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Can CSR Ameliorate the Impact of HIV/AIDS Epidemic

Dr. Homyar Keki Gardin

MBBS (Hons), Fellow HIV Medicine, PGDBM (XLRI), PGDHRM
Academic Head and DNB Course Director in Tata Main Hospital, Jamshedpur, Jharkhand

Abstract

Corporate Social Responsibility (CSR) is the contribution a company makes to society through its core business activities, its social investment and philanthropy programmes. Corporations concerned with CSR are generally large-sized companies and multinationals Small and medium-sized companies do not give much importance to CSR citing reasons such as inadequate resources to implement a CSR policy. The popular CSR activities undertaken are related to environment and health. Whilst HIV/AIDS, the fourth largest killer disease in the world, is decimating societies and negatively impacting business world, very few organisations take it up seriously as a health CSR. HIV/AIDS is easily prevented and further transmission reduced. Building on views of Professor Sorab Sadri, Jayashree S and others we take the concept further to what may be termed Corporate Social Investment (CSI) and examine how corporates can take it up and help ameliorate the impact of HIV/AIDS epidemic.

Key Words: CSR; Business excellence; HIV/AIDS; Continuum of HIV Care,

Introduction

Corporate Social Responsibility (CSR) is a concept where companies contributes to society through its core business activities and its social investment programmes. The CSR activities in our country has undergone changes over the past century from a philanthropic mode to getting integrated into business strategy.

However, not many organisations include health in their CSR programmes and even fewer focus on HIV/AIDS interventions as an important component of it. This is in spite of AIDS being the 4th largest killer disease in the world and is a component of the Millennium Development Goals.

This paper aims to suggest how corporates through their CSR on health issues can undertake interventions in different areas of continuum of HIV care to maintain not only a healthy work force but also the community in its areas of influence so as to effectively curb the march of HIV/AIDS epidemic.

The paper is divided into four parts. The first part deals with the elusive and cunning virus, Human Immunodeficiency Virus (HIV), that has played havoc across the globe. The second part touches upon the CSR and corporate excellence. The third part deals with HIV Prevention, Care Cascade and Continuum of Care and the focus areas of intervention by CSR. The fourth part concludes by directing strategies to deal with the points on addressing the Continuum of Care.

HIV/AIDS

Since more than 3 decades, the AIDS pandemic fuelled by poverty, gender inequality and social norms, has swept across continents directly affecting 75 million and indirectly affected many more, raising issues which question the very basic of values of life. It has negative impact on economies, eroded relationships, human worth and dignity, snapped societal fabric, destroyed families forcing an increasingly large population of vulnerable people i.e. women and orphans, elderly, widows and children into labour or sex trade.

There are success stories as well as failures of society and Governments trying to rein in the epidemic and its negative fallout on human endeavours.

At the bottom of the pyramid is the human being, who is infected with the HIV. As years go by this virus damages his immune system to a point about a decade later where he becomes susceptible to any and every infection. His life is disrupted as on most days he is unable to carry on with his routine tasks and finally becomes bed ridden.

Early years of the epidemic went in search for the cause and by 1983 the causative virus, Human Immunodeficiency Virus (HIV), became known. There was optimism of a cure too. If one recalls in 70s and 80s science, technology and research tools had progressed a lot and surely a cure was around the corner. Drugs were researched and made available; initially only a single one named Zidovudine which was followed by many more that by the advent of a new millennium there were almost a score of them. Yet, this virus was never brought to kneel in spite of increasing knowledge about the virus, availability of medicines, treating specialists and funds. What more could be done to stop and reverse the course of HIV/AIDS epidemic? The answer lies in going back to basics of Virus life cycle and its host – the human being and addressing them through CSR.

Understanding the Virus

In order to see how CSR can ameliorate the effect of HIV/AIDS, it is important to understand the dynamics of HIV infection.

AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus, HIV (Human Immuno-Deficiency Virus) whose origin is still a mystery but probably from apes. Probable cases of AIDS began in the late '50s and spanned America, Africa and Europe. Research has shown a similarity in genetic structure of HIV- 2 and SIV (Simian Immuno-Deficiency Virus). In 2014, an international team of scientists, led by University of Leuven in Belgium and Oxford University, has reconstructed the genetic history of the HIV-1 group M pandemic, the event that saw HIV spread across the African continent and around the world, and concluded that it originated in Kinshasa between 1909 and 1930.

The first cases of AIDS in significant numbers were seen in USA in 1981 amongst previously healthy, young adult homosexuals. Soon it was also found in haemophilics. In India, the first case of HIV was reported in 1986 and soon thereafter amongst a few commercial sex workers (CSWs) in Mumbai.

Routes of Transmission

HIV is transmitted from person to person through sexual contact, contact with body fluids especially blood and blood products, sharing contaminated syringes and needles, during child birth and breast feeding.

The other less common routes of transmission are cosmetic equipment (used for tattooing, ear and nose piercing, manicure and pedicure); traumatic contact (as in games or accidents) and contaminated medical equipment.

The infection can occur only where there is a virus, a route of transmission for the virus (during which the virus should not be exposed to elements outside human body for long) and a hospitable environment for transmission to occur in.

HIV is not transmitted through casual social contact. Being near a person with HIV infection or working with him/her does not constitute a risk.

Global Scenario

New HIV infections among adults and adolescents decreased by 50% or more in 26 countries between 2001 and 2012. Approximately 2.3 million people became newly infected with HIV in 2012, down from 3.4 million in 2001. Women and children less than 15 years constitute more than 50% of cases. Every day globally approximately 5,500 new cases are being detected and 3,300 people are dying of AIDS.

The Indian Scenario

Vital Statistics

As per National AIDS Control Organization (NACO), there is approximately 2.1 million People Living With HIV/AIDS (PLWHA) in India in 2014. Efforts by Governmental as well as Non-Governmental agencies have helped curtailed the number of new cases getting infected. Yet a lot needs to be done especially amongst the Injecting Drug Users who have the highest prevalence in India.

Human resource is a valuable input in production especially in Indian industries which are still labour intensive. Almost 90% of HIV+ persons is in the age group 15 to 49 years, two thirds of which are between the ages of 20-40 years. As the virus strikes the productive and reproductive population it threatens ideas which lead to innovations, economic contribution declines and with it the future enterprise and in turn the country's GDP ($2,314 Billion in 2014).

India is the second most populous country in the world with 1.261 billion citizens in 2014 with a population density of about 383.7 people per square kilometer, in a country little more than one-third the size of U.S.A.. The majority of people, approximately 72.18% of the population, reside in rural areas. Unfortunately, 25.76% of this rural population is below poverty line, the overall national figure being 21.92% in 2011 – 12. There is a movement of people from the rural to the urban areas to seek employment.

In The McKinsey Quarterly 2007 Number 3 article "Tracking the growth of India's middle class" the authors Eric D. Beinhocker, Diana Farrell and Adil S. Zainulbhai have projected that the Indian Middle class consumers base will increase dramatically and a term "Bird of Gold" is coined for the Indian consumer market. The middle-class consumers is increasing and it is projected that by 2015, there will be new opportunities for business with an estimated 240+ million of this class of consumers. Per capita income today is $1,249. India's comparative advantage is its vast wealth of competent human resources. Employment in organized sector, both Public and Private sectors, was about 9.04 million in FY06. In FY08, there were approx. 13.4 million registered units of small-scale industries employing 32.2 million people. The majority of 402 million labour force, almost 90% were employed by unorganized and informal sector in FY01. Often this huge labour force are migrants who usually seek work in towns and cities during non-farming months between March and August every year. They do not have any familial, social or health support in their place of work resulting in health problems arising out of alcoholism, drug addiction or diseases such as Tuberculosis and HIV/ AIDS. Corporates can fund Youth Resource Centres (YRC) as a CSR activity. The YRC is a drop-in centre for local youth who can play indoor games, have sessions on career counselling and read books and magazines.

HIV spreads via commerce i.e. between migrant labourers, truckers, people in uniformed services and salesmen and the commercial sex workers (CSWs) with whom they have sex. Those infected in turn infect their spouses when they return to their villages during their holidays.

Another issue of modern living considered an epidemic plaguing modernity is stress. Stress can arise at the workplace. People indulge in alcohol, drugs and casual sex to diffuse this stress. Surveys amongst clients of CSWs indicate that a third are college students, a third are migrant labourers and another third are businessmen. The United Nations General Assembly's second World Happiness Report ranks countries based on several measures of well-being and analyzes the factors that contribute to that well-being. The scores are an average of results between 2010 and 2012 and ranks India at 111. Fortunately many organizations are encouraging their employees to do yoga/meditation/aerobics before starting their working day to reduce stress apart from having trained peers to handle one-to-one interactions amongst employees.

There is an inseparable link between health care and socio-economic development. Poor health reduces not only the quality of life, but also the life expectancy and economic productivity. In India, the exact figures on man-hours lost per annum and their impact on cost and the loss of profit is difficult to obtain especially as most of the labour is associated with the unorganized sector and its ills.

In India, as in other developing countries, health services are stretched thin. Health expenditure stands at 2.4% of GDP in 2009. Many of the sick people are just about getting the bare minimum of health care services. In 2009, there is one hospital bed per 1,111 people and 1 Physician per 1,670 population. The life expectancy is 67.14 years (2012), but this will change in the face of an AIDS epidemic with some dying early due to AIDS and some living till old age as Highly Active Anti-Retroviral Therapy (HAART) brings 'near normal' life expectancy and its associated old age related Non-Communicable Diseases often accelerated by HIV. Both these scenarios mean that visits to health care institutions will go up.

India has 21% of world's burden of diseases. Every year, hundreds of thousands of people are affected by infections like Gastro-enteritis, respiratory tract infections, etc., leading to an average loss of 4-5 man-days per illness but, with tuberculosis and AIDS related infections, this loss can be up by months.

In AIDS, approximately 20% of those infected with HIV are ill due to various infections mentioned above at any given time and it is estimated that 50% of them will develop full blown AIDS in 10 – 11 years' time. The number of man-days lost due to various illnesses is bound to go up. The direct effects will be loss of production, additional cost of manpower replacement and their training, all of which will push profits down.

Let us consider NACO's estimate of 2.4 million HIV+ people in India a decade ago. If we assume that each HIV+ person is well enough to work for 75% of their period of 10 years of their illness, after they are

diagnosed, the workdays lost per HIV+ person would be 912.5. If we consider half of the two million HIV+ people to be develop AIDS in 10 years, then the total workdays lost would be 912.5 million. It is also possible that 20% of these HIV+ people who are in Stage IV of full blown AIDS would require an attendant when ill which translates to 182.5 million workdays of the attendant. Thus, if we consider those who get infected in 2014, a total of 1095 million workdays will be lost due to AIDS affected people and their attendants by 2024. This effect may not be very visible in India due to a large work population, but this scenario was very present in many Sub-Saharan countries till a few years ago.

Currently the cost of treating a HIV+ person with Anti-Retroviral Therapy (ART) on three drug first-line regime for a year is approximately Rs. 12,000 ($179 @ Rs. 67 per 1$) which when considered against per capita income of Rs. 74,920/- ($1,118 @ Rs. 67 per 1$) in 2013-14 is 16% of the income. If more than one member of the family is affected then the proportion of cost of ART to income goes up. The burden of treating 1 million HIV+ cases would be $179 million per annum which is a huge amount whether borne by the Government, Corporates or individuals. This amount can be used for other health initiatives of National priority such as safe drinking water and sanitation.

Measuring the impact of CSR activities in HIV/AIDS is still quite difficult to compute. The calculations above show the magnitude of financial burden. The HIV/AIDS workplace business case reveals the following advantages for the company namely increased productivity and decreased health costs for employees due to a healthy workforce. We will examine it further in the next two parts.

The CSR and Corporate Excellence

The CSR activities in our country has undergone changes in marked phases over the past century taking into the need of the hour. These phases have started as Philanthropy and is currently integrated as an important part of sustainable business strategy. A few Corporates such as Tata Group, Indian Oil Corporation, to name a few have incorporated CSR as part of the organisation's DNA from the very inception. However, whilst large scale and multi-national companies carry out CSR activities the medium size and small scale industries shy away from doing it citing lack of resources to implement it. For many years, companies have been told by all stakeholders that CSR is good for business, but till 90s relatively few studies documented the business case for engaging in CSR activities. Professor S. Sadri prophesied in early 1990s that an organisation needs a social infrastructure to maintain its social acceptability through CSR. Today many management scholars such as Jayashree Sadri, Amit Kumar Bhowmik, Shernaz Sarkari, Sharukh N. Tara, Anil K Sharma to name a few have emphasized on corporate excellence. CSR is accepted as a pillar that supports this excellence where stakeholders appreciate an organization taking the extra step to bring an impact in life of people and environment not associated with its products or services.

Till recently CSR was on voluntary basis and in some cases as an isolated activity in an organisation's calendar, but since April 2014 it is mandatory that companies give at least 2% of their three-year average net profit to CSR activities as part of the New Companies Act and that CSR activities should be undertaken only in "project/programme" mode and not as "one off events" such as marathons, charitable contributions etc.

We observe the Macro-economic impact of HIV/AIDS in increased healthcare and social security costs together with falling profitability of organisations due to reduced productivity from absenteeism. The organization would also incur expenses for training of replacement and recruitment of new employees. This leads to reduced international competitiveness and foreign investment is discouraged.

At the Micro-economic level, this will be reflected in reduced earning power of the HIV+ employee who is unable to work leading to a lower purchasing power of households, changing the age and sex distribution of labour force with widows, elderly and children forced into work often in exploited and deplorable conditions. A difficult task is to factor in the cost of loss of quality of life, fear of discrimination, broken homes, loss of culture with the death of elders and subsequent increase of AIDS orphans? Can India afford an AIDS Epidemic? Will our industries run if the community around them from which their working force is drawn becomes ill from HIV Infection? In order to prevent such a situation, the Corporate world has to act now by taking steps to include HIV/AIDS interventions as part of their CSR Health Initiatives for their employees and the community. Globally, specially studies from Kenya and S. Africa have shown that direct business action in preventing and treating HIV/AIDS has favourably impacted the balance sheets and preserved the

greatest resource i.e. the employees. Simple initiative such as AIDS Awareness Programmes is not only cost-effective as it costs only a fraction of the expenses incurred on treating a few HIV+ employees, but also that the results are tangible as awareness leads to a gradual change of behaviour and greater acceptance of HIV+ people.

Ethical behaviour also prevents organisations from terminating jobs of HIV+ employees or doing surreptitious pre-employment testing for HIV. Emphasis on business ethics is highlighted by Professor Jayashree Sadri in her research on Business Ethics and corporate governance which mentions that they are the path to business excellence and hence employee happiness and customer satisfaction, a win-win for all. Amit Kumar Bhowmik and Shernaz Sarkari have also emphasised that in the present volatile fast changing global environment with its cut throat competition the prime key to success is corporate excellence.

Several studies show that companies practicing CSR do better financially with 18% higher profits and have a better image than companies that do not. Nowadays investors are more attracted to companies that practice CSR. A Global Investors Opinion Survey 2002 by McKinsey & Company, focusing mostly on developed countries, confirms that institutional investors are prepared to pay a premium of more than 20% for shares of companies that demonstrate good corporate governance. This trend continues.

There is certainly hope that when CSR meets HIV/AIDS the latter will be brought under control as we will see in the next part.

HIV Prevention, Care Cascade and Continuum of Intervention by CSR

To tackle the HIV/AIDS infection, curtail its progress and reverse the epidemic, we need to focus on two broad areas namely Primary Prevention and Secondary Interventions. This is also in sync with the UNAIDS World AIDS Day Theme 2010 – 15 "Zero New Infections. Zero Deaths. Zero tolerance to Stigma and Discrimination." The most important being Primary Prevention. Prevention is critical. The old saying "Prevention is Better than Cure" applies here very well. The lessons about AIDS are that new epidemics can be prevented and the worst ones can be turned around. A key factor to any successful intervention is looking beyond the conventional ones of institutional interventions, be it at the national level or at the organizational one.

Organisations should start AIDS Awareness Programmes in their areas of operation as part of their CSR Health initiatives and sustain it for long term benefits. Target population should be between 15 – 49 years as this is the most vulnerable group and already mentioned above. Programmes can be tailor-made to suit the different demographic strata such as High School/College students, house-wives; migrant labourers; uniformed personnel; business person; long distance truckers; Transgenders; Injecting Drug Users and Commercial Sex Workers to name a few. Awareness sensitizes people leading to safer sex practices which in turn would lead to primary prevention and address the first component of UNAIDS World AIDS Day theme 2010-15 mentioned above i.e. "Zero New Infections". It will also address the third component namely stigma and discrimination which deters people from getting tested, incites them to infect others due to reactionary vindictive behavior and prevents people who are infected from receiving adequate care and treatment. Greater awareness and subsequent sensitisation to the issues reduces stigma and discrimination as common myths and perceptions are dispelled.

It is said that there are three waves of HIV/AIDS epidemic namely 'Epidemic of HIV' of 1980s during which the virus spread like wildfire mostly due to lack of knowledge of its cause and disease dynamics. Then came the 'Epidemic of AIDS' of 1990s and early 2000s wherein people who were earlier infected due to HIV/AIDS were dying due to AIDS related infections. Finally from mid 2000s onward is the third wave of the epidemic i.e. 'Epidemic of Stigma and Discrimination'. Here it may be mentioned that WHO statistics showed that the epidemic had peaked in 2001 and that of deaths in HIV+ people peaked in 2005. An important reason for its decline thereafter was due to greater awareness and advent of Highly Active Anti-Retroviral Therapy. Even then in 2009, only 50% of HIV+ persons who needed HAART were getting it.

To address the secondary interventions we need to examine the HIV Care Cascade, a path breaking concept highlighted by Centers for Disease Control and Prevention, USA, and Health Resources and Services Administration. It shows a continuum from the point of detection of HIV to retention in treatment of HIV+ people and also the areas where interventions should be focused for halting further transmission of HIV. Expert health agencies have shown that only 25 – 35% of PLWHA who were detected HIV+ are virally suppressed mainly due to the two main gaps in the HIV Care Cascade i.e. linkage to a treatment centre

and retention in care. A flow diagram is given in Annexure I.

The session titled "Treatment Cascade: Operational Challenges in Scaling Up Test and Treat" at the 2013 International AIDS Society (IAS) Conference in Kuala Lumpur, Malaysia, showed the barriers at each cascade point for different for countries.

In the above-mentioned IAS Conference, Ms. Katharina Kranzer, Specialist Registrar Medical Microbiology and Infectious Diseases at University College London Hospitals, stressed that interventions such as decentralization of services, task-shifting, point-of-care testing and service integration, peer support offers a critical step to reduce stigma especially amongst vulnerable groups such as Transgenders & MSMs and that food incentives & home-based care (HBC) which can enhance retention and continuity of care as critical strategies to achieve the results of the cascade.

In the recent Conference on Retroviruses and Opportunistic Infections held in Boston February 22-25, 2016, highlighted studies done in Uganda which showed that simplified clinical procedures enabled 70% of patients to start HAART as soon as they became eligible for it.

Let us consider a person who finds himself "at risk" of being infected or is undergoing treatment of an infection which is not responding to standard regimen of medicines. After counselling he is tested and is detected HIV+. This is the first part of the cascade. Thereafter he is engaged in care and undergoes tests such as CD_4 Cell Count to know his immune status as well as the Viral Load in his blood, both tests are the gold standard markers for disease monitoring. If his blood CD_4 Cell Count values are lower than the cut off value set by WHO, NACO and other similar health agencies, he is started on HAART, a multi-drug combination of anti-HIV medicines. Thereafter, for achieving return of immune status to normal values and Viral Load to undetectable levels he has to be retained in care to ensure full adherence to his medication. The above steps and the barriers seen are given in Annexure II.

Corporates through their CSR can take up one or more areas of continuum of HIV care to help HIV+ person achieve good health and thereby reduce morbidity and mortality. Corporates can partner with local or National NGOs to roll out their programme or can encourage their employees to take up Employee Volunteerism by doing CSR activities in a structured way in Organisation's work time. The suggested points of interventions is elaborated upon below.

A) For the general population the following can be undertaken:

1) **AIDS Awareness Programmes and Behavioural Change Communications** conducted at regular intervals for all demographic strata. Apart from raising awareness these also lead to sensitisation of the target audience with reduction in stigma and discrimination against PLWHA. If done in a sustained manner, this is the most cost-effective intervention as it leads to "safer behaviour" and hence prevents new HIV infections.

2) **Counselling services and/or "Drop in" centre** provide an opportunity to have "one-to-one" session with a person "at risk". This builds confidence of the person and allays fears and myths of taking a test for knowing the HIV status. It is also a confidence building opportunity for someone who is already a diagnosed HIV+ case. Once a person is aware of his/her status, they will take steps to prevent further transmission of the HIV to others. Counselling is a cornerstone to long term retention of HIV+ person and their family members in their continuum of care. As with grief, PLWHA also undergo the steps mentioned in Kubler-Ross model of Grief reaction and it is imperative that a person is brought to the Stage of Acceptance as soon as possible as it has a positive effect on outcome of HIV Care Cascade.

3) **HIV Testing Centres** in India are quite common these days as compared to a few decades ago. The ideal one is an **Integrated Counselling and Testing Centre (ICTC)** where facilities of counselling as well as testing are available under one roof itself such as those in Government Hospitals, Link Centres and Primary Health Centres. This helps in a higher percentage persons undertaking the test and an important entry point into the HIV Care Cascade.

The above mentioned three interventions also plays an important role in Stage II i.e. 'Asymptomatic Stage' of the HIV disease cycle. Corporates can sponsor testing and counselling facilities.

4) **Workplace and community interventions** can range from just AIDS Awareness Programmes to having a counselling centre too.

5) **Life skills seminars** help in guiding people to proactively tackle issues such as Peer pressure, addictions, stress and poor self-esteem which are predisposing factors for unsafe sexual and truant behaviour. Sexually Transmitted Infections, a strong predisposing factor to HIV infection, and HIV/AIDS are thus prevented.

6) **Availability of Safe Blood and its components** – Blood accounts for approximately 2% of transmission of HIV. Corporates can encourage blood donation by employees and their family members, link up with local Government recognised Blood Bank and/or partner with Voluntary Blood Donors' Association to ensure availability of HIV-free blood for use by the needy.

B) From point of infection onwards – the continuum of HIV care:

1) Spouses and partners of HIV+ person should be counselled to visit the ICTC to know their HIV status. Role of counselling mentioned above is thus an important one. **Counselling and Behavioral Change Communications** is important for adherence to treatment as well as for retention in care and hence should be an ongoing activity for PLWHA.

2) **Nutritional care** is a vital component of treatment. Research has shown that micro-nutrients such as Selenium, Manganese and Zinc help in maintaining the integrity of immune system. Dietary counselling guides HIV affected people to eat healthily making use of food that is available locally.

3) The spectrum of HIV from Stage I i.e. 'Stage of Infection' to Stage IV i.e. 'Stage of Full-blown AIDS' takes about 8 – 10 years in an average person who has not taken any treatment. Usually in Stage III i.e. 'Stage of AIDS related Complex', various **Opportunistic Infections** occur in HIV+ persons which are rarely seen in a normal healthy person. Approximately 20% of HIV+ are in this Stage. Medicines that are given as prophylaxis to prevent Opportunistic Infections or as specific treatment for those seen in patients can be provided by Corporate sponsored Drop-in Centres or Clinics.

4) When Stage III is present, providing **Highly Active Anti-Retroviral Therapy** (HAART) is important which preserves the immune system and reverses the damage caused to it. It also reduces the Viral Load in the infected person making the risk of transmission of the virus to his/her partner less. It also addresses "Zero New Infections" and "Zero Deaths" of the UNAIDS World AIDS Day Theme 2010-15. Organisations can supply or sponsor HAART for PLWHA especially children. It may be mentioned here that HAART for Paediatric age group is difficult to obtain and often there is a shortage of the syrup version of these medicines. According to NACO, without care and treatment one third of children living with HIV will die in their first year of life and 50% by second year of life.

5) Two areas of great impact are:

a) '**Post Exposure Prophylaxis**' **(PEP)** – in discordant couple i.e. where only one partner is HIV+ infected, exposure of the non-infected partner can occur through 'unsafe sex' practices. Standard regimen as suggested by WHO and NACO are advocated for the exposed HIV negative person in such a situation. This helps prevent new infections, which is also part of the UNAIDS World AIDS Day 2010-15 Theme.

b) '**Preventing Parents To Child Transmission**' (**PPTCT**) – is through globally accepted standardised interventions which reduce the risk of transmission of HIV from an HIV+ pregnant mother to her baby. The risk is approximately 30% during Ante-Natal to Post-Natal phase i.e. from pregnancy to delivery to breast-feeding. PPTCT using standardised WHO or NACO guidelines reduces this risk to as low as 2%.

Four pillars of PPTCT Programme are:

I. Primary Prevention of HIV Infection in women and their partners – keeping the partner safe through "safer sex" practices and Post-Exposure Prophylaxis.

II. Prevention of unintended pregnancies – by practicing "safer sex practices.

III. Prevention of HIV transmission from mother to child – as mentioned above there are various approaches suggested by WHO and NACO strategies that reduce the risk of transmission to the unborn child to a minimum.

IV. Treatment of PLWHA (women and children) as per NACO guidelines helps maintain integrity of the immune system and prevents its further damage. It also reduces the infectivity in the person.

The interventions that Organisations can undertake for the above 4 Pillars are:

- Promoting barrier methods of Family Planning to prevent infection as well as pregnancy.
- Enrollment in PPTCT programme - Organisations can link HIV+ pregnant women to their corporate hospitals or to partner health institutions where safe delivery techniques as well as PPTCT guidelines can be implemented. It is well known that even today majority of Indian pregnant women are still delivered at home by 'dais' who are either trained at Government Health Centres or by their elders as an ongoing family tradition. Hence, during home delivery the dais are exposed to infected body fluids when they deliver HIV+ pregnant women. Government health services provide "kits" which dais can use as Personal Protection Equipment (PPE) and safer delivery at home. Corporates can make institutional delivery free or subsidised to motivate these HIV+ pregnant women to shift to institutional delivery from the preferred one at home.
- Linkage of newborn to ICTC – for follow up to know the status of the newborn and to start early interventions, if required.
- Advocating Safe Infant feeding practices.
- Making HAART available to discordant couples.

6) Many times an HIV+ falls ill due to seasonal infections. They get worried as they are not sure if the simple illness is the beginning of a more serious Opportunistic Infection. As a result they visit hospitals and local clinics only to find that the infection is not a serious one. These visits increase the medical expenses, leads to absenteeism and subsequent loss of salary, all of which add to their financial burden. For the Organisation it is loss of man-hours, delay in achieving targets and loss in productivity. Corporates can conduct training sessions for People Living with HIV/AIDS on '**Home-based Care**' (**HBC**) with the help of their employees or with partner NGOs. This initiative helps the PLWHA to take care of simple infections at home itself and also be able to recognise when a visit to a Clinic is imperative.

7) When HIV+ person is in Stage III and IV, he/she is unable to attend work for 50% or more of working days. This leads to absenteeism and loss of man-days and production as well as loss in pay which in turn affects the purchasing power of the affected family. The first major fallout is that children are removed from schools as the family is unable to pay school fees. The long term effect is a generation of uneducated people. Sometimes it makes grandparents come out of retirement to start work again. Women and children seeking work are financially and sexually exploited too. Organisations can prevent these through **Economic Rehabilitation programme** for HIV+ person or their family members wherein vocational skills are taught to family members making them financially independent. Children, especially AIDS Orphans, can be sponsored for their education along with vocational training making them skilled for jobs at graduation. Women can be taught house-keeping skills that can increase their employability in establishments.

C) Programme interventions for an 'evolving epidemic' vs 'mature epidemic':

a) In the beginning of an epidemic as it is evolving, interventions focussing on Knowledge-Awareness-Behaviour i.e. AIDS Awareness Programmes and Behavioral Change Communication are required. These initiatives raise the level of awareness, sensitise public to the HIV/AIDS issue thus helping in reducing stigma and discrimination and most importantly prevents new infections. A Drop-in centre or Counselling centre is an added advantage. Linkage with ICTC helps detection of HIV+ people and subsequent enrolment in care cascade.

b) As the epidemic matures, the interventions which Organisations can undertake are providing HAART, medicines for Opportunistic infections, Counselling, PPTCT, PEP, HBC, and building skills for economic rehabilitation.

D) The HIV+ pregnant woman – the interventions for this is dealt with in detail above under continuum of care.

Strategies to Deal with the CSR Points Addressing the Continuum of Care

The Corporate Social Responsibility can be directed towards one or more interventions discussed above. The Corporates should address the continuum of care by:

- Management through using tools like **strategic planning** and **technical strategies** for cost

effective implementation of the components of Continuum of HIV Care.

- **Service Providers** who can either be the internal resources including Employee Volunteerism or partner agencies if the Organisation does not have the human resources or capacity to do it on their own.
- **Capacity Building** which should be done at all levels and for all stakeholders. This causes 'ripple effect' in rollout of the programme as well as increase the reach and depth of interventions in a short span of time where each trained person is capable of having an impact on people in their circle of influence.
- Measuring for impact through robust **Monitoring and Evaluation** as this provides a feedback to the initiatives and help in further refinement of interventions in the continuum of care. Often good programmes run into the ground due to poor Monitoring and Evaluation. This activity should be done by internal programme auditors as well as by a neutral external agency. The importance of the latter is in ensuring that the internal guardians do their task well and is highlighted in "Who will guard the guardians" by Amit Kumar Bhowmik and Shernaz Sarkari as well as dealt at length by Sorab Sadri, Dhun S. Dastoor and S. Jayashree in the book "The Theory and Practice of Management Ethics".

UNAIDS mentions that as the HIV/AIDS epidemic is contained or controlled, it will also result in 'increased life expectancy, unconditional acceptance of people's diversity and rights, and increased productivity and reduced costs as the impact diminishes.'

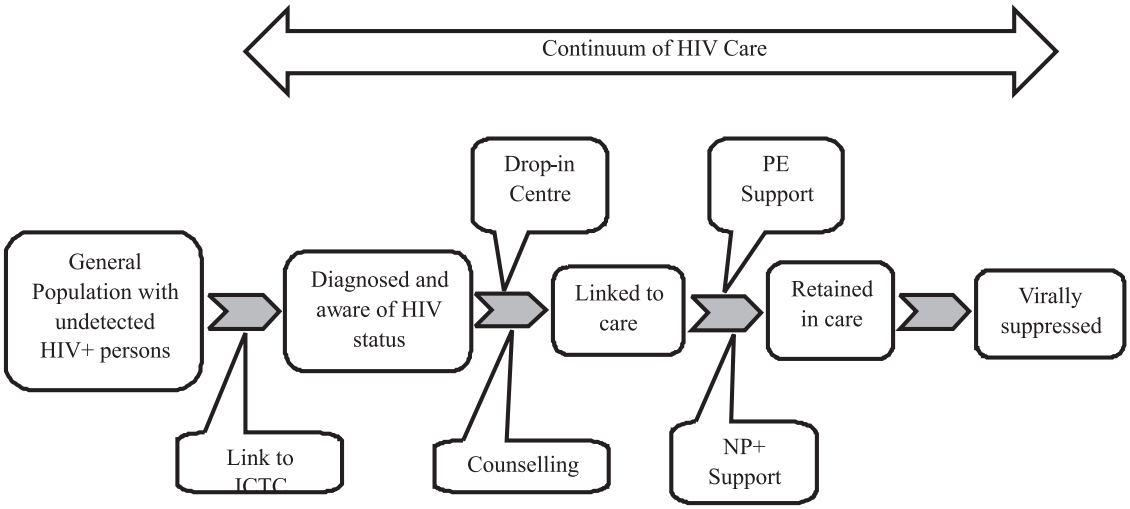
Conclusion

Understanding the undercurrents of socio-medical aspects of HIV/AIDS and the HIV Care cascade helps us in identifying areas where CSR health interventions can have maximum impact. Whilst CSR usually focuses on environment and some areas of health, HIV/AIDS the 4th largest killer in the world, is not on the roadmap of many organisations. If HIV/AIDS, specifically its Care Cascade areas, is also included as an area under CSR, it will be cost effective as greater impact will be seen with minimum resources ensuring healthy population by reducing new infections and preventing early deaths. In the long run, it is a Win-Win situation for all – Corporates benefit from this not only because a healthy person may be a future worker, but also due to the goodwill earned from their stakeholders especially the investors. Thus, we see that CSR does play an important role in ameliorating not only the effect of HIV/AIDS, but also reversing the epidemic.

Annexure – I

The Continuum of Care begins from the point where a person visits an ICTC and is till the point of viral suppression.

Expert health agencies have shown that only 25 – 35% of PLWHA who were detected HIV+ are virally suppressed. This gives an opportunity for corporates to undertake CSR initiatives to bridge every gap in the continuum of care so as to increase the number of HIV+ persons who are virally suppressed.



Annexure— II

Cascade Step	Problems identified	Barriers or gaps
✓ Testing for HIV	• Does not visit test centre • Reluctance to get tested • Does not collect test result/report	➢ Lack of privacy or confidentiality ➢ Fear of the "unknown" ➢ Poor Pre-test counselling ➢ Insensitive or unfriendly staff
✓ Engaging in care	• Reluctance to continue in counselling or treatment programme • Irregular visits	➢ Care Centre is inaccessible ➢ Rude behaviour of staff; stigma and discrimination towards People Living with HIV/AIDS ➢ Lack of out-patients or indoor services or service providers such as counsellor; doctor. Irregular supply of medicines.
✓ CD_4 / Viral Load testing	• Irregular visits or drop-out from follow-up testing • Requires testing at regular periods	➢ Test centre is inaccessible. ➢ Expensive – if paid 'out of pocket' ➢ To take leave for visits ➢ Non-availability of staff; kits; ➢ Rude behaviour of staff; stigma and discrimination
✓ ART	• Requires regular visit to ART centre	➢ ART is expensive unless provided free by NACO or is sponsored ➢ Shortage of medicines, especially Paediatric syrups, at ART Centres
✓ Full adherence	• HAART defaulters	➢ Poor pre-medication counselling ➢ "Treatment Fatigue" due to regular intake of HAART ➢ Stoppage of medicines due to side effects ➢ Clinic is inaccessible ➢ Not able to explain to family, friends and colleagues regarding regular visits to (ART) Clinic ➢ Sharing of HAART by other HIV+ family members too.

Annexure – III

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
CDC	Centers for Disease Control and Prevention
CSI	Corporate Social Investment
CSR	Corporate Social Responsibility
CSWs	Commercial Sex Workers
GDP	Gross Domestic Product
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IAS	International AIDS Society
ICTC	Integrated Counselling and Testing Centre
NACO	National AIDS Control Organisation
NP+	Network of Positive People
PE	Peer Educators
PEP	Post Exposure Prophylaxis
PPE	Personal Protective Equipment
PPTCT	Preventing Parent To Child Transmission
SIV	Simian Immunodeficiency Virus
WHO	World Health Organisation
YRC	Youth Resource Centre

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