HIV AIDS

A Continuing Global Epidemic

STANDARD LIFE INVESTMENTS

Introduction

It is now quarter of a century since the first cases of AIDS were detected. In the intervening period, AIDS has killed more than 25 million people, orphaned millions of children and slowed economic development, even reversing it in some cases. Around 40 million people now live with HIV. The epidemic is growing in many parts of the world, but is worst in sub-Saharan Africa. Our study has looked at the extent of the problem, its relevance to business and the various responses to it. It culminates in the examples of three major UK companies and their approach to managing their exposures to the disease in sub-Saharan Africa. These studies will serve as useful reference for comparison of the approaches taken by multinationals operating in similarly affected areas, be that sub-Saharan Africa or other low-income, high disease-rate regions.

Political Response

In 2001, at a session of the UN General Assembly, leaders from 189 Member States committed to targets for delivering effective HIV prevention, treatment, care and support. The aim is to start a reversal of the global epidemic by 2015. This Declaration of Commitment on HIV/AIDS requires members to report regularly to the General Assembly on progress, using indicators developed by The Joint United Nations Programme on HIV/AIDS (UNAIDS).

The UNAIDS programme brings together the resources of ten UN system organisations. Co-sponsors include UNICEF, International Labour Organisation, World Health Organisation and the World Bank. As the directing and coordinating authority on international health work, the World Health Organisation (WHO) takes the lead in the UN system on the global health sector response to AIDS.

Overall, leadership and political action on AIDS have increased significantly since 2001. Around 90% of reporting countries now have national AIDS strategies and 85% have a national body to coordinate AIDS efforts, while 50% have evaluation/monitoring frameworks.[1]

However, prevention programmes still reach only a small minority of those in need. According to UNAIDS, in low and middle income countries HIV prevention programmes are failing to reach many of those at greatest risk. Surveys indicate that fewer than 50% of young people have comprehensive knowledge levels on HIV. Only about 10% of homosexual men and fewer than 20% of injecting drug users received any type of HIV prevention services in 2006. Between 2001 and 2006, the number of people on anti-retroviral therapy in low and middle income countries increased from 240,000 to almost 1.5 million. Globally, however, anti-retroviral drugs still reach only one in five who need them. Ongoing obstacles to expanding treatment include the concentration of treatment sites in urban areas (ie. lack of provision to dispersed populations) and inadequate efforts to address vulnerable populations such as sex workers, homosexuals, drug addicts, prisoners and refugees. Another barrier is the number of HIV positive individuals who are unaware that they are infected, as they do not request testing. Testing must be voluntary and this is a major weakness in the global fight against AIDS. However, the alternative in many countries could be systemic discrimination. In China, for example, the lack of guaranteed confidentiality is a potential problem.

Geographic Trends

The AIDS epidemic is continuing to grow and there is evidence that some countries are seeing a resurgence in new HIV infection rates which were previously stable or declining. In 2006, around 40 million people globally were estimated to be HIV positive and 2.9 million died of AIDS (2.8 million died in 2005). :

- Sub-Saharan Africa remains the worst affected region with South Africa's epidemic showing no evidence of a decline. In 2006, around 20% of working-age adults in South Africa had HIV. Approximately 25 million people in sub-Saharan Africa are HIV positive - almost 63% of global cases.
- In the Middle East and North Africa, recorded HIV infection rates are very low, not exceeding 0.1%. However, available data suggests that the epidemics are growing in several countries including Algeria, Iran, Libya and Morocco.
- In Asia, around 8 million people are HIV positive and recent increases in infection rates are particularly evident in Indonesia, Papua New Guinea, Vietnam, China, Bangladesh and Pakistan. However, nearly two-thirds of all HIV cases in Asia are in India, due to the sheer size of the population rather than a high prevalence rate. Both India and China have the potential for major epidemics, driven in part by their growing mobility.
- The Caribbean region remains the second most affected region in the world. National adult HIV prevalence exceeds 2% in Trinidad and Tobago and 3% in Haiti and the Bahamas.
- In Latin America, 1.6 million people are living with HIV, one-third of whom live in Brazil (the region's largest country). However, the most intense epidemics are in Belize and Honduras, both with 1.5% of the population HIV positive.
- In Eastern Europe, there are indications that infection rates have increased sharply since 2004. The Russian Federation has the largest epidemic in Europe, with estimates suggesting that 1% of the population have contracted the disease.
- Even in North America and Western Europe things have stalled, with the number of new infections not improving in the last two years, particularly among homosexual men, suggesting that HIV prevention programmes have relaxed.

Overall, 4.3 million new infections occurred in 2006; approximately 65% of them in sub-Saharan Africa.[2]

The UNAIDS Executive Director, Dr Piot, summed up the above figures saying "It appears that countries are not moving at the same pace as their epidemics."

Company Response Examples

Anglo American

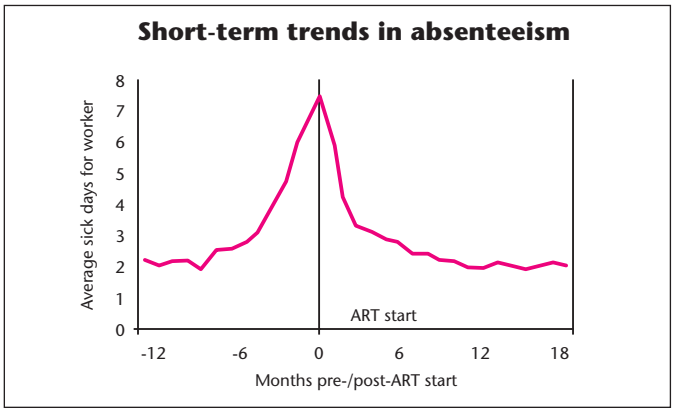
The company has 121,000 employees in Southern Africa and they estimate the prevalence of the disease in the workforce is 23% (28,000 employees). Voluntary HIV testing and counselling is offered, and in 2006, 63% of their workforce took this up. Around 8,500 (30%) of their HIV positive employees have enrolled in disease management programmes of which some 4,500 are on anti-retroviral drugs.

Anglo American has made a formal commitment to promoting HIV education and awareness in the areas where they operate, working with government authorities, NGOs and religious groups. They seek partnerships with donor organisations as a way of extending access to treatment to dependants and local communities.
They also lobby national governments about the need to raise awareness of the risks associated with HIV/AIDS at a national level. A proactive government prevention and education strategy will likely reduce the burden on companies and improve the effectiveness of a corporate programme.

The main challenge for Anglo American is to get all of their employees to know their HIV status voluntarily. This is not easily achieved as there is a fear that if they are HIV positive they will face discrimination. Anglo American have attempted to address this fear through policies that prohibit discrimination against potential employment candidates based on HIV status, and also discrimination against existing employees. The company had targeted 50% of employees to be voluntarily tested by the end of 2006, but after a slow start they actually achieved 63%.

Once HIV infection has taken place, it typically takes 8 to 11 years before the onset of AIDS. Treatment can delay this onset. Companies such as Anglo American have developed 'wellness programmes' to prolong the health of their HIV positive workers for as long as possible. These programmes include regular monitoring (CD4 counts), the provision of anti-retroviral therapy (ART) for those at the relevant stage of infection, nutritional and psychological support. Of course, this requires voluntary testing to have taken place.

Anglo American have been carrying out an economic evaluation of the impact of HIV/AIDS since 2003 with the Aurum Institute for Health Research. The study has evaluated the impact of HIV and AIDS without ART, and also the costs and benefits from implementing the treatment programme.
Results to date show that HIV/AIDS costs to Anglo companies would constitute 2% of payroll (range 0.12-2.55% based on 2003-2005 data) if ART was not available. The projected costs would peak between 2007 and 2009.
Costs per patient on ART have been declining over time, due to falling drug prices and the spreading of fixed costs over a greater number of patients. Two years of implementation cost between R915 (approx. £144) and R 1,700 (£267) per patient per month. The cost of HIV testing is estimated at R116 (£8) per employee.
Offset against this treatment cost are short-term savings achieved through a reduction in absenteeism. Across business units, absenteeism shows a continual decline from 6-12 and 18 months after commencing treatment, levelling off in later months. This is illustrated in the graph below.



Source: Anglo American

Savings resulting from this reduction in absenteeism are "somewhere in the range of 20% to 60% of the treatment provision costs" according to Anglo, depending on the business involved. This excludes any additional savings related to increased labour productivity while at work.

The resultant reduction in hospitalisation costs has also produced savings "within a range of 45% to 70% of the costs over the first 18 months of a worker's anti-retroviral treatment provision" according to the company.

Anglo American conclude from the analysis to date that, in the short run, the cost of ART is more than covered by the reduction in absenteeism, reduced healthcare costs (particularly hospitalisation), retention of skilled employees and improved productivity. They report that 94% of employees taking medications are capable of a normal working life.

A welcome side effect of the company's efforts to tackle HIV is that far fewer Anglo Coal employees are contracting tuberculosis (TB). The number of new cases of TB has dropped by almost 75% since 2001. Increased health awareness and medical testing as a result of HIV programmes have led to early diagnosis and treatment of those with TB. Because their immune system is weakened, people with HIV are at a much higher risk of developing active TB. Anti-retroviral treatment for HIV can help to prevent TB and other opportunistic diseases.

Dr Brink, who implemented Anglo American's policy on making treatment available to their employees, points out that despite the cost savings from less employee absence and avoidance of costs for death in service and pensions for dependents, "at the end of the day it was a moral decision – it's something that no employer in South Africa can ignore."[5]

Company Response Examples (continued)

GlaxoSmithKline

The issue facing pharmaceutical companies such as GSK is a very different one to those facing mining companies in areas of high incidence of HIV/AIDS. For GSK the main issue is access to their product. Before 2001, when the leading HIV drug companies set up a partnership to tackle the issue, they received a lot of criticism from NGOs about lack of HIV drug provision to developing countries. This has been addressed by establishing an initiative with relevant UN agencies, called the Accelerating Access Initiative (AAI). The other members of this initiative are Abbott, Bristol Myers Squibb, Roche, Merck, Boehringer-Ingelheim and Gilead.

Lack of political will and insufficient medical infrastructure are cited by GSK as the biggest barriers to accessing appropriate healthcare in developing countries such as those in sub-Saharan Africa. However, they are making efforts to help by making their essential medicines as cheap as possible. For example their HIV/AIDS drugs are available at not-for-profit prices to public sector customers and non-profit organisations in these areas.

Shipments of Preferentially Priced Combivir, Epivir and GSK-Licensed Generics – (millions of tablets)						
	2001	2002	2003	2004	2005	2006
GSK Combivir	3.5	6	11	32	45	27.5
GSK Epivir	1	1.7	5.2	34.4	81.3	58.8
Generic ARVs supplied by GSK-licencees (estimated)	-	-	-	-	-	120
Total	**4.5**	**7.7**	**16.2**	**66.4**	**126.3**	**206.3**

Source: GSK

Combivir, their leading anti-retroviral is available for $0.65 a day. These not-for-profit prices include delivery and insurance costs. Orders may be of any size, and the drugs will be available indefinitely.

In 2006 they shipped fewer Combivir and Epivir than in the previous year (see table above) because of more customers purchasing anti-retrovirals from generic manufacturers licensed by GSK. This, GSK point out, demonstrates that their licencing policy is working.
In the last year, the generic manufacturers licenced by GSK have significantly increased their manufacturing capacity and ability to supply larger quantities of anti-retrovirals at lower prices. The company estimates that their licensed generic companies supplied over 120 million tablets of their versions of Epivir and Combivir to sub-Saharan Africa.

The World Health Organisation has recently included abacavir as a recommended first line treatment. GSK subsequently managed to reduce the not-for-profit price of abacavir-containing anti-retrovirals by 30% and made their two new anti-retrovirals, Kivexa and Telzir, available at not-for-profit prices.

Product diversion has historically been a problem for pharmaceutical companies, with not-for-profit medicines being illegally shipped back for sale in wealthier countries. This denies treatment to patients in poorer countries. In response, GSK has introduced anti-diversion measures such as supplying red rather than white Combivir and Epivir tablets.

A report from the Accelerating Access Initiative suggests that by the end of 2006 more than 738,000 people living with HIV/AIDS in developing countries were receiving treatment with at least one anti-retroviral supplied by the seven pharmaceutical companies in the AAI (compared to 220,000 people on treatment in 2004 and 600,000 in 2005).[6]

Unilever

Unilever have business operations throughout the world, and therefore have businesses and local employees in areas of high incidence of HIV/AIDS.
They acknowledge that countries differ greatly in the quality of clinical infrastructure and the cultural attitudes to the disease. Therefore, the role of the private sector must vary accordingly. Where public health systems prevail, Unilever's contribution will concentrate on schemes of education and prevention. Elsewhere, direct involvement in treatment and care may be necessary. Their policies are most advanced in sub-Saharan Africa where the company's programmes have been developed over many years and are shared widely with other companies and in society.
The framework to manage HIV/AIDS addresses the needs of individuals at key stages of prevention and treatment:-

- Awareness through educational programmes for all employees.
- Prevention (including prevention of occupational exposures; distribution of condoms)
- Establishing the HIV status of individuals through voluntary testing.
- Encouraging HIV positive individuals to receive treatment. (Access to ART is provided).

Unilever Kenya has had this framework in place for the last 15 years or so, operating a long running campaign to communicate to its employees about the disease. Initially this was a brave step as the condition was still a taboo subject. Early on in the campaign, Unilever Kenya recognised that the problem of HIV/AIDS stretched beyond their own operations, and that working in partnership was the only way to tackle the causes. It therefore approached other major companies to pool their efforts in fighting the pandemic. This coalition, called Neighbours Against AIDS meets regularly to share ideas and experiences. It includes companies such as GSK, GM and BAT.

Partly as a result of the coalition, awareness of HIV/AIDS is now almost total among the Kenyan population, according to the Corporate Relations Manager. The Neighbours Against AIDS coalition is now concentrating on encouraging people to go for HIV tests and to think about the risks associated with their sexual relationships.

Unilever share their learning with other businesses, making their programmes available as models on both the 'Global Business Coalition' and 'Global Health Initiative' websites.[7]

Economic Impact

The macroeconomic impact of HIV/AIDS is difficult to accurately predict, but there has been analysis of the issue. The disease principally affects people in their most productive years of life (young adulthood) and thus has a negative impact on productivity, healthcare expenditure, care demands, disposable income and savings. In the long term this reduces the market size, reduces human resources for production and investment and thus leads to lower economic growth. Ongoing estimates by the World Bank suggest that the macroeconomic impacts of the disease may be significant enough to reduce growth of national income by up to a third in countries with adult prevalence rates over 10%.

Beyond the macro impacts on companies (impact on markets, labour, savings and investments), there are two broad areas where HIV/AIDS is likely to impact on individual business operations:

(i) Declining productivity – increased absenteeism, increased organisational disruption (staff turnover, skills loss, declining morale)

(ii) Increased costs – recruitment, training, insurance cover, health costs, funeral costs (where businesses provide this), supplying cheap/free aid (e.g. pharmaceutical companies).[3]

Another concern for companies is that they may be forced to compensate for government policy shortcomings. Those businesses that are affected by HIV/AIDS will need to have different responses depending on the quality of government response to the problem by the countries in which they operate. As a result of the importance of a country's response to the issue, many companies are attempting to include the domestic government in their HIV/AIDS strategies. They understand that they need to work with the government to ensure an effective, holistic response to the disease. Many companies are weighing up the benefits of internal programmes against reliance on public health programmes in the host country of their operations. However, while 50% of business leaders expect the disease to have an effect on their operations within five years, less than 10% have taken steps to conduct a quantitative HIV/AIDS risk assessment.[4]

Responses which have been identified as recommended action for companies operating in areas of high disease incidence include[3]:-

- Promote education / prevention;
- Create workplace policies to ensure help for infected employees including access to medicines;
- Provide grants to HIV/AIDS organisations;
- Encourage other key players (public and business sectors) to get involved in partnerships.

Conclusion

HIV/AIDS has most certainly not gone away, as evidenced by the numbers published by UNAIDS which are reported in this paper. Data quality on the prevalence, prevention and treatment of the disease is not perfect, but has improved immensely since the 2001 UN Declaration of Commitment on HIV/AIDS, and serves to illustrate the size of the epidemic and the current situation of the various responses to it. Geographically, sub-Saharan Africa remains the worst hit area, but growing numbers with the disease in other areas, particularly India, China and Russia, are cause for concern. The macro and micro impacts of the disease are of relevance to the companies in which we invest, to varying degrees and in different ways. The three examples demonstrate how different companies manage the impact that HIV/AIDS has on their particular business. These should serve as reference for the analysis of other companies with significant operations in areas of high disease incidence, particularly in lower income regions.

[1] "2006 Report on the Global AIDS Epidemic", UNAIDS, 2006.
[2] "AIDS Epidemic Update 2006", World Health Organisation & UNAIDS, 2006.
[3] "The Business Response to HIV/AIDS: Impacts and Lessons Learned", The Global Business Council on AIDS, The Prince of Wales Business Leaders Forum and UNAIDS, 2000.
[4] "Business and HIV/AIDS: A Healthier Partnership?", World Economic Forum, 2006.
[5] "Update on Anglo American's Response to the AIDS Epidemic in South Africa", Dr Brian Brink, 2006.
[6] "Corporate Responsibility Report 2006", GlaxoSmithKline, 2007
[7] "Combating HIV/AIDS in sub-Saharan Africa", Unilever, 2006, and "Kenya: Fighting HIV/AIDS", Unilever, 2006.