HIV, TB & Malaria
Management & Prevention in the Oil & Gas Supply Chain
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Opening Note

Executive Summary

Introduction
Context
HIV, TB & Malaria within the Oil & Gas Industry
Management & Prevention: Key Activities

Scope & Methodology
Report Scope
Report Methodology

Key Findings
Priorities & Risk Perception
Oil Company Programs
Contractor Programs
Contracts & Contractual Clauses
Monitoring & Compliance
Financing Institutions

Best Practices Observed

Recommendations

About the Authors
Opening Note

Business contributions to tackling the global HIV/AIDS, tuberculosis and malaria epidemics have increased dramatically in the past 10 years. At the Global Business Coalition on HIV/AIDS, TB & Malaria (GBC), we have seen hundreds of companies – regardless of industry, size, core business and geographic presence – act both individually and collectively to reduce disease burden and improve health outcomes. These corporate actions are increasingly aligned with the priorities and strategies of the global health community and governments, ensuring maximum impact.

The oil and gas industry has played an important role in confronting these three epidemics through robust workplace and community programs. Still, given the sheer number of companies represented by the industry, there is much more it can do. There are thousands more employees, dependants and communities to protect from the ravages of HIV, TB and malaria. Every industry player, from the large multinational to the smallest local supplier, has a role to play.

This report sheds light on the state of disease prevention and management in the upstream end of the industry’s vast supply chain – and provides practical guidance for both oil majors and contractors/suppliers to mount efficient and effective disease management programs. In conducting our research, we identified the key drivers, major successes and ongoing challenges that companies face in developing such programs. We hope that the insights revealed prompt more companies – in the oil and gas sector and beyond – to take action.

We are pleased to collaborate once again with Booz & Company in undertaking the research that led to this report. Booz’s commitment to global health – through the application of its core research and consulting competencies – is a model of GBC member engagement. Together, we look forward to supporting the oil and gas industry’s efforts towards fighting these diseases in the years to come.

John E. Tedstrom
President and CEO
Global Business Coalition on HIV/AIDS, TB & Malaria
June 2010

Booz & Company is again proud to partner with the Global Business Coalition (GBC) in the development of this publication on the management and prevention of HIV, TB and malaria in the oil and gas supply chain. GBC and Booz & Company have been working together closely for over three years now, and we hope to continue to collaborate on a variety of projects going forward in the hope of bringing some meaningful change to the way in which some of these diseases are managed.

With its focus on the oil and gas supply chain, this particular project has thrown up some difficult challenges for the industry. However through leveraging a number of relationships in the industry, we hope that some very positive revelations of what best practice can look like can now be readily shared across companies. The oil and gas supply chain is very large, geographically dispersed and complex with many players operating across it. This report aims to provide some insight into how different parts of the supply chain are proactively and reactively managing the challenges of HIV, TB and malaria, and also identify where gaps are still in evidence. Identifying, maintaining and building on best practices, whilst taking action to improve areas where gaps are occurring is precisely what this report hopes to kick start. Whilst the challenges are still very significant particularly amongst the contractor community, there are some areas that have seen significant improvement and that must now be built upon to see improvement on a much broader basis.

Jake Leslie Melville
Partner, Booz & Company
June 2010
Executive Summary

Many oil and gas companies work in regions where HIV, TB and malaria are highly problematic health issues and can pose a strong risk to worker productivity. It is also clear that oil and gas activity is likely to increase in many of these high-risk regions over the next decade. In addition to the endemic risk, the typical characteristics of oil project life often serve to exacerbate the risk of contraction of these diseases and/or make treatment provision difficult.

Our report focuses on the upstream and midstream supply chain where contractors, suppliers and other indirect employees represent a large portion of the workforce and the risk of contraction is particularly high. To better understand the oil company and oil services contractor responses to HIV, TB and malaria, we examined the level of engagement, drivers behind it, reasons for inaction, areas of high impact and how progress could be made.

While the oil and gas industry has made inroads in addressing HIV and malaria, TB has received little attention by comparison. However, increased action on all three diseases is needed. Oil companies are ahead of the curve in developing HIV and malaria programs but the contractor community has not been as active.

There is wide variation in company interaction on these health issues. However, our survey showed that there is more interaction between oil companies and oil services contractors than there is between oil services contractors and their sub-contractors. For example, all oil companies stated that they either always or sometimes monitored their contractors on HIV, TB and malaria management but 35 percent of contractors said that they never monitored their sub-contractors on these issues.

We found that contractor action on health issues is largely dependent on guidance from oil companies and – in some cases – financial institutions if they are providing funding. Contractual clauses on these diseases are becoming more prevalent and are generally considered effective but our survey showed that there is still room for improvement here. Language needs to be tightened and made more consistent and monitoring needs to be improved and occur more frequently.

In addition to client requirements, risk perception remains a primary driver of health initiatives but our research showed that the perception of the risk of these diseases as well as their impact was mixed. More work needs to be done to evaluate the impact on worker productivity in order to drive greater action.

Overall, we found that the sub-contractor community remains the most poorly served in terms of disease prevention and management programs yet it is this community which is the most at risk. Interaction across the industry supply chain needs to be increased in order to ensure that this group is not excluded from health initiatives.

Recommendations

For All Players in the Oil Industry Supply Chain
1) Ensure an adequate understanding of disease-risk profiles and develop programs accordingly
2) Document the impact of HIV, TB and malaria on worker productivity
3) Increase company/contractor/sub-contractor interaction in developing programs

For Oil Companies and Oil Services Contractors
4) Increase the prevalence of company-driven contractual clauses
5) Incentivize contractors and sub-contractors to prioritize HIV, TB and malaria management

For Oil Companies and Industry Bodies
6) Develop contractual clauses from a collective industry perspective
7) Develop a standard mechanism for auditing contractual compliance

For Industry Bodies
8) Focus research on the sub-contractor community
9) Extend research to financing institutions

For Financing Institutions
10) Increase the prevalence of financing institution-driven contractual clauses
Introduction

Context: HIV, TB & Malaria

HIV
According to the latest estimates, 33 million people worldwide are living with HIV/AIDS today1. Currently only 20 percent of those at high risk of contracting HIV have access to HIV prevention services and 90 percent of those living with HIV have never been tested for the virus2. Sub-Saharan Africa remains the epicenter of the pandemic and contains 75 percent of those infected with the virus3.

However, HIV/AIDS is a growing problem in other key countries of industry operation, including Russia and China. In these countries an early and aggressive policy response is critical. South Africa is an example of how quickly HIV can become a problem if it is not suitably addressed in its early stages: in the early 90s, roughly 1 percent of the population was thought to be infected but within a decade, 20 percent of the population was infected. In the case of China, an official Chinese government report published in 2009 stated that for the first time HIV/AIDS was China’s leading cause of death from infectious diseases4. In Russia, HIV prevalence has now risen to more than 1 percent of the population5. Although developing adequate treatment programs in these countries is important, prevention is critical in order to curb the growth of disease.

The impact of HIV/AIDS on business and industry can be dramatic. Much of Africa’s economic growth has been stunted by the ramifications of the disease. For example, nearly two-thirds of businesses in sub-Saharan Africa already report at least some impact on their operations by HIV/AIDS while the International Labor Organization (ILO) estimates that 18 countries in sub-Saharan Africa will have 10–30 percent reductions in their workforces by 2020 due to HIV/AIDS6.

Tuberculosis (TB)
Globally, 9 million people contract TB each year and 2 million die, mostly in developing countries7. More than 80 percent of all TB cases occur in only 22 countries, including nine in Africa, 11 in Asia (including China), and Russia8.

The global HIV epidemic has helped to contribute to the resurgence of TB. People living with HIV are particularly vulnerable to TB and TB is the leading cause of death of HIV-positive individuals in sub-Saharan Africa.

The recent emergence of multi-drug resistant TB (MDR-TB) and its deadlier counterpart, extensively-drug resistant TB (XDR-TB) has posed new challenges for prevention and treatment. Eastern Europe and Russia are home to the highest concentrations of drug-resistant TB. China and India have the largest actual numbers of persons with MDR-TB; together the two countries account for 50 percent of the world’s cases9.

TB’s impact on business and communities is severe. Each year it reduces the annual incomes of the world’s poorest communities by $16 billion, according to the World Economic Forum. 75 percent of those who catch TB are between the ages of 15 and 54, meaning that business has a direct line to those most vulnerable: employees and their families10.

Malaria
Each year, there are approximately 250 million cases of malaria11, which result in the death of roughly one million people, the majority
of whom are young children in sub-Saharan Africa. Malaria is widespread in tropical and subtropical regions, including parts of the Americas, Asia, and Africa but sub-Saharan Africa remains the worst affected region.

Like HIV and TB, malaria also has a high impact on worker productivity and is partially responsible for the poverty in the most afflicted areas. Malaria outbreaks have been known to derail progress on large-scale projects and the disease is currently ranked the 8th highest cause of loss of disability-adjusted life years (DALYs), a measure of overall disease burden. It is estimated that malaria costs Africa more than $12 billion in direct costs and lost GDP each year. One study estimated the value of production lost to malaria is 2–6 percent of GDP in Kenya, and 1–5 percent in Nigeria.

*TB is the leading cause of death of HIV-positive individuals in sub-Saharan Africa.*

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1. UNAIDS and WHO, AIDS Epidemic Update 2009
2. Ibid.
3. Ibid.
8. Ibid.
9. Ibid.
Context: Oil & Gas Industry

Much of the current large-scale oil and gas project activity is occurring in less developed countries around the world. Regions such as West Africa (Nigeria, Angola, Ghana, Cameroon, Gabon, and Uganda), and Asia (India, China, S.E. Asia, E. Russia) are very important for national and international oil company growth aspirations, and for the nations themselves within whose borders the resources are produced. Also the demand growth for oil and gas in many of these developing economies is very significant. Indeed oil and gas demand in China, India, Latin America and Africa is expected to at least double between 2005–2030. The result will be increased project activity in all of these geographies and throughout the value chain across exploration and production, oil refining and gas liquefaction, and downstream operations.

As a whole, the industry employs tens of millions of people and the numbers of people

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**Exhibit 1: Global demand for oil & gas 2005–2030**

<table>
<thead>
<tr>
<th>Year</th>
<th>Gas mboed</th>
<th>Oil mboed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>128</td>
<td>80</td>
</tr>
<tr>
<td>2015</td>
<td>156</td>
<td>95</td>
</tr>
<tr>
<td>2030</td>
<td>192</td>
<td>112</td>
</tr>
</tbody>
</table>

* Million barrels oil equivalent a day

Source: Booz & Company analysis and World Energy Outlook

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**Exhibit 2: Average growth rate of regional oil & gas demand 2005–2030 (%)**

<table>
<thead>
<tr>
<th>Region</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>4.1</td>
<td>2.9</td>
<td>2.7</td>
<td>2.5</td>
<td>2.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Europe</td>
<td>3.0</td>
<td>2.8</td>
<td>2.6</td>
<td>2.4</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Pacific</td>
<td>3.2</td>
<td>3.0</td>
<td>2.8</td>
<td>2.6</td>
<td>2.4</td>
<td>2.2</td>
</tr>
<tr>
<td>Russia</td>
<td>3.4</td>
<td>3.2</td>
<td>3.0</td>
<td>2.8</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>China</td>
<td>3.6</td>
<td>3.4</td>
<td>3.2</td>
<td>3.0</td>
<td>2.8</td>
<td>2.6</td>
</tr>
<tr>
<td>India</td>
<td>3.8</td>
<td>3.6</td>
<td>3.4</td>
<td>3.2</td>
<td>3.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Other Asia</td>
<td>3.9</td>
<td>3.7</td>
<td>3.5</td>
<td>3.3</td>
<td>3.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Middle East</td>
<td>3.2</td>
<td>3.0</td>
<td>2.8</td>
<td>2.6</td>
<td>2.4</td>
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<tr>
<td>Africa</td>
<td>3.1</td>
<td>2.9</td>
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<td>2.5</td>
<td>2.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Latin America</td>
<td>4.3</td>
<td>4.1</td>
<td>3.9</td>
<td>3.7</td>
<td>3.5</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: Booz & Company analysis and World Energy Outlook
involved in the development, construction and operational phases of some of the larger oil and gas projects can run to tens of thousands. Much of the current project work continues to be in Africa, Asia and Russia. The project workforce tends to be young, male and often migrant, and with people sourced in on a temporary contract basis. Certainly during the construction phases of a large onshore project, there may be five contractor staff for every direct oil company staff member. Once operational, this number may drop but it is not unusual to have three contractors for every direct employee. The project sites themselves are often in remote places with limited infrastructure, including a lack of housing, healthcare provision and transport. However, once a large construction project starts, the numbers of people living near the project site can often swell ten-fold as people migrate to the site from all corners in search of work.

Another important characteristic of these large project and operational sites is the difficulty in aligning the various stakeholder groups. National and local government officials and regulators need to work in tandem with the oil company operator and/or venture partners, who in turn need to work directly with the various service contractors and providers on the ground. In turn, the contractors and sub-contractors will often form a complex web of contracting relationships that can employ thousands of workers from the very skilled to the basic laborer. These workers

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2. WHO Global TB Control, 2009
3. UNAIDS and WHO, 2008 report on the global AIDS epidemic
6. University of Oxford’s Malaria Atlas Project (MAP), http://www.map.ox.ac.uk
and their respective contractor companies need to have links into the local communities that are co-located to the project site. In such an environment, mandating any kind of policy or procedure across such a broad range of stakeholders can be extremely challenging.

In summary, and particularly in the context of health, the various participants in a large project need to manage a complex set of inter-relationships with limited control or leverage over many of the stakeholders involved.

HIV, TB & Malaria within the Oil & Gas Industry

HIV, TB and malaria are prevalent in many of the areas where the oil and gas industry operates today and can have high impact on worker productivity. As outlined above, all three diseases are particularly problematic in Africa but HIV and TB are growing concerns in China and Russia also.

The working conditions on oil projects often serve to aggravate the risk of contracting these diseases as outlined below:

**HIV**
- Contractor workforce employs high levels of migrant workers who are separated from partners and families for extended periods of time
- Income disparities between contractor employees (with high disposable income) and others living in the surrounding community
- Frequent transport of goods and materials across distances
- Lack of access to disease prevention methods
- Low level of risk awareness amongst subcontractors and the surrounding community

**TB**
- Employee housing can help facilitate transmission when workers are living in close confinement
- Frequent employee travel and migration interrupts daily TB treatment

**Malaria**
- Construction of pipelines and facilities leads to environmental changes (e.g. standing water pools) that can result in an increase in local mosquito populations
- Travelling employees – especially those from non-endemic areas – are particularly vulnerable due to lower natural immunity to the disease
Management & Prevention: Key Activities

Below we have listed some of the core program components necessary for an effective company-driven intervention on health issues.

Shared Program Components

• Internal stakeholder mobilization (with company leadership, management, etc.)
• Management-level training and guidelines
• Employee awareness and prevention education
• Partnerships with external stakeholders
• Access to diagnosis and treatment

In addition to the shared elements, company health managers must take into account a number of disease-specific components when planning and implementing programs. Each disease has a unique pathophysiology, set of interventions, and mix of social, economic and cultural factors to consider.

Issue-Specific Components

HIV
• Corporate level policy addressing non-discrimination and pre-employment HIV testing
• Access to condoms and other preventative measures
• Gender and culturally sensitive education and awareness
• Access to voluntary counseling and testing
• Collaborative activities to address HIV and TB co-infection
• Access to antiretroviral therapy (ART) treatment

Tuberculosis
• Access to prompt and accurate diagnosis
• Access to TB treatment using directly observed therapy (DOT)
• Collaborative activities to address HIV and TB co-infection
• Environmental measures to prevent transmission

Malaria
• Malaria prevention for non- and semi-immune populations via chemoprophylaxis
• Bed net distribution
• Vector control measures e.g. indoor residual spraying (IRS)
Scope & Methodology

Report Scope
Previous GBC/Booz studies have included a baseline report on the impact of HIV/AIDS on business and a look at public-private partnerships to combat HIV/AIDS and TB in Russia, China and India. We focused our research on HIV, TB and malaria activities within the oil and gas supply chain. In particular, we focused on upstream and midstream activities in Africa, China and Russia where research into HIV, TB and malaria has previously been limited.

In conducting our research, we sought to find out how oil industry players perceive the risk and impact of these diseases. By baselining what prevention and management initiatives are in place with oil companies and their contractors – as well as how the parties interact on these issues – we aimed to identify where the problems are most acute and also how they could be best combated. The report also serves to highlight best practices that can be copied throughout the industry as well as a series of next steps to improve the current practice.

Exhibit 4: Oil & gas value chain

Area of Study Focus

Upstream (Exploration & Production)
- Pure focus on exploration and production (E&P) of hydrocarbons
- Includes players of all sizes from small operators to large majors and NOCs (National Oil Companies)

O&G Treatment, Transportation and Storage
- Involves treating the hydrocarbons (natural gas liquefaction, storage in bunkers etc. and transportation through pipes and/or marine tankers)

Refining and Processing
- Refining of crude hydrocarbons into end products (transportation fuels, lubricants & petrochemicals)
- A separate value chain exists for the petrochemicals industry

Transport and Distribution
- Bulk transport (typically through pipelines or railway trains) of fuels like diesel, petrol etc.
- Also includes intermediate storage
- “Last mile” transport to retail outlets and industrial consumers

Retail Marketing and Sales
- Gas stations (petrol pumps) and other outlets where consumers can purchase fuel and lubricants for vehicles
- Typically include convenience stores as well

These are typically very large-scale projects with large numbers of employees and contractors

Report Terminology

Oil companies refers to integrated oil companies such as Shell, BP, Chevron and Repsol who are active across the oil industry supply chain, managing the upstream, midstream and downstream activities.

Contractors refers to oil services firms who are active in upstream and midstream operations and are employed directly by oil companies as primary contractors to manage the exploration, production and – in some cases – the transportation of oil for major projects.

Sub-contractors refers to secondary or tertiary contractors directly employed by oil services firms and can often consist of many manually-skilled laborers with a high proportion of local content.
Report Methodology

We invited 34 oil companies and services contractors to complete a survey regarding HIV, TB and malaria activity and also participate in a 1–2 hour structured interview. We selected companies based on their inclusion in either the Global or Fortune 500 lists and prioritized companies with a geographic focus in Africa, Russia or China. We also partnered with a GBC member company who distributed surveys to its global suppliers. We received survey responses from:

- 17 oil services contractor CMOs/health officials/project managers
- 4 oil company CMOs/health officials

We interviewed:

- 9 chief medical officers (CMOs)/health officials from oil companies/oil services contractors
- 2 representatives from two financing institutions: the World Bank and the International Finance Corporation (IFC)

Interviews were conducted by Booz and GBC staff members with both industry and disease-specific expertise.

Our interview and survey questions covered the following topics:

- Programs and activities currently in place for HIV, TB and malaria
- Perception of the risk and impact of these three diseases
- Oil company/contractor interaction in addressing these diseases
- Contractor/sub-contractor interaction in addressing these diseases
- Utilization of contractual language to drive improvement in prevention and treatment
- Monitoring to ensure compliance with contractual language
- Opinions on how prevention and management of these three diseases could be improved

### Study Participants

<table>
<thead>
<tr>
<th>Type</th>
<th># of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP* Oil Company</td>
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</tr>
<tr>
<td>Shell* Oil Company</td>
<td>101,000</td>
</tr>
<tr>
<td>Marathon* Oil Company</td>
<td>28,855</td>
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<tr>
<td>Repsol Oil Company</td>
<td>41,000</td>
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<tr>
<td>Chevron* Oil Company</td>
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<tr>
<td>ConocoPhillips Oil Company</td>
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<td>Schlumberger Oil Services</td>
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<td>FMC Technologies Oil Services</td>
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<tr>
<td>Moody International Americas Inc. Oil Services</td>
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<tr>
<td>Nalco Company Oil Services</td>
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<td>CCC* Oil Services</td>
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<tr>
<td>Fluor Oil Services</td>
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<tr>
<td>Tidewater Oil Services</td>
<td>8,500</td>
</tr>
<tr>
<td>Kellogg Brown &amp; Root Oil Services</td>
<td>51,000</td>
</tr>
<tr>
<td>Solar Turbines Incorporated Oil Services/Renewables</td>
<td>6,600</td>
</tr>
<tr>
<td>Yokogawa Electric Corporation Oil Services/Renewables</td>
<td>6,300</td>
</tr>
</tbody>
</table>

*Denotes GBC member company
Key Findings

Priorities & Risk Perception
Safety has continued to remain the number one priority for oil companies and their contractors in recent years. Safety incidents not only result in direct impact on personnel (including occasional loss of life) but also dominate headlines, dent share prices and significantly affect employee morale. When company incidents concerning the environment occur, they tend to have far-reaching consequences as well, hence the ‘S’ and the ‘E’ of HSE often receive the most attention. On a positive note though, the oil and gas industry has seen on-going improved performance in both safety and environmental damage prevention over the last 20 years. In contrast, health issues have traditionally received less management focus and are often not monitored to the same level of detail. As one oil company CMO said “Safety is the first priority, with health issues lagging. Safety issues have immediate impact whereas health tends to be more long term so the sense of accountability is more diluted. This does not mean that the impact of disease on business is less though – in fact it can be significantly higher in the longer term.”

In order for health issues (such as HIV, TB and malaria) to be given more attention in the future, it is critical that the risk profiles associated with their impact are fully understood. In the survey conducted, risk perception was rated as the most important driver behind health priorities by both the oil companies (50 percent) and their contractors (71 percent) (Exhibits 5,6).

Exhibit 5: Key drivers behind health priorities
Oil companies

<table>
<thead>
<tr>
<th>Risk</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reputation</td>
<td>25%</td>
</tr>
<tr>
<td>Leadership/Senior management</td>
<td>0%</td>
</tr>
<tr>
<td>Contract clauses from financing institutions</td>
<td>0%</td>
</tr>
<tr>
<td>Contract clauses from clients (oil majors)</td>
<td>0%</td>
</tr>
<tr>
<td>Productivity cost</td>
<td>25%</td>
</tr>
</tbody>
</table>

“Safety is the first priority, with health issues lagging. Safety issues have immediate impact whereas health tends to be more long term so the sense of accountability is more diluted. This does not mean that the impact of disease on business is less though – in fact it can be significantly higher in the longer term.”

Oil Company CMO
HIV, TB and malaria were not present in any of the interviewee’s top five most pressing health issues at the global level. Instead, issues such as stress, obesity and heart disease (which have more impact in the Western world) were a bigger priority.

In order for HIV, TB and malaria to become better prioritized, their perception as high risk diseases must be significantly increased and better understood. While the level of risk will vary according to geography, for these diseases to be suitably managed accurate risk assessment procedures for each country/ basin/project must be implemented. Interviews suggested a company reason for the above is that risk measurement itself varies significantly across companies and across different areas of the supply chain.

Most oil companies interviewed had processes in place for measuring health risk. One oil company stated: “These diseases are examined from three risk perspectives: economic, operational and reputational.” In the case of HIV, this oil company uses Maplecroft (an intelligence mapping software) analysis to assess risk in conjunction with reports on local prevalence. Countries are then grouped into low, medium and high risk and the extent of HIV programs are adjusted accordingly.

Another oil company had a health risk map for each country in which it operates. Diseases are mapped on a 2x2 matrix rated by Hazard (level of risk and number of people exposed) and Uncertainty (amount of information and level of control). In the case of a country like Angola, while HIV and malaria were both rated at the highest hazard level, both had below average ratings for uncertainty, i.e. they were perceived to be poorly controlled or monitored. In this case the highest-risk diseases were also the most poorly monitored. Risk perception is important but risk management is also essential.

Some other oil companies were driven more by local government policy. One oil company CMO commented “In one country, the local government mandates that everyone is screened for HIV before entry and this makes HIV a ‘non-issue’ in that country from the company perspective.” In such a case, disease risk is clearly being assessed solely from a direct employee perspective and does not take into account the local contractual workforce. It is important to note that pre-employment testing can also engender a false sense of security. Even if employees are found to be free of the disease in question they are still at risk of contraction.

In the case of contractors, health risk assessment have tended to be less well structured overall. Instead of a formal set of procedures driven by central HQ, health risk assessments are often left to the discretion of the country or regional manager. The CMO of one contractor firm said: “Our company is managed on a very decentralized basis. I oversee the health issues but I really leave program decisions to the discretion of regional health managers.”
As a result, the programs in place for these types of diseases vary significantly according to location. This contractor interviewed above had no prevention or management processes in place for HIV, TB or malaria in Russia and China (apart from basic TB screening). Yet extensive programs and resources had been devoted to these same diseases in West Africa (particularly Nigeria) for both direct employees and their dependants.

Another oil services company believed that the risk levels for HIV, TB and malaria were marginal. The HSE manager interviewed said “we don’t see enough cases of the three diseases for them to be a real issue. When the cases do arise, appropriate actions are taken immediately. But the numbers are low. For example, we have seen four malaria cases in Angola (the company provides routine antimalarials to employees), out of 16–18 million man hours. HIV is considered to be even less of an issue.” This same manager also said that while reporting on malaria was fairly thorough, HIV was barely monitored. This suggests that HIV may be considered low-risk because the risk is poorly assessed. In fact HIV prevalence rates in Angola are 2.5 percent\(^*\). A lack of research and documentation of risk will lead to faulty risk perception at the project level.

### Oil Company Programs & Oil Company/Contractor Interaction

Where health programs are established and well structured, oil companies are generous about extending these programs to their contractors. The survey showed that oil company health programs for HIV, TB and malaria are usually extended equally to both their direct employees and their contractors. *Exhibits 7, 8, and 9* present select highlights of oil company activity on the three diseases for these two groups. Seventy-five percent of companies offer HIV-related information, education and communication (IEC) materials to both employees and contractors (*Exhibit 7*). Similarly, half of the company respondents distribute bednets to direct workers and contractors.

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**Exhibit 7: HIV activities in place**

<table>
<thead>
<tr>
<th>IEC materials (posters)</th>
<th>75%</th>
<th>75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer education</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Condom availability</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Staff trainings</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>KAP survey</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>None</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

\(^*\) For employees; \(^\star\) For contractors

Exhibit 8: Malaria activities in place
Oil companies

n = 4

Exhibit 9: TB activities in place
Oil companies

n = 4
contractors (Exhibit 8). TB activities tend to be more concentrated to the employee population. Fifty percent of oil companies have TB-related staff trainings for workers; only 25 percent offer the same to contractor (Exhibit 9).

In some cases, this is an informal set-up, for example, one oil company we spoke to said that if they have built a clinic then they are happy to allow contractors and sub-contractors access.

Many of the contractors confirmed this by saying that their employees often received their health training courtesy of the oil company programs. On the positive side, there are several examples where contractors are not always simply passive recipients of these programs. One oil company interviewed is now actively working with its contractors in specific high risk regions to develop programs jointly that are fit for purpose for both parties. Not only does this enable a simple cost sharing arrangement, but it also serves to engage the contractor community more deeply and ensure a more tailored approach to prevention and treatment. It also creates a sense of joint accountability for the whole workforce.

However, as positive as these initiatives often are, there is still significant room for improvement. Although most of the oil companies we surveyed work with contractor health teams, this is not the case across the board. In our survey, roughly 25 percent of contractor health officials said that they had never had any explicit interaction with their oil company clients on HIV, TB and malaria. Approximately 60 percent said that they interacted with oil companies in some countries on these issues while roughly 20 percent said they always discussed these issues with oil companies (Exhibit 10).

The extent of oil company and contractor interaction on these issues is in part reliant on the type of project in question. One oil company CMO commented that there has been far more successful health management in downstream projects such as refinery upgrades and product pipeline builds than there has with various upstream projects (field development, E&P company projects). This could in part be because company upstream projects tend to be very large and often involve many more players, and are thus organizationally more complex. Also E&P projects in frontier basins can often involve significant local content provision (i.e. local sub-contractors) and these smaller companies in turn can be more challenging to work with on health issues.

“The further down the food chain you get, the less involved the oil companies can be because frankly they don’t have contractual control.”

Oil Company CMO
Linked to the above, while oil companies extend their own health programs to their direct contractors, this access is usually not available to the sub-contractor community. As one oil company CMO said, “The further down the food chain you get, the less involved the oil companies can be because frankly they don’t have contractual control.” Another oil company health official commented that, “When a direct contractor goes on to hire a sub-contractor, that’s where things can get complicated. It’s ultimately the job of the contractor in part to manage their sub-contractors’ health agenda. It’s important to differentiate between what is under our (the oil company’s) control and what is out of our operational control. On direct project sites, the health management requirements roll over to us but on third-party sites, we tend to be far less involved.” In this case, third party sites might refer to assembly or lay down yards outside of the operational remit of the main project site.

Although there is variation in how close and frequent interaction between the oil company and contractor health teams is, what is indisputable is that the oil companies are strongly influential in determining how contractors manage their health issues. One contractor CMO said “Our own health requirements are largely driven by our client’s contractual and managerial requirements.”

Oil companies interviewed tended to agree. An oil company project manager said that there had been instances where contracts have been terminated due to the poor health of the contracted workforce. Such action can indeed send a powerful message.

To support the point above, the survey findings showed that contractor health officials rated their oil company clients as being almost as influential as their own management in driving contractor health initiatives (Exhibit 11).

“**Our own health requirements are largely driven by our client’s contractual and managerial requirements.**”

Oil Services Contractor CMO

However the reality of the bidding process can result in more basic principles being applied. As one contractor CMO said, “Projects will often go to the lowest bidder. Since these health programs can cost additional money, we are reluctant to invest in them if it means that we become less competitive price-wise.” If adequate HIV, TB and malaria programs are to be designed and implemented by contractors as part of the bid package, then the oil companies need to recognise that these costs will impact the prices they are presented with. More importantly, a consistent framework for effective programs must be provided up front so that at least when it comes to the cost of disease prevention programs, there is a level playing field to work with.
Exhibit 12: HIV activities in place
Oil services contractors

Exhibit 13: Malaria activities in place
Oil services contractors

n=17
The survey results showed that in comparison to oil companies, many contractor health initiatives for HIV, TB and malaria are generally less developed and also tend to have a narrower reach in terms of the audience they are addressing.

Looking across the survey results for contractors, results are quite mixed in terms of initiatives, focus and general consistency across diseases. For example, 35 percent of contractor respondents have no HIV programs in place and 53 percent offered no HIV support to their sub-contractors (Exhibit 12). Amongst oil companies the figures were better: 25 percent had no HIV programs in place and 25 percent offered no HIV programs to their contractors (Exhibit 7). With regards to TB, a similar picture emerged. For example, 35 percent of contractors (versus 25 percent of oil companies) had no TB programs in place for employees and 76 percent of contractors (versus 50 percent of oil companies) offered no TB programs to their sub-contractors (Exhibits 9, 14).

In the same way as mentioned above, health provisions developed by contractors for their sub-contractors are often driven by oil company requirements. One contractor said: “Client requirements do drive our engagement of our sub-contractor community. If a client requires a clause, then the impacts of that invariably cascade down to sub-contractors.”

Oil Services Contractor CMO
programs and initiatives. Yet in most cases, it is this community which is potentially the most vulnerable. The sub-contractor categories tend to consist of the highest number of local employees and can often be the least skilled. As a less well-educated and less well-off group of people, the sub-contractors are therefore potentially most at risk of contracting the diseases and most at risk of not getting treatment. Of all the areas highlighted in the findings section, this is unsurprisingly the area that is most concerning.

On the positive side, there have been instances where sub-contractor communities have grouped together to help improve the health management of their own community. In South Africa for example, smaller road transport contractors have been working together with trade associations to help create critical mass, share cost and implement their own health programs. However, these kinds of examples are still quite rare and the question for large oil companies and primary contractors is around how to encourage local sub-contractor communities to do more for themselves.

Contracts & Contractual Clauses
Health clauses in contracts are a relatively recent phenomenon but are becoming more common. By formalizing company expectations for the health of the contractual workforce, clauses can be a powerful lever for driving health management processes and initiatives.

To provide some detail of the sorts of contractual clauses related to health issues, we have included an example of an oil company’s HIV clause as written into many of its contracts.

Sample HIV clause from an oil company

In line with COMPANY policy and program, all Contractors shall implement the following measures on the Management, Prevention and Control of HIV/AIDS:

A. The Carrier shall ensure risks associated with the spread of HIV are evaluated in the context of both Health Risk Assessment and Health and Social Impact Assessments as applicable with appropriate planned mitigation and risk management measures.

B. The Carrier shall have and implement a NO-DISCRIMINATION policy with employment qualification independent of HIV status to the extent permitted under country laws.

C. The Carrier shall ensure all workers are regularly exposed to visual and language-appropriate educational materials (brochures, posters) on HIV/AIDS prevention to create awareness and build knowledge.

D. The Carrier shall actively disseminate HIV prevention information to workers at least twice yearly using Toolbox talk and shall ensure that all workers complete a mandatory HIV prevention and risk awareness session as part of onboarding/induction training.

E. The Carrier shall ensure that condoms are readily accessible by workers at work sites, accompanied by language-appropriate promotion of safe sex practices.

F. The Carrier will provide referral into available HIV/AIDS services, including counseling, voluntary testing, care and treatment access points.

G. The Carrier shall allocate time for worker participation in COMPANY-sponsored HIV prevention interventions, as appropriate e.g. peer educator training.

H. Contractors shall ensure that extra precautions are taken to safeguard the health and wellbeing of minority female workers, who are at increased vulnerability.
In the survey results, both contractors and oil companies agreed that contractual clauses are one of the most effective ways of driving much deeper and greater commitment to managing HIV, TB and malaria (prevention and treatment). All oil companies and 81 percent of contractors stated that contractual clauses were “very effective” or “effective” (Exhibits 15, 16).

However, despite a clear recognition that clauses baked into contracts can be an effective lever for enforcing action, the survey results also showed that contractual clauses are more prevalent for some diseases than others. For example within the contractor community, only 29 percent of contracts had clauses for their sub-contractors on HIV and TB issues, and 47 percent of contracts had clauses for malaria (in places where these diseases were high risk). This is in contrast to all of the oil companies surveyed having existing clauses for HIV (where it is a relevant risk) and 50 percent of contracts had clauses for malaria management. Interestingly, none of the oil companies surveyed had any such clauses for TB management.

Overall, while health clauses are seen to be a very good lever, there is clearly room for improvement. The interviews and survey findings suggest that there is still a wide variation in the consistency and quality of clauses produced by the industry, and that many are written in language that leaves their mandate – and compulsion to comply – somewhat open to interpretation. When contractors were asked whether contractual language about health initiatives was at all standardized across the

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Exhibit 15: How effective are clients’ contractual clauses in driving commitment on HIV, TB and malaria?  
Oil services contractors  
\(n=17\)

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Exhibit 16: How effective are contractual clauses in driving contractor action on HIV, TB and malaria?  
Oil companies  
\(n=4\)
industry, 87 percent responded that language varied significantly between clients, and 33 percent agreed that language was often vague. In addition 40 percent of respondents admitted that contractual clauses are rarely enforced (Exhibit 17).

During our interviews, oil companies admitted to struggling with appropriate contractual language that is both specific enough to be directive and measurable, and yet broad enough to be universally applied. One interviewee from an oil company has been working to overcome this by creating a more systematic, company-wide approach to managing the health of their contractors through the establishment of “guidance language” to help contractors identify which health risks are relevant to their areas of operation.

**Monitoring & Compliance**

Clauses will have limited impact if actions are not monitored. Likewise, the extent of monitoring varies by company, by health issue and by project. One contractor CMO commented, “Contract clauses may exist but they often don’t come into play and are rarely enforced by our clients.”

In part this is because the success of health initiatives can be difficult to measure. Representatives from oil companies concur that a company roadblock in effective monitoring lies in the challenge of determining what health data to collect and how to go about collecting it. As one oil company CMO noted “As in safety, it would be great to have similar measures for health performance as well. However, it is easier to ‘count accidents’ than come up with data on health.” While companies would like to use health performance as a criteria when selecting a contractor, clear KPIs (Key Performance Indicators) and a reasonable framework for evaluation are currently fairly ill-defined.

As such, one oil company focuses more on providing support and advise to their contractors on how to implement programs – such as helping staff conduct health impact assessments – instead of formally auditing their performance or compliance.

However, our survey showed that more frequent clausal compliance monitoring and clearer KPIs defined for monitoring
are perceived by both oil companies and oil contractors to be just as important as an increase in the prevalence of clauses themselves in driving action (Exhibit 18, 19).

While monitoring does exist amongst the oil companies – all of those surveyed said that they either always or occasionally monitored their contractors on HIV, TB and malaria management – the same is not true of the contractor community. 35 percent of contractors surveyed responded that they never monitored their own sub-contractors on HIV, TB or malaria management, exposing a clear area of potential opportunity for improvement.

Sub-contractor action is considered by the oil companies to be purely the responsibility of the contractors. One representative from an oil company, whose own clauses and monitoring efforts are relatively robust, said “the responsibility for ensuring sub-contractor compliance lies with the contractor – not us – as it falls outside of our operational control.”

Financing Institutions

Financial institutions that fund large, capital-intensive infrastructure projects in the oil and gas industry are also able to drive progress on these issues. As one oil company CMO said “There needs to be someone saying: the projects won’t get funded unless the criteria are met.” However, how influential these institutions are at present is unclear. In our survey, 50 percent of oil companies surveyed
believed that the financing institutions had high impact.

However, none of the contractor CMOs we surveyed agreed with this. Many said that they had never seen a HIV, TB or malaria-related contract clause from a financing institution and only 6 percent said that contract clauses from financing institutions were a key driver of health priorities, as opposed to 47 percent for oil company/client contract clauses (Exhibit 6).

The International Finance Corporation (IFC), a member of the World Bank Group, has chosen not to develop standardized clauses for fear of making unnecessary demands where there is low risk. Instead, in the case of HIV/AIDS, the IFC has developed an “IFC Against AIDS” program that is utilized when necessary. Sabine Durier, Principal Operations Officer at IFC, said, “If we had generalized contractual language stating that all clients must develop an HIV/AIDS program, some companies would unnecessarily be required to put resources toward something that is not an issue for them, for example if they are operating in a low prevalence area. The starting point has to be a needs assessment developed jointly with the private enterprise to create a plan that is best adapted for the operations and communities of the company, and then monitor against that plan.”

In contrast the World Bank does use contractual clauses, although these are limited to certain sectors such as large infrastructure projects within the transport industry. However, in the Bank’s experience, contractual clauses alone are not enough to drive change. Until the late 80s, the World Bank only had general health clauses in its contracts but as the HIV epidemic rose, HIV-specific clauses were developed as well. Despite their efforts, the organization quickly found that the clauses had limited impact. Accordingly, companies were directed to collaborate with local NGOs which had expertise in local HIV programs.

However, this also proved to be unsatisfactory as accountability for action was unclear. To facilitate completion of contractual terms in the future, the Bank has since printed a detailed pamphlet, The Route to Good Living, aimed at the transport industry describing the exact roles and responsibilities of all key stakeholders. The pamphlet, combined with highly detailed HIV-clauses (e.g. specifying how many condoms to be distributed to each staff member annually) aims to clarify expectations and eradicate room for misinterpretation. Clearly, the World Bank has found that contract clauses alone are not the answer, but they can be a useful tool for community engagement and a starting point for future progress.
Best Practices Observed

Best Practice Programs
During our study, we encountered numerous examples of excellent initiatives in place. Below is a selection.

Malaria
Example program: Marathon

Background: Marathon Oil’s Bioko Island Malaria Control Project (BIMCP) – an integrated malaria control program implemented in partnership with the Government of Equatorial Guinea since 2003 – employs four key interventions: vector control, case management, surveillance and evaluation, and education and awareness. Targeting Marathon employees, contractors and the broader island community, the program has reduced Anophelene mosquito abundance by more than 90 percent and infection prevalence in children aged 2 to 5 has dropped from 57% to 18%. Overall ACT treatment needs dropped by 62%.

Engaging Contractors: Tools for action
At the global level, Marathon requires general health clauses in all contracts. Contractors must be immunized and demonstrate fitness for duty; both processes are managed by third party providers. At the project/country-levels these clauses are adapted to local disease prevalence. The company has been implementing malaria-specific clauses in Equatorial Guinea since 2005 due to initial worker productivity issues. These clauses stipulate that all contractors have access to IRS, protective clothing and, for expatriate employees, take malaria prophylaxis. Contractual compliance is monitored through clinic visits and, in recent years, has reached close to 100 percent compliance. Contractor engagement is further supported through cost-sharing for the running of on-site clinics and the provision of technical assistance for program development.

Clause Utilization Best Practice
Based on feedback from respondents, in order for a contractual clause to be effective, it needs to be clearly stated, reasonable and measurable. Where possible, language should be standardized across oil companies, so contractors are familiarized with their intent and expectations. We suggest that the following aspects are considered:

1. Clarity: Clauses should have clear goals and clear metrics for measuring performance
2. Appropriateness: Mandates are appropriate for the level of risk
3. Pragmatism: Clauses provide goals that can be met given current constraints
4. Affordability: Costs associated with mandate are within reasonable means or additional funding is provided
5. Specificity: The beneficiaries of these programs need to be stated clearly so that the sub-contractual workforce is not ignored

Key takeaways:
Oil companies, first and foremost, must signal their commitment to health initiatives and translate this prioritization to the contractor. Oil companies should start with a health risk assessment and use the findings to tailor contractual clauses so they are appropriate and actionable.

Clauses should be in clear language to state expectations, performance indicators and, where possible, incentives for compliance and consequences for non-compliance. Contractors should be supported with information and resources (where appropriate) to meet these health goals. KPIs and other monitoring tools must be in place to create a feedback cycle to highlight opportunities for improvement. Through working in partnership, contractors and oil companies can use these clauses to drive better health outcomes for their workers and, in turn, better productivity across the project.
HIV

Example program: Royal Dutch Shell

Background: Royal Dutch Shell’s global HIV/AIDS program is centered on a risk-based approach, driven by two priorities: local disease prevalence and HIV risk. Based on this data, countries are grouped into three categories, or levels of action. Factors such as Shell’s ability to contain the situation in country and the company’s maturity in country (employees, programs, etc.) are also considered when selecting a grouping.

Level one: Low prevalence (<0.5%)
• At this level, countries have access to global resources, training tools and Annual World AIDS Day campaign resources. Often, structured group activities are limited to one per year but all core elements of the policy apply including non-discrimination, education and awareness and access to testing, counseling and treatment.

Level 2: Higher prevalence (0.5–1% and or targeting of higher risk groups)
• Includes the full range expected in a workplace program – an annual plan, committee, leadership involvement, peer education, risk analysis, non-discrimination policy and stakeholder engagement.

Level 3: Highest prevalence (>1%)
• 1 percent or more, higher risk work groups and a community dimension. In addition to all of the elements above, programs include monitoring and evaluation to assess ongoing effectiveness.

Engaging contractors: Tools for action
Realizing that contractors make up a large part of the workforce at risk for HIV, Shell engages two key groups: truck drivers and camp contractors. Often, contractors are working side-by-side with employees, so activities like testing, education are inclusive and do not differentiate between the two groups. Contractors are thus informally engaged at the project-site level.

Globally, health-specific clauses are included in contracts, but specific diseases are not mentioned. Recently, the company has begun to create “guidance language” to help contractors identify which risk (out of hundreds) are relevant to their area of operation. In places where HIV is an identified risk, the company has had its greatest success working on the downstream side – with hauliers and truck drivers. Upstream engagement is significantly more challenging given the complexity and number of players operating in this part of the value chain. HIV-specific clauses require contractors to offer testing and counseling services to employees; some also require access to treatment.

TB – More Action Is Needed

Our research revealed low levels of TB prevention activity among both majors and contractors. Only half of the majors offered information, education and communication (IEC) materials on TB to employees; the number was slightly less (41 percent) for contractors (Exhibits 9, 14). We found no examples of company-driven TB programs that were as advanced as HIV and malaria programs.

In part, this may be due to heavy government interaction on the disease. One oil company CMO commented: “We are still trying to understand what our role on TB should be. In Russia, Kazakhstan, China and other state-dominated countries, TB screenings are mandated by the government in order to allow work permits and licenses. In these cases it is really the government that drives the programs.”

However, in light of rising HIV-TB co-infection and the increasing prevalence of drug-resistant TB, increased action from industry majors and contractors is necessary. Basic educational programs on the signs and symptoms of the disease should be developed and in cases of infection, innovative approaches to facilitate treatment completion (which can take up to 2 years) should be put in place.
The oil and gas industry has the capacity to have an enormous impact on HIV, TB and malaria. Following our research, we propose the following actions:

For All Players in the Oil Industry Supply Chain

1. Ensure an adequate understanding of disease-risk profiles and develop programs accordingly
Both companies and contractors need to ensure that the disease risk profiles are adequately understood. Where oil companies already have detailed risk assessment processes in place, the information gathered needs to be communicated to contractors and in turn this should be shared with sub-contractors. TB in particular needs assessment and program development.

2. Document the impact of HIV, TB and malaria on worker productivity
Contractors and companies both stressed that industry action would be swifter if HIV, TB and malaria could be shown to be impacting the bottom line. One oil company CMO said: “Showing impact on productivity is critical for making suitable disease prevention an industry standard” while another contractor CMO said “What would drive change? A better assessment of cost impacts. Cost impacts not only if an employee gets ill but also if a member of an employee’s family gets ill and needs care.” No research has yet enabled a cost-benefit analysis of implementing health programs. Companies or contractors, in collaboration with technical agencies and NGOs, should document how the diseases affect workplace performance.

3. Increase company/contractor/sub-contractor interaction in developing programs
Companies, contractors and sub-contractors need to work more closely in developing programs together and sharing best practices.

For Oil Companies and Oil Services Contractors

4. Increase the prevalence of company-driven contractual clauses
Companies and contractors agree that health contractual clauses have impact. Though the majors surveyed for this report utilize contractual clauses, all other IOCs and NOCs should adopt this mechanism as well. Contractors also need to work to develop clauses for their own sub-contractors where relevant.

5. Incentivize contractors and sub-contractors to prioritize HIV, TB and malaria management
Incentives can be just as powerful as penalties as a way of triggering action. If oil companies formally recognize contractor efforts, then contractors will be encouraged to drive further improvement. Likewise the same is true of the contractor and sub-contractor relationship.

For Oil Companies and Industry Bodies

6. Develop contractual clauses from a collective industry perspective
The adoption of standardized language or a universal clause would clearly help contractors translate a mandate into action. At present, some contractors are frustrated at the mixed contractual expectations that they find themselves working with. One contractor CMO said: “Oil company clients should agree
a clear set of expectations and communicate those to the contractors.” Another respondent suggested that industry bodies like GBC and OGP/PIECA could help to facilitate efforts to standardize norms and expectations across the industry.

7. Develop a standard mechanism for auditing contractual compliance
Clauses will have limited impact if compliance is not monitored. One oil company CMO said: “The thing that would make the biggest difference would be an effective mechanism for auditing compliance.” In order to enable this, a clear set of key performance indicators (KPIs) need to be developed and utilized across the industry. Industry bodies such as GBC can help facilitate this.

8. Focus Research on the Sub-Contractor Community
Smaller sub-contractors were not interviewed for the purposes of this report. Future research should be directed specifically towards the sub-contractor community in order to better understand the pressures that they face.

9. Extend Research to Financing Institutions
The role of financing institutions in promoting health and HIV, TB and malaria clauses should be further explored. Future research should involve other financing institutions, such as the African Development Bank, to understand their current levels of activity. Lessons learned from clause utilization in other industries can be extended to the oil and gas sector (for example, the World Bank’s experience in the transport industry).

For Financing Institutions

10. Increase the prevalence of financing institution-driven contractual clauses
Tying project financing to health action could have high impact. Donors can leverage and build on lessons learned from the World Bank’s experience in implementing clauses in other industries.
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Thank you to GBC member, Getty Images, for allowing us the use of images in this report. Pages 24, 27 (top photo) and 29 by Brent Stirton/Getty Images.
If your company is interested in joining GBC, or if your company is already a member and desires more resources or a consultation on addressing the key issues of HIV/AIDS, TB and malaria, please contact one of our offices listed below:

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**About GBC**
The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) is an alliance of over 200 international companies leading the business fight against HIV/AIDS, TB and malaria. GBC works to leverage the private sector’s unique skills and expertise in the global response – including developing comprehensive workplace policies; supporting community programs; utilizing core competencies; facilitating leadership and advocacy by business leaders and brokering public-private partnerships. The official focal point of the private sector delegation to the Global Fund to Fight AIDS, Tuberculosis and Malaria, GBC maintains offices in New York, Paris, Johannesburg, Beijing, Nairobi and Moscow.

Visit [www.gbcimpact.org](http://www.gbcimpact.org) to learn more about GBC.
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