historical direct medical and other expenses linked to a cohort of HIV+ employees enrolled in AFA between 2000 and 2002 and a cohort of HIV+ employees who are assumed to probably have been HIV+ and who died between 1997 and 1999 who did not have access to ART. This will help to **assess the direct cost benefits associated with providing employees with comprehensive care, support and treatment**. This analysis will also be extended to refine the economic impact analysis conducted by the University of Natal, Boston University and the WHO.
- Starting in 2003, DCSA will **extend its activities into the community** focusing on three **training** interventions: (1) partnership with South African HIV Clinicians Society to develop specific training modules for disease management and to train 80 GPs at each location in the SA HIV/AIDS Clinical Guidelines, and management and treatment of STIs and TB; (2) partnership with Family and Marriage Society of South Africa (FAMSA) and St Bernard's Hospice to develop training standards for home based care (HBC) to train 80 HBC volunteers in four communities surrounding East London; (3) partnership with provincial departments of education to train and provide ongoing programmatic support to peer educators at neighbouring schools in all three locations.
- **Institutionalizing and horizontalization of the interventions** so that DCSA can continue to achieve the project's objectives once the project agreement with GTZ ends. DCSA has retained the services of a PhD student to help execute this project.

Private Sector Intervention Case Example
Company: DaimlerChrysler Industry: Automotive Location: South Africa Programme: HIV/AIDS

Case-specific HIV/AIDS Resources

Documents

DCSA 2002 HIV/AIDS Policy
DCSA 2001 KAPB Assessment
DCSA 2002 Guidelines and References
DCSA 2001 Prevalence Assessment
DCSA August 2002 Project Presentation
GTZ 2001 Public Private Partnership Strategy Proposal and Budget
DCSA 2002 Community Strategy
DCSA 2001 Communication Strategy
DCSA Posters, Pamphlets, and Brochures
Medical Scheme and AFA Guidelines (Provided with the permission of AFA. Their contact details are listed below.)

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[1] DCSA believes this economic impact assessment overestimates the direct expenditures incurred by DCSA. For example, the death and disability component is an insured product provided out of a fixed allowance from the employer contribution to employee benefits. If the premiums were to increase as a result of higher death and disability claims, DCSA would redistribute its pension allocation to cover the higher premiums, but not incur additional costs. Much of estimated productivity loss is measured in salaried workers but DCSA will not hire additional salaried workers. Instead the existing workers will simply work longer hours to meet their performance goals. Also, in the last couple of years, DCSA has experienced improving, not declining, efficiencies. DCSA is conducting a cohort analysis to calculate the true direct costs incurred by DCSA both with and without comprehensive treatment. It is hoped that this analysis will resolve some of these open questions.

This case study uses the following exchange rate: 10 South African rands to 1 United States dollar.

The World Economic Forum Global Health Initiative Private Sector Case example is developed in collaboration with the featured company. However, GHI member companies and partners, the World Economic Forum and the contributing company do not necessarily subscribe to every view expressed herein. The case is based on a self-reporting model. Although the GHI makes reasonable efforts to ensure the accuracy of the statements, this report should not be viewed as an external audit of the programme described.

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