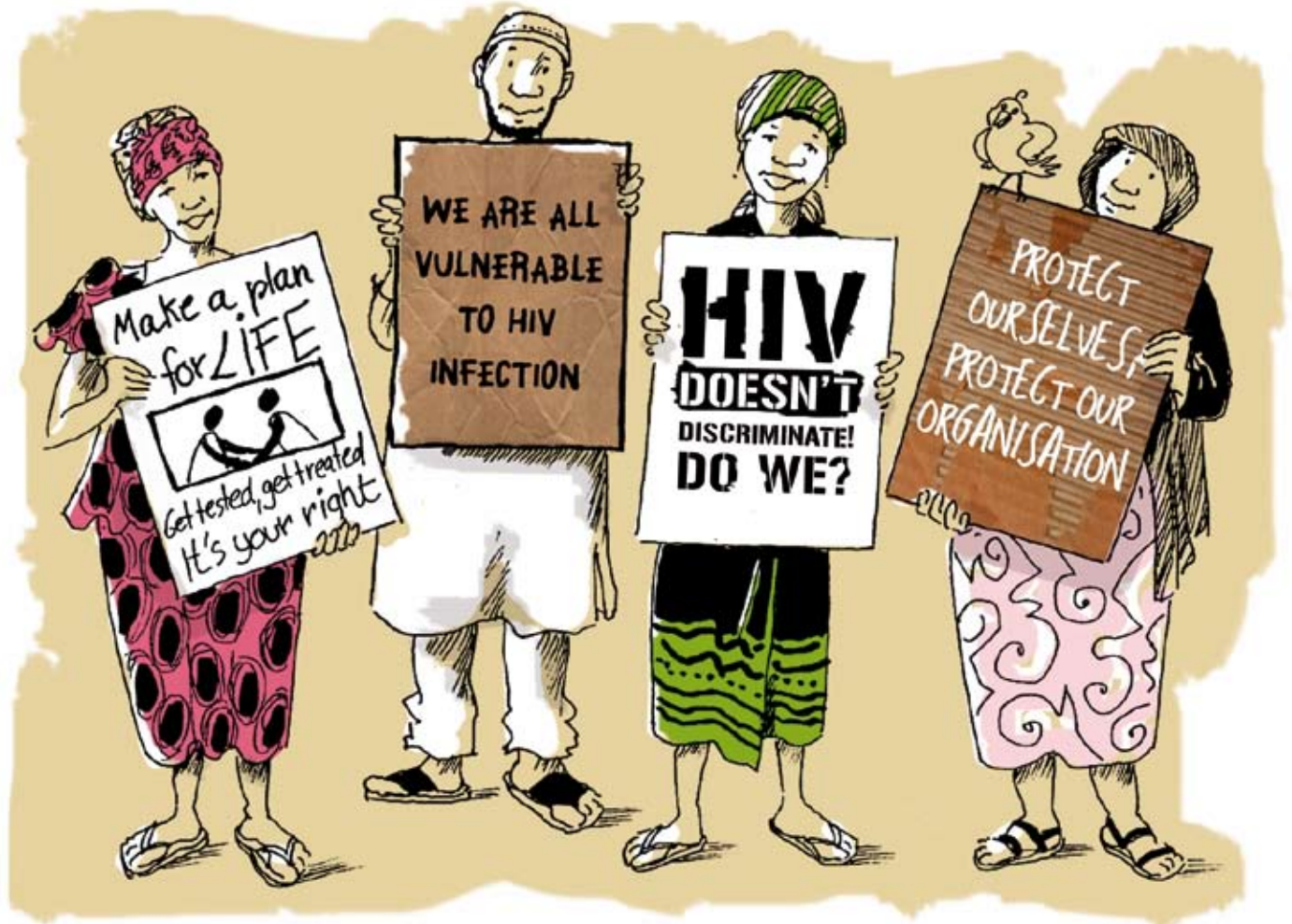# Managing HIV in the Workplace
A Guide for CSOs

STOP AIDS NOW!

Our guiding principles and commitments

WE KNOW that HIV and AIDS are affecting our partners' work.

WE BELIEVE it is better to manage HIV in the workplace than to ignore it and suffer worse consequences.

WE MANAGE HIV in our own organisations, and support our partners to do the same. We fund reasonable costs towards managing HIV as part of core costs. What is 'reasonable' will vary according to context.

WE COMMIT to try to convince other donors to support their partners' efforts to manage HIV in the workplace.

WE ENCOURAGE our partners to try to convince their other donors, and to seek funding to manage HIV in the workplace from them, if needed. We don't want our partners' efforts to be dependent on, and limited by, the support we can give them.

Acknowledgements

Thanks also to Petra Rohr-Rouendaal for the great illustrations. You can buy her manual-and-CDs package *Where There is No Artist* from **www.developmentbookshop.com.** It contains over 1,200 of her illustrations, which you can use in your own materials providing they are distributed for free.

Table of contents

Introduction

If you work in a Civil Society Organisation **(CSO)** then this guide is for you. It's about what you can do to reduce the effects which HIV and AIDS have on you, your organisation and its work.

This is the full version of the guide. There is also a summery. It has the same structure but less detail.

CSOs include faith-based organisations, trade unions, lobby groups, community groups, national and international non-government organisations (NGOs), and NGO networks and coalitions.

'Managing HIV in the workplace' is about organisations reducing the effects of HIV and AIDS on their work and what they can achieve. It means the same as 'internal mainstreaming' or 'mainstreaming HIV at the organisational level' or 'addressing HIV in the workplace'.

If you don't have much time, you could go straight to the chapter which is most relevant to you:

Read Chapter 1 if you are not sure if your organisation needs to manage HIV

> Jump to page 6

Why manage?

Go to Chapter 2 to find out about seven steps to developing your response

> Jump to page 16

How to develop?

Go to Chapter 3 for ideas about activities to manage HIV and help on budgeting and financial issues

> Jump to page 36

What to do?

There's a copy of the shorter version on the CD which you should have received with this guide. Alternatively, it and all the other supporting documents are available at **www.stopaidsnow.org/cso-tool**

If you want to remind yourself about HIV transmission, stages of HIV infection, and AIDS, read the fact sheets on the guide's CD or at **www.stopaidsnow.org/cso-tool**

Chapter 1: Why manage HIV in the workplace?

Our organisations have a mission or vision of how we want to change things for the better.

This chapter explains how HIV can threaten our organisations' ability to achieve their goals. Where staff are directly or indirectly affected by HIV, organisations suffer from higher costs and lower productivity. In other words, it costs them more to do less.

Managing HIV is a way of reducing HIV's effects on our organisations, so protecting how they work and what they can achieve. Managing HIV also benefits staff members, their families and the wider community.

Ignoring HIV

Sometimes we can miss a meeting, or ignore a phone ringing, without a bad outcome. But ignoring HIV has consequences. HIV causes more damage in places where people deny it exists, are scared of it, and are not prepared for it.

Look what happened in this CSO (based on the experiences of a real organisation in Southern Africa):

The CSO's best community worker was sick and off work a lot. She worried that she had HIV but did not test for fear of stigma. Her colleagues tried to do her work but they were overburdened. Her projects suffered. When she became very sick the hospital tested her for HIV and gave her treatment, but it was too late. She died, and was lost to her family and the CSO. The organisation paid for her burial, and death gratuity of three month's salary. It took several months to replace her. By then her community projects had stalled, and the investment in them was wasted.

A year or so later, the Finance Officer also became ill. He began using the CSO's resources for his own use, and forged expense claims. He rarely came to work. Others tried to cover his tasks, but made a lot of mistakes. When he did come to work he was unreasonable, and shouted at his colleagues. The Director tried to be understanding, but after a lot of stress she sacked him. A key donor did not renew the CSO's contract, following delays and errors in financial reporting.

Later, people noticed that one of the admin staff had a husband who was on-and-off sick. Other staff whispered about it, saying that she will be next. She felt depressed, without friends, and was unable to work as well as she used to.

What were the effects of HIV, stigma and AIDS on the staff and the organisation?

How does this case study relate to your workplace?

Managing HIV

Instead of ignoring HIV, we can try to address and manage it. This cannot make the problem of HIV go away, but it can make us and our organisations more resilient. Your CSO can become stronger to resist and cope with HIV.

What if that same CSO was managing HIV? Let us imagine how the same situation could turn out differently:

The CSO's best community worker was sick and off work a lot. She worried that she had HIV, and talked with a colleague who supported her to test. She found she was HIV-positive. This was terrible news, but at least she knew from awareness raising and other activities that her employer had a commitment to support her through its critical illness policy. The CSO helped her to get antiretroviral treatment (ART) and her health improved. She gradually became open with other staff members about her situation. In her work, she put more effort into developing community leadership, so that the projects could continue without her if she became sick again. One project was particularly successful, and she was put in charge of expanding it.

A year or so later, the Finance Officer also became ill. He began using the CSO's resources for his own use, and forged expense claims. He rarely came to work. Others were able to do key parts of his work because they used shared files and systems. The Director confronted him, and urged him to get advice from a doctor. Eventually the Finance Officer was convinced by the community worker's experience: how she had regained her health and how the CSO was supporting her. He tested positive and began ART. The financial reports to a donor were delayed, but the Director was able to explain that the delay, caused by staff illness, had been resolved using the CSO's critical illness policy.

Later, people noticed that one of the admin staff had a husband who was on-and-off sick. She and her husband knew their HIV status because they had taken tests at the CSO's family testing day: he was HIV-positive, and she was not infected. Following counselling they had vowed to use a condom when they had sex. At work she valued the support she got from her colleagues, and that the CSO allowed her to work flexible hours when her husband was ill.

What did this organisation do, and how did its efforts to manage HIV reduce its negative effects?

How could you make your organisation more like this?

How HIV and AIDS affect organisations

The main effects of HIV and AIDS on organisations are:

- More staff absences, due to employees being ill, looking after ill relatives, and attending funerals;

- Higher staff turnover, and loss of skilled labour and institutional memory, because staff leave due to illness or death;

- Lower morale, due to the psychological impact of illness and death, having to do absent colleagues' jobs, and stigmatisation.

These effects lead to higher costs and lower levels of productivity, as shown in Figure 1.

Figure 1: How HIV and AIDS lead to higher costs and lower productivity
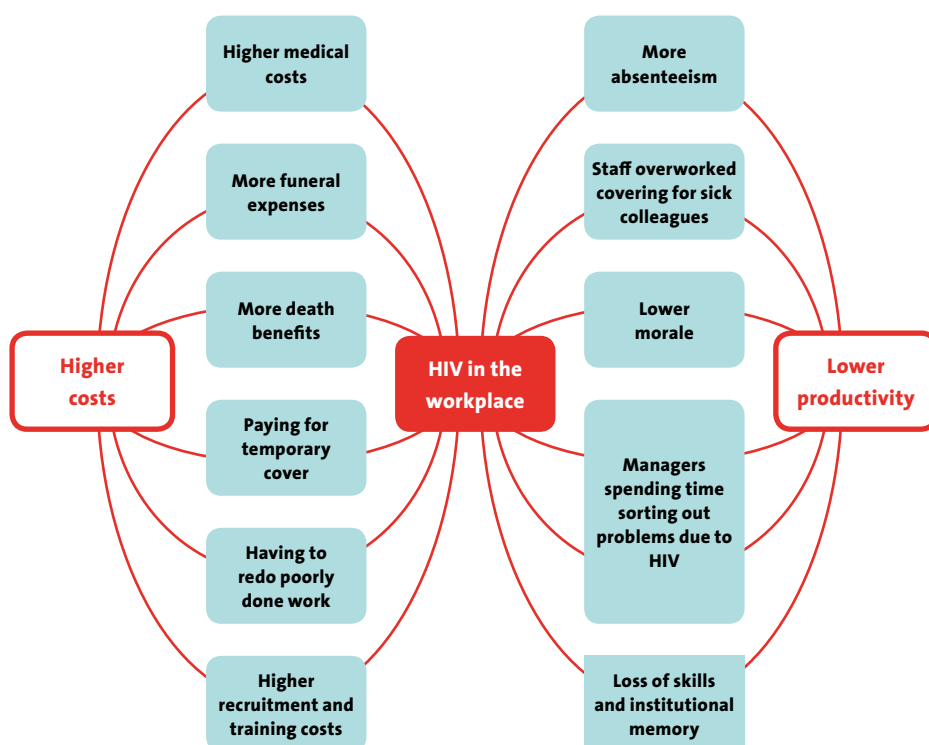
In Kenya and Uganda new cases of HIV have been analysed by sub-groups of the population. In both countries the largest group – with around 44% of infections – is heterosexual couples in a regular relationship[1].

66 Having sick staff means the whole vehicle slows down and we are not performing well in some areas. Our reports are 3–4 months late as a result. It is affecting our output and hampers the quality of our work."

66 Sometimes a programme will come to a standstill because a person holding critical information reports ill for a whole month."

66 HIV issues eat my time. I am crying for that time. I have to constantly chase people. I have to do things for them. Should I really be draining my energy on this?"

CSO managers, INTRAC Praxis Paper 13, 2005, www.intrac.org

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1   HIV Prevention Response and Modes of Transmission Analyses, both March 2009: Kenya & Uganda (also available for Lesotho, Swaziland and Mozambique), available from www.unaidsrstesa.org

It's clear that HIV and AIDS affect organisations, but how big is the impact? We have very little data on this.

One study in 2005 by INTRAC[2] looked at the impacts of HIV and AIDS on 29 CSOs in Malawi, Tanzania and Uganda. At the time those countries had HIV prevalence rates of 14%, 8% and 7% respectively, and the CSOs were mostly not doing very much to manage HIV. Using some cautious assumptions, it found that their staff costs had gone up by 7%. It also estimated that productivity had gone down by at least 10%.

At the micro level, the Ugandan CSO CDRN documented the story of the sickness and eventual death of Dorothy, one of its employees. They estimate that the financial cost to the organisation was almost $10,000, but stress that the emotional toll was greater[3].

STOP AIDS NOW! recently did some research[4] among 30 CSOs in Ethiopia, where the HIV prevalence rate is around 4%. A quarter of the staff had taken care of a relative with an HIV-related sickness, and 13% had taken one or more children orphaned by AIDS into their household. Just over half of the staff thought that their work performance had been affected by HIV. The proportion reporting each effect was:

- Absences from work to attend funerals – 44% of staff;

- Absences from work to take care of relatives – 20% of staff;

- Increased workload because of illness of other staff – 14% of staff;

- Doing additional jobs to pay for medical bills or orphans - 8% of staff;

- Reduced performance due to stress at home – 6% of staff;

- Reduced performance due to personal weakness – 2% of staff;

- Absent from work due to own illness – 2% of staff.

66 **There are times when the organisation is really in trouble. For example, when two people announce deaths and everybody is affected emotionally…. morale declines…"**

66 **There is ill health among staff, but at the end of the month the organisation still has to pay a full salary, even though people are producing at about 40% of expectations."**

CSO Manager in Botswana, HIV/AIDS and Development, The Impact of HIV/AIDS on NGOs and Their Programmes, www.idd.bham.ac.uk/research

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2   *The Organisational Impacts of HIV/AIDS on CSOs in Africa,* Praxis Paper 13 by Rick James and others, 2005, INTRAC, available from www.intrac.org. We note that respondents who are asked to recall HIV's impacts often underestimate because (a) they are relying on memory rather than data (b) they have incomplete information as people hide their sickness and (c) they may hide impacts (eg one respondent from a faith-based CSO reported no deaths, whereas the researcher was aware of 7 deaths within the organisation).

3   Praxis Note 12, *'Robbed of Dorothy',* available from www.intrac.org. These costs would have been lower if (a) Dorothy had known her

HIV status before she got sick, and had taken treatment to prevent opportunistic infections (b) if free ART had been available (c) if Dorothy had started ART before her immune system was badly damaged, and maintained the treatment (her church advised her to stop taking it, leading to her death) and (d) if the organisation had enforced its policy of 3 months sick leave (which it did not feel able to do, as her husband had abandoned her and her 3 children).

4   *Report of Applied Research Baseline Study,* STOP AIDS NOW! Ethiopia, 2009, available from www.stopaidsnow.org. Two of the 30 organisations focused on people living with HIV.

The costs and benefits of managing HIV

Of course, managing HIV in the workplace is not free of cost.

One cost is the **staff time** your CSO will use to come up with plans, and to put them into action. You may also need **extra money,** for example, if your CSO hires trainers to help you run workshops, or helps with the insurance or medical costs for staff.

The actual costs in time and money vary a lot between CSOs in different countries. But whatever they are, you might think that ignoring HIV has to be cheaper, because that doesn't cost anything. Yet in the case study on page 7, when the CSO ignored HIV the consequences included: staff away from work; a failing project; the death of a valued member of staff; misuse of resources; management stress; a sacked member of staff; loss of a donor; underperforming staff; and bad feelings among staff. The costs of the consequences of doing nothing can be substantial.

We don't have much information on the costs and benefits of managing HIV in the CSO sector. Many CSOs don't record sick leave, and CSOs' outputs are often hard to measure. But recent research among companies in Zambia showed that, on average, the benefits of managing HIV were three times the costs[5]. So for every kwacha (or dollar) spent, they saved three.

It is no coincidence that businesses were the first organisations to manage HIV. They are very sensitive to higher costs and reductions in productivity because they mean lower profits. Many businesses have recognised that it is cheaper to manage HIV than to ignore it. This is also the experience of many of the CSOs supported by STOP AIDS NOW!'s projects in Uganda, Ethiopia and India. They have found that investing some time and money now allows them to get benefits now, and to avoid higher costs in the future.

So, managing HIV within organisations is cost-effective. It is also necessary, particularly in places with high HIV prevalence, if your organisation is to protect its ability to deliver its outputs.

> **If you lose someone you have trained for 20 years, that is a great loss. Condoms and AIDS education cost peanuts."**
>
> Manager, Action Against AIDS in the Workplace, 2002, www.ilo.org

> **Some CSOs have reduced the financial costs of managing HIV to very little by using free services for HIV testing, counselling, prevention and care.**

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5   *The Costs and Benefits of HIV Workplace Programmes in Zambia,* HLSP Insititute, 2009, free download from www.hlspinstitute.org

What benefits can your organisation expect?

CSOs that have chosen to manage HIV report various benefits[6]. These include:

- Staff are better informed, and more able to talk about HIV and sexuality issues;
- There is less stigma and discrimination in the workplace;
- Staff feel more confident that they can keep their job if they are HIV-positive, and are more willing to disclose their status;
- More staff and their family members get tested for HIV (in STOP AIDS NOW!'s Uganda project, 65% of CSO staff had tested, compared to 13% of the population);
- Staff report safer sexual behaviour, so are less likely to get infected with HIV;
- More HIV-positive staff link to **positive living** networks, prevent opportunistic infections and use **ART**, so have better health and longer lives;
- Staff become more gender sensitive leading to less discrimination against women and transgendered members of staff;
- Staff feel more valued and, through participatory approaches, have a greater sense of togetherness;
- Staff capacity is enhanced, and the organisation is stimulated to improve its work by adapting its programmes to take account of HIV, or by doing AIDS work;
- The positive effects spill over to family members and the wider community.

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6   From STOP AIDS NOW! applied research reports, and *Addressing HIV and AIDS in the Workplace: lessons learnt from Civil Society Organisations and Donors*, STOP AIDS NOW!, 2009, www.stopaidsnow.org/downloads plus some additions from various reviewers.

66 **Now people are no longer shy to talk about HIV and AIDS. People can ask me for condoms – right away they say "Eric I want condoms" and I do give them as it never used to be."**

Ugandan CSO, STOP AIDS NOW! Applied Research (unpublished interview).

66 **In an organisation a staff member got AIDS and was sick to death. His wife had passed away leaving their two years old son behind. By support he got from the organisation, he was able to recover and returned to his job. He had food support, medical support including ART, and emotional and social support from his colleagues as well. Now he is one of the best workers and his son has reached to grade 10."**

Ethiopian CSO, correspondence with the author, March 2010.

Positive living is about living well when HIV-positive: taking good care of oneself, and not transmitting HIV to others.

ART is short for anti-retroviral therapy. It consists of at least three antiretroviral drugs (ARVs). They suppress the HIV virus and stop the progression of HIV disease.

What about low-prevalence countries?

The argument for managing HIV is strongest for the highly-affected nations of Africa. In many places HIV has affected every person and every organisation in some way. But is it worthwhile to manage HIV if you work in a place where HIV prevalence is low (below 1% and concentrated among certain groups)?

In comparison to a CSO in a high-prevalence country, CSO employees in a low-prevalence country are certainly less likely to be HIV-positive. This is because there are fewer people to get HIV from. But the risk is not zero. There are people who are HIV-positive around, and not all of them belong to the groups who are most at risk. Staff members could have HIV infection already, or could become infected. No one is immune to HIV infection. And, of course, a low prevalence rate can go up.

India has a low prevalence of about 0.3%, but HIV infection is not concentrated only among injecting drug users and men who have sex with men, as often thought. Most infection occurs through heterosexual sex (including where sex is sold), and women account for around 39% of HIV-infected adults.
www.avert.org/hiv-india.htm

The risks are lower, but organisations in low-prevalence settings can still be affected by HIV – and are certainly affected by other health problems.

66 ...staff members have more confidence in the system and the organisation... And management is much more aware and much more responsive than it was in the past."

Ugandan CSO, STOP AIDS NOW! Applied Research (unpublished interview).

66 Earlier we wouldn't talk much about HIV because we didn't know much. Now we have got to know a lot... everybody is cooperating which was not there earlier....it's had an effect on stigma because of this increase in awareness."

CSO staff member, STOP AIDS NOW-South India Project Applied Research (Phases II and III) Study, 2010.

It makes sense, then, that staff in low-prevalence settings understand the basic facts about HIV, including how to prevent infection. It's much cheaper to prevent HIV infection than to treat it. For organisations working on HIV it is also important that staff relate HIV to their own lives, and not only to their client groups.

Chapter 1: Why manage HIV in the workplace?

We do not, though, need to focus on HIV alone. If your organisation has no human resource policy, you could start there. Setting out employees' rights and responsibilities will help your organisation to manage its staff and treat them fairly. If your human resource policy is implemented it can:

- Reduce workplace discrimination against employees and potential employees with regard to HIV status, gender or sexuality;

- Reduce **sexual harassment** and **sexual trading** in the workplace;

- Reduce the impacts of staff sickness and death on the organisation, by setting out rules regarding sick leave, compassionate leave, and associated benefits;

- Improve how effective your organisation is in its work.

We can also include HIV in a wider effort to manage chronic illnesses, and to improve staff health. For example, if staff sickness due to malaria is common in your organisation, then you'll want to address that. Tackling certain health problems will also reduce the likelihood of getting HIV. These include sexually transmitted infections, and drug abuse including alcohol abuse. Encouraging staff to value their health is another way of indirectly making them, and your organisation, less vulnerable to HIV and its impacts.

Sexual harassment refers to unwelcome sexualised behaviour, including rape. Nurses in a Ugandan hospital, for example, reported harassment by their male supervisors, particularly when at workshops away from the hospital. They feared that to refuse a superior would be to risk their jobs.

Sexual trading refers to demands for sex in exchange for a job or promotion.

❝ The management of an organisation in Asia did not see the need to address HIV in the organisation, until a close family member of one of the managers turned out to be HIV-positive. Then it did become a priority. Why do we have to wait till it affects us directly?"

Oxfam Novib Programme Officer, correspondence with the author, March 2010.

Why manage?

How to develop?

What to do?

Chapter 2: How to develop your response

Your organisation could develop its response to HIV in many different ways. There is no single "THIS is the way to do it!" However, we know the rough order of events from many CSOs' experiences. This chapter sets them out as a series of seven steps:

Step 1:   Get things started

Step 2:   Form a working group

Step 3:   Define your task

Step 4:   Find out about the issues in your organisation

Step 5:   Draft a policy and talk about it

Step 6:   Agree the policy and turn it into action

Step 7:   Learn from what happens

Step 1: Get things started

If you feel that your organisation should do something to manage HIV, your first challenge is get others involved. There are some things you can do alone, such as personally challenging stigma. But to manage HIV it's crucial that there's a broader commitment from within the organisation.

For this first step, your goal is to get your organisation to form a working group or committee which takes responsibility for the process.

How can you get things started? Here are some ideas:

- Read this guide, so that you are well-informed;

- Talk to colleagues, managers and board members who you think may be interested;

- Share this guide or the shorter version of this guide with colleagues;

- Organise a meeting including a presentation from a CSO that is addressing HIV in its workplace;

- Invite someone living with HIV to speak about their experiences in the workplace;

- Put the topic of HIV and the workplace on the agenda of a suitable meeting.

66 **Without commitment you cannot do much. You have seen organisations that have money but they are not committed. So to me, we have little resources but still we go ahead and do whatever we can do, especially care and support, treatment….**
So it is all about building commitment. If the board is not committed, if management is not committed, nothing I think can move."

Ugandan CSO, STOP AIDS NOW! applied research (unpublished interview).

Dealing with negative reactions

When talking to others you may meet resistance, denial and other negative responses to managing HIV in your workplace. These can block your organisation's response.

On the next four pages you'll find some common reasons for not acting to manage HIV, and some ideas of how you could respond to them. Use them to develop your advocacy skills.

You can also use these images and statements to get your colleagues talking about managing HIV. They are set out ready to use in the Workshop Ideas folder of this guide's CD.

What's so special about HIV? There are a lot of health problems around!

You could...

Acknowledge the significance of other health problems, but explain that HIV is different because:

- Infection is most common among people of working age, so it has greater impacts on the workforce.
- For many years after infection there are no symptoms. Most people who are HIV-positive do not know they have HIV in their blood.
- HIV's links with sex, morals and death have lead to it being highly stigmatised. This stops many of us from getting tested and treated, leading to greater impacts.

- Preventing HIV means talking about sex and sexuality, and addressing gender and power inequalities.
- HIV infection is incurable and, if not treated, fatal.

Remind your colleagues that you do not have to focus on HIV alone. You can instead manage critical illnesses, or promote well being, within your organisation.

You know, HIV does not really affect us

You could....

- Remind people that if anyone in your organisation has had sex without a condom, has had a blood transfusion, or used a non-sterile needle, you could already have staff who are HIV-positive.
- Find out the HIV prevalence rate for your city or country from **www.unaids.org** and relate it to your organisation.
- Talk about the effects that you are aware of in your organisation or community.
- Suggest an anonymous survey to ask staff about the effects of HIV in the workplace and in their families.

- Share information about how HIV has affected other organisations (see Chapter 1).
- Explain that it is good to respond in advance of HIV's effects, and that prevention is cheaper than treatment.

This is our workplace; we do not discuss private matters here.

You could...

■ Explain that "private" issues can be present in public places. For example, sexual harassment and sexual trading (sex-for-favours) happens in workplaces.

■ Also, "private" behaviour affects organisations, just as workplace behaviours (stigma or support) affect individuals.

■ Assure people that the organisation will not try to control their private lives; it values supporting them to protect and keep their health.

■ Help people to feel safer by using anonymous research methods, and allowing men and women to discuss issues separately. Assure them that no one will be made to discuss issues which they wish to keep private.

We are a faith based organisation. All our staff lead moral lives and cannot be infected with HIV.

You could...

■ Point out that HIV is just a virus: it does not discriminate or make moral judgements, it just takes the chance to spread whenever it can.

■ Download Positive Voices from the Called to Care toolkit at **www.stratshope.org.** Share with your colleagues the 14 case studies of religious leaders who are HIV-positive or personally affected by HIV. Or, from the same site, get the DVD What Can I Do? and learn from the experiences and wisdom of Canon Gideon Byamugisha, the first African priest to disclose his HIV-positive status.

■ Explain that someone who has had just one sexual partner can still get HIV if that partner has had other sexual partners. Query if all people of faith have only ever had sex with one other person, who has only ever had sex with them.

■ Explain that HIV infections can happen through blood transfusions, or other medical practices, if safety procedures have not been followed.

■ In a workshop setting, get people to do the quick self-assessment which is on this guide's CD.

■ Share research findings: one study found that faith-based organisations experience as many HIV-related deaths as secular CSOs, but are less likely to admit to them, and more likely to underestimate the proportion of staff who may be HIV-positive (see Praxis Paper 13, which is on this guide's CD and at **www.stopaidsnow.org/cso-tool**).

■ Check what your organisation preaches. Does it link HIV with morals? Is its message increasing stigma?

If I allow discussion then staff will want treatments which we cannot afford.

You could...

- Assure managers that there are low-cost ways of managing HIV (*see page 47 of Chapter 3*). These are much better than making no effort to manage HIV.
- Find out about free ART and other services in your locality. Organisations can help staff by having a good referral system, with up-to-date information on where and how to access ART.

- Assure managers that if staff understand the organisation's budget limits they will not demand unaffordable benefits. It's in everybody's interest that the benefits can be sustained by the organisation.

We already know about HIV and AIDS!

You could...

- Query if staff really know about HIV and AIDS, or is it just assumed (particularly if your organisation does HIV and AIDS programme work)? Also query if staff relate the issue to themselves, not only 'the community' or their clients.
- Explain that knowing the facts is only the first step. For example, we might *know* about condoms, but are all female staff able to negotiate condom use with their sexual partners?
- Question if your workplace is free of stigma and discrimination, if all staff have tested for HIV, and if all staff do (or would) seek and get health care for HIV-related sickness. Unless the answer is truly 'yes' for all of these questions, your organisation would benefit from managing HIV.

- If your organisation does AIDS work in its programmes, consider if work for its staff has been forgotten, or seen as not needed. Your staff may also fear or experience stigma because, as people working on AIDS, they 'should know better'.
- Invite an HIV specific organisation which has a HIV workplace program to explain how it has helped them.

You could...

- Explain that ignoring HIV now (to save time) may lead to much greater problems (time and money) in the future.
- Consider if some current pressures are caused by not managing HIV. For example, people having to cover for a sick colleague, or low morale among staff.
- Recommend a simple approach, which can be formal or informal.

You could...

- Explain that you don't have to make a separate funding application. Instead, integrate the cost of managing HIV in the budgets of future funding applications.
- Point out that the costs of managing HIV need not be high, particularly if you are able to refer staff to free health services (see the section on low-cost responses on page 47).
- Suggest opening up dialogue with your donors (see Step 5 of Chapter 2). Use Chapter 1 of this guide to persuade them. Managing HIV within organisations is cost-effective. It is also necessary, particularly in places with high HIV prevalence, if your organisation is to protect its ability to deliver its outputs.
- Share the document *HIV in the Workplace: 20 Ways for INGOs to Help Partners* (on this guide's CD, or available from **www.stopaidsnow.org/cso-tool**). It describes what other donors are doing.

Step 2: Form a working group

Step 1, getting things started, is usually informal. At Step 2 the process becomes more official, as the organisation creates a working group or task force of people to take responsibility.

Who should be in this group? It will depend partly on the size of your organisation. We know from many CSOs' experiences that it is best to:

■ **Include women and men, people of different ages, and, if possible, someone living with HIV.** It's important to make sure different perspectives are represented.

■ **Include people from each level of the organisation.** This helps to involve the whole organisation:
  - senior level mangers with decision-making powers;
  - mid-level members of staff;
  - lower-level members of staff;
  - volunteers (where relevant).

■ **Include people with different roles:**
  - someone with responsibility for staff (human resources department);
  - someone with responsibility for finances (accounts department);
  - someone involved in the organisation's work (programmes department);
  - someone involved in the organisation's HIV work, if you have any;
  - a member of the board, if that is appropriate.

Many organisations make one person the Focal Point for HIV, and another the Back-up Focal Point:
■ the Focal Point (FP) is the main contact point for the process;
■ the Back-Up FP works with the FP, and can take over if the FP leaves, is away, or cannot work;
■ the FPs need to be senior enough in the organisation to be able to delegate tasks, and to get items onto meeting agendas.

Overall, it is best if the individuals want to be in the working group, and that they can make the time to participate in it. The issue of time is particularly important for the Focal Points.

Many organisations rotate some of the membership of the working group every 6 months or so. This increases participation and ownership amongst staff.

66 As a focal point person, one challenge is time – to give it all you have and yet be very committed to other assignments is a challenge. To keep the staff fire burning is difficult. To sustain their interest is not easy."

Ugandan CSO Focal Point, STOP AIDS NOW! Applied Research (unpublished interview).

Step 3: Define your task

Your working group first needs to be clear about what it is expected to do! It can set out its responsibilities and share them with staff, so that everyone knows what is going on, and how they can take part.

The first decision is to choose between an informal or formal approach.

An informal approach

A truly informal approach is what happens organically when staff respond to illnesses and misfortunes including HIV. There's no working group or written policy, just individuals responding as they see fit. For example, encouraging a sick colleague to 'take all necessary tests', doing tasks for a colleague who is unwell, or helping transport someone to hospital.

Your working group might choose to take – or to stick with - an informal approach because your organisation:
- does not have written policies;
- is newly formed or just beginning to operate formally;
- has problems planning ahead and making commitments because it has little or no money;
- has a short life-span, for example, it only exists to run a certain event or project;
- has managers who are not convinced about the need to consciously manage HIV in your workplace; who don't want to invest time in developing a policy; or who don't think that a policy will improve the response.

CSOs can do a lot to respond to HIV without a written policy. You might build on what some staff already do. For example, helping each other with medical or funeral costs, and visiting sick colleagues. Your working group might add some new activities, for example, running an HIV awareness session, or making female condoms available in addition to male ones. By thinking about what is already happening, and what more could be done, you try to improve the response.

The main advantage of an informal approach is that it is quick and low-cost for the organisation, though staff members may be using their own money to help their colleagues. There is less need to consult, to plan, to budget, to raise funds, to monitor. An informal approach also builds on a culture of caring; people help each because they want to, not because a policy says they must.

However, there are also disadvantages to having no written policy:

- people can't be sure of what is expected of them, nor what they can expect;

- the best-liked people get the best response; others, such as those blamed for their infection, may be discriminated against;

- there is no protection against discrimination, for example, colleagues getting different amounts of paid sick leave or days off work;

- those with authority or influence may make decisions which favour them at the expense of the organisation;

- the focus tends to be on care for colleagues who are very sick, rather than putting efforts into prevention and early treatment to prevent sickness from occurring;

- managers do not have any guidance to help them control costs: the organisation may suffer high costs due to staff sick leave, staff away caring for others, or paying out for treatment costs, because no limits have been set;

- prevention activities tend to be irregular, as there is no organisational commitment to running them;

- the practices are dependent on individuals' efforts; when key people leave, the response may cease;

- it's difficult to raise extra funds, and the organisation's efforts are invisible to donors and other stakeholders.

Between an informal and formal approach

There is also a 'half-way' position between an informal approach and a formal written policy. This is to have some written guidance. This could simply describe what your organisation intends to do without making formal commitments.

For example:

- We want staff to protect themselves from HIV infection.

- We aim to provide prevention information and free condoms.

- We aim to treat staff fairly regardless of their HIV status.

- We encourage staff to take care of their health.

- We aim to inform staff about places offering HIV testing and counselling and places offering ART.

- We want to encourage staff to live positively if they have HIV.

- We are proud of our culture of care. We support efforts to help each other in times of need, so long as it does not have too much impact on our work.

This written guidance at least sets out intentions for all to see. However, without commitments and saying who is responsible for what, no one is accountable, so things may be left undone. As the saying goes "everyone's job is no one's job".

You can read more about informal responses to HIV in the workplace in Praxis Note 46 *Who Needs an HIV Policy?* **on this guide's CD or at** www.stopaidsnow.org/cso-tool

A formal approach

Your working group is likely to go for a formal approach if your organisation:

- already has policies about staff terms and conditions including health, in which case the working group's task will be to review and alter those policies;

- is in the process of developing human resource policies, or wants to develop them;

- has enough stability to plan ahead, and expects to stay in business;

- wants to manage HIV by setting things out clearly for all staff to see – their rights and their responsibilities;

- wants or needs to show donors that it is responding to HIV in the workplace.

Note that a formal approach does not mean an end to informal arrangements between staff, such as condolences funds, and acts of kindness.

> **In 2001 we set out some ethical principles to guide our work on HIV within and outside the organisation. They were discussed, and put up on the notice board, but we didn't follow-up. Concrete plans only followed later, when we took a formal approach and made a policy."**

Director of an Indian CSO, correspondence with the author, February 2010.

Some organisations find the term 'policy' a bit scary. We're going to keep using it here, but you could use another word, such as 'guidelines', 'rules', 'principles', 'conditions', 'statement of commitment', or 'position'.

Deciding on the focus of the policy

If your organisation is taking a formal approach, it will also need to decide on the focus of the policy: is it looking at HIV and AIDS alone, or critical illnesses including HIV and AIDS? Or would it be better to focus on promoting good health and well being in general, including HIV prevention, treatment and care?

Table A below sets out the advantages and disadvantages of each approach.

Table A: advantages and disadvantages of focusing on HIV, critical illnesses, or well being

Advantages	Disadvantages
Focus on HIV	
✔ Makes sure we face HIV and its taboos. ✔ Helps us to wake-up to the special case of HIV. ✔ Can be added to existing health policies. ✔ Likely to lead to a more thorough response e.g. efforts to tackle stigma. ✔ Donors may be more willing to fund.	✘ Could lead to unfair treatment of staff with other critical illnesses. ✘ May be inappropriate in places where HIV rates are very low.
Focus on critical illnesses	
✔ Equal treatment for all staff with critical illnesses, including HIV. ✔ Useful where HIV rates are low, or where there is denial about HIV.	✘ Have to consider all critical illnesses, so it's more complicated. ✘ Can mean that we forget HIV don't give it enough attention.
Focus on well being	
✔ More positive approach may be more appealing to staff. ✔ Useful where HIV rates are low, or where there is denial about HIV. ✔ May help us to bring out wider issues such as sexual harassment and gender discrimination.	✘ Much wider focus, so much more complicated (e.g. can raise issues such as low pay and poor office environment contributing to ill health). ✘ Easy to forget HIV. ✘ Donors may be less willing to fund.

For simplicity, in this guide we'll talk about formal HIV policies. If you're going for an informal approach, or one focusing on critical illnesses or well being, you will need to adapt the steps to your needs.

❝ In one CSO where staff were made to contribute to the HIV and AIDS health fund a staff member commented "In this organization you are almost persuaded to be HIV positive, while suffering from diabetes is no one's concern! Those with HIV get preferential treatment and privileges".
For all staff to support HIV initiatives, those with cancer and other serious diseases need to be supported too."

Independent consultant, correspondence with the author, March 2010.

❝ Our policy is incorporated in the HR policy, although we thought it better to have separate deep details... In the HR policy, we talk about the HIV policy in place and some aspects that are general. But then the HIV workplace policy goes into details."

Ugandan CSO, STOP AIDS NOW! applied research (unpublished interview).

Step 4: Find out about the issues in your organisation

Before drafting a policy, it's useful to research the current situation regarding HIV, your staff, and your organisation. By doing so you can get employees thinking and talking about the issues, and use the findings to shape the content of the your policy to manage HIV. The methods outlined here also generate interest in managing HIV and a commitment to doing so. We note, though, that not all CSOs do this step.

Assess the organisation's situation

We feature three assessment methods here. They both involve gathering staff members to stop and think about the organisation and HIV, how capable it is to manage HIV, and what it can do next. The outcomes can be useful to convince managers and the board of the need to manage HIV.

Some CSOs do a **risk analysis.** They use a series of workshops, involving staff from different levels, to tackle four tasks:

1. Learn about HIV as a threat to their organisation.
2. Look at how vulnerable the staff and the organisation are to HIV infection and AIDS.
3. Consider the organisation's strengths and weaknesses in coping with HIV and AIDS.
4. Think about action: what can the organisation do to reduce both the risk of HIV infection among its staff, and the impacts of AIDS on its staff and its work?

IIRR-Ethiopia's HIV and AIDS Risk Analysis Tool is on this guide's CD and at www.stopaidsnow.org/cso-tool. You can also read about their approach in Praxis Note 41 *Catalysing Workplace Responses to HIV*, which is on this guide's CD and at www.stopaidsnow.org/cso-tool

Oxfam Novib has developed the **12-boxes assessment** method. CSOs use it to assess their competence in responding to HIV and gender both in the workplace and in their work. The process generates a list of priorities for action, and increases commitment among staff to address HIV. This assessment takes 3 days, and requires external facilitators.

The 12-boxes facilitators' manual *(Test Your Organisation with the 12-Boxes Framework)* is on this guide's CD and at www.stopaidsnow.org/cso-tool

We've also developed a quick self-assessment framework in relation to managing HIV. Your organisation could use it to identify areas of weakness, and to develop ideas of what to do next. *The Quick Organisational Self-assessment Framework* is on this guide CD and at www.stopaidsnow.org/cso-tool

Ask staff

Instead of an assessment of the organisation itself, you could focus on staff members' knowledge, attitudes, behaviour and practice. If you use a survey, you will get more truthful answers if people know it is anonymous (so no-one can tell how any individual answered).

Ask the right questions and you can find out:

■ Whether staff know about:
- the basic facts of HIV;
- where to get counselling and testing;
- where to get treatment.

■ Whether they hold stigmatising beliefs.

■ How staff feel about:
- the value of HIV testing;
- using condoms;
- whether the organisation is a supportive environment with regard to HIV;
- whether they would feel safe to tell colleagues that they are HIV-positive.

■ The behaviour of staff, such as:
- how open they are to talk about HIV and safer sex;
- whether they have taken an HIV test, and why;
- their sexual behaviour.

You can also, on the form, ask staff for their ideas about what the organisation should be doing to manage HIV.

There's a 20-question anonymous survey which you could use on this guide's CD and at www.stopaidsnow.org/cso-tool. It has a spreadsheet too, to help analyse the results. It uses 8 indicators which relate to managing HIV in the workplace.

The results of the survey will help the working group to identify things which need doing, and things which don't. For example, if staff have good knowledge about HIV, you don't need to run basic awareness workshops. (Instead you could encourage them to post their queries in a box, and then jointly discuss those questions and issues.)

Importantly, the results also create a baseline. You can repeat the survey in a year or two and compare to results. This is one way of monitoring if staff are being positively affected by your organisation's efforts to manage HIV.

If staff in your organisation have access to the internet, you could set up your survey on-line. You can use sites such as http://freeonlinesurveys.com for free, but with limits (up to 20 questions, up to 50 respondents, and everyone must fill in the survey within 10 days). If you pay a monthly fee of about 22 Euros/$30 then there are no restrictions, and you get the results in a spreadsheet.

An alternative to a survey is to have group discussions. These can be a good way to explore issues. People are likely to feel more comfortable to talk in same-sex groups, or with staff of the same level.

Step 5: Draft a policy and talk about it

So, it is time to start thinking, writing and discussing! If this part seems a little scary, please keep these points in mind:

■ You don't have to use lots of technical and legal terms. It's best if you write in plain and local language, which all staff can understand.

■ You are not committing your CSO to what the policy says for ever. State what period the policy covers. At the end of that time, you can make any changes that are needed.

■ Your policy does not have to be 100% comprehensive 'best practice'. Strive for 'good practice', and make sure your policy fits your organisation. Don't promise things you can't fulfil.

■ Don't be afraid to ask for help. Maybe you could get some help from another CSO nearby which has already been through the process?

There's a list of organisations involved in the STOP AIDS NOW! project on this guide's CD and at www.stopaidsnow.org/cso-tool. They, and other organisations, may be able to help you.

■ Use existing resources and avoid duplicating effort. You may not need to make your own HIV leaflets, or to set up counselling services within your organisation.

■ Don't feel you have to do everything all at once. You can do things in phases.

A policy which fits
It's really important that your policy fits your organisation and its context. This means:

Thinking about costs from the start
What can your CSO afford in terms of **time** and **money**? How much time will these activities take? Are services available locally for free? Can staff make a contribution? Would your donors give extra funding? How can you integrate the costs and include them in future grant applications? What will you do if a donor pulls out?

It really helps if you do your budget in a spreadsheet. So long as you have put the formulas in correctly, the sums will always be accurate. It also makes it easy to change things (e.g. 'what if we budgeted for twice as much counselling & testing?') and see the effect on the total cost.

For more about what makes a good budget, see section 5 of 'What's it Likely to Cost: a Guide to Budgeting for Managing HIV and AIDS in the Workplace' on this guide's CD and at www.stopaidsnow.org/cso-tool

❝ ...unlike other organisations that do a copy and paste - we had a very, very consultative process to develop the policy. So I am very proud of the fact that it is developed by the staff and used by the staff. And therefore they own it."

Ugandan CSO Focal Point, STOP AIDS NOW! applied research (unpublished interview).

❝ We have a fear of the unknown – if we go this way, shall we find the money to cover this? We do not want to promise the moon in developing a policy, which we cannot then deliver."

CSO manager, Praxis Paper 13, www.intrac.org

Fitting in with your country's laws
Your employees' terms and conditions need to fit with national labour laws and any HIV legislation. You could refer to your national HIV policy frameworks, or check with other CSOs about this.

Fitting in with other policies within your organisation
There should not be any conflict between policies, especially policies that relate to staff welfare.

Who to involve

Staff members and volunteers

If staff are to 'own' and use the policy, they need to be able to discuss, agree on and accept it. Do this by meaningfully involving them in the process. Debating the issues is important to get people talking and thinking. For example, 'What level of confidentiality do we need and how will we achieve it? Do we include family members or not? Do we give support to staff members' orphaned children? What are the cost implications, and can we afford and justify them?' Make sure everyone is able to comment on the draft policy, and to discuss what is and isn't included.

You might be tempted to skip the process of discussing the policy. But by talking, everyone can appreciate that managing HIV is not only about meeting staff needs, but also about making sure the organisation can do its work well. Equally, it is not only about employees' rights, but also about their responsibilities. The process should also create a positive feeling among staff.

People living with HIV

For effective responses to HIV we also need to meaningfully involve people who living with HIV. Why? Because people who know they are HIV-positive:

- may find it hard (due to stigma) to influence what is in the workplace policy unless you make the effort to involve them;
- have particular perspectives and experiences, which can improve the policy;
- can be very effective in influencing others by sharing their experiences - for example, on the benefits of testing or treatment;
- reduce stereotyping and stigmatisation of people living with HIV by being present and involved in discussions;
- can also shape and improve the organisation's response to HIV in its work.

66 **Condom provision and use was a contentious issue because we are a religious organisation. However, we brought someone in with Christian values to convince staff and management of the need."**

Ugandan CSO Focal Point, STOP AIDS NOW! Applied Research (unpublished interview).

66 **Our HIV Coordinator is HIV-positive, as well as some of the nurses and a driver, and all play important roles in our HIV activities. The driver, for example, is one of the most active in the peer club, helping distribute condoms whenever we go out to communities."**

Ugandan Medical CSO, Addressing HIV and AIDS in Ugandan CSOs, 2009, STOP AIDS NOW!

www.stopaidsnow.org/downloads

Your organisation could involve its own staff members who are known to be HIV-positive, or it could collaborate with a CSO with openly HIV-positive employees or members. Many of the CSOs in STOP AIDS NOW!'s Uganda project networked with organisations of people living with HIV.

Donors and service providers
If your organisation will need donor funding to implement its policy, it will need to open up dialogue with its donors too.

Use Chapter 1 of this guide to persuade your donors of the value of managing HIV in the workplace. Tell them about *HIV in the Workplace: 20 Ways for INGOs to Help Partners,* and *Good Donorship in a Time of AIDS* (on this guide's CD and at www.stopaidsnow.org/ cso-tool). These documents describe what other donors are doing.

As part of estimating costs you'll also need to talk to service providers. Do you need to make any special arrangements so that your staff can access other organisations' services? Find out what the possibilities are, and discuss the options with staff.

If people tested now and found out that they are positive they would be able to come out very openly. Because we had a staff who tested positive and was really a very good advocate and encouraged people to test and let others know about their HIV status."

Ugandan CSO, Addressing HIV and AIDS in Ugandan CSOs, 2009, STOP AIDS NOW!
www.stopaidsnow.org/downloads

Following key principles

When drafting your policy, be sure to follow the 10 principles which the ILO set out in its *Code of Practice on HIV/AIDS and the World of Work:*

1. A workplace issue	**6. No screening for purposes of employment**
HIV and AIDS are a workplace issue because they affect the workforce, and because the workplace can play a vital role in limiting the spread and effects of the epidemic.	Testing for HIV at the workplace should be carried out as specified in the Code, should be voluntary and confidential, and never used to screen job applicants or employees.
2. Non-discrimination	**7. Confidentiality**
There should be no discrimination or stigma against workers on the basis of real or perceived HIV status - casual contact at the workplace carries no risk of infection.	Access to personal data, including a worker's HIV status, should be bound by the rules of confidentiality set out in existing ILO instruments.
3. Gender equality	**8. Continuing the employment relationship**
More equal gender relations and the empowerment of women are vital to preventing the spread of HIV infection and helping people manage its impact.	Workers with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.
4. Healthy work environment	**9. Prevention**
The workplace should minimize occupational risk, and be adapted to the health and capabilities of workers.	The social partners are in a unique position to promote prevention efforts through information, education and support for behaviour change.
5. Social dialogue	**10. Care and support**
A successful HIV and AIDS policy and programme needs cooperation and trust between employers, workers, and governments, and the active involvement of workers infected and affected by HIV and AIDS.	Workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

Principles 1 to 8 are the foundations of any response. The question of what shall be in your policy mostly applies to principles 9 and 10, concerning prevention, and treatment and care. For more about your options, and the relative costs of different activities, see Figures 2 and 3 in Chapter 3.

The ILO's *Code of Practice on HIV/AIDS and the World of Work* is on this guide's CD, in English, French and Spanish.

❝ On the issue of condoms, we had a lot of debate…. those who don't believe in condoms were like "Hey! What are we promoting? We are promoting immorality!" And others were saying that this is a problem which is with us…. we have to try to sensitize people – we are not saying that when we put them there, so everybody go and get one and try it on and make use of it …we are just saying "Just in case you need it, at least you have it". Then we had to overcome the issue of where to put them…"

Ugandan CSO Focal Point, STOP AIDS NOW! Applied Research (unpublished interview).

Why manage?

How to develop?

What to do?

Who will be included in your policy?

In this guide we have referred to 'staff members' as being the people who benefit from your organisation's policy. Within that category your organisation will need to decide how to handle salaried staff and staff on short-term contracts. It may also want to include others too:

Volunteers

If your organisation relies on volunteers, are there ways you could include them in some parts of your policy? For example, can they take part in awareness raising and other sessions? Can you channel information to them about how to access HIV testing and treatment? Can you supply them with condoms, or include them in anti-stigma training?

Family members

Many organisations include family members in awareness raising activities and HIV testing events, such as family picnics. This is not expensive, and is often an easy thing to agree on.

❝ In our organisation, we found it difficult to talk to our adolescent children about sexuality and their HIV vulnerability. We also wondered if our children would find it easier to ask questions of someone other than their parents.
We gathered all our teenagers and a staff member with grown-up children did the facilitation. It worked!
Having a workplace policy not only helps staff but our families too…"

Director of an Indian CSO, correspondence with the author, January 2010.

However, the question of whether to include family members in private health benefits is much harder. Indeed, CSOs in the STOP AIDS NOW! project in Uganda found it to be one of the most difficult issues to discuss and agree upon.

All of us want the best for our families. So if our employer is paying for benefits for us, we would like our family members to have those same benefits too. This seems fair. However, we also know there are limits to what our organisations can afford. In some situations staff members have a lot of dependants. They may include more than one spouse, their own children, and other children for whom they have responsibility.

In terms of your organisation's productivity, there are some good reasons for giving family members health benefits:

- staff will spend less time away from work looking after sick relatives;

- staff are less likely to get their relatives' infections e.g. TB and HIV (because ART reduces the amount of HIV in someone's blood);

- staff are less likely to share medication with relatives (this causes their own treatment to be ineffective and, with ART, leads to drug resistance and the need for more expensive second line drugs);

- staff will have less guilt, and better morale, knowing that their family members can get the same treatment as them.

If your organisation plans to link staff to free treatment, it can make arrangements for family members also to get free treatment. If your organisation opts to pay for staff treatment, it may have to compromise over what it can offer family members. Some organisations offer no health benefits to them, or lesser benefits. Others restrict how many relatives are included: for example, one spouse plus three children. Another strategy is to share the cost with staff members. There's much more about different ways of giving health benefits to staff and family members in Table E in Chapter 3.

Finally, many CSOs face the issue of what to do about the orphans of deceased staff members. This is not part of managing HIV, because paying for orphans' school fees does not help protect the organisation's productivity. Indeed, the expense will be an on-going cost for the organisation. You organisation has to decide what to do, depending on its culture and ability to meet such costs.

66 A big discussion was "Who should the policy cover?" It was clear that okay, the staff first. What about other dependants of a staff? ... most people agreed that four dependants should be catered for. Then the other thing was "Can these members be catered for if the staff finally dies of the problem?..."

Ugandan CSO, STOP AIDS NOW! Applied Research (unpublished interview).

Why manage?

How to develop?

What to do?

Step 6: Agree the policy and turn it into action

A common problem is that the process of drafting the policy and its budget may take a long time. Try not to let it drag on! (But also, do not rush the parts where you are involving employees.) It can help to keep your board informed throughout the process, to reduce the chances of delay in getting their approval.

While the process is happening, you may feel that you cannot get on and do anything about HIV. This is not true. Organisations taking an informal approach do everything without a policy! If your policy has not been finalised, you could make a start with some low-cost activities such as awareness raising.

Once the policy is agreed, what next? We know that medicine can only help us if we take it. It doesn't help us just by existing. It's the same with the policy. It won't help if it just sits in a file. At this step you need to:

■ Make sure everyone knows what is in the policy. All staff need to know what is expected of them, and what they can expect. Do you need to translate the policy into a local language? Or make a short-and-simple version? Or tell people about it rather than expect them to read a written document? How will you ensure new members of staff know about HIV and the policy?

■ Make an action plan. Perhaps you can do this in a participatory way. For every item, discuss and decide who needs to do what, by when? Here's a simple example of an action plan for the first few months of implementing a low-cost policy:

Table B: Example of the first few months of an action plan

Activity	Who	What	By when	Monitoring
Provide condoms to staff	Florence	Order 3 cases from Ministry, and follow-up as necessary	March 26	
	Gabriel	Collect cases from Ministry	within 3 days of notification	
	Florence & John	Keep a weekly tally of the number of condoms taken, and ensure that condom baskets are refilled	on-going	Give figures to Molly at the end of each month
	Florence	Reorder when first 2 cases are used up	on-going	
	Molly	Investigate options for getting female condoms	April 14	Molly discuss findings with Isaac
Run a workshop on HIV stigma	George	Fix a date with People Living with HIV and AIDS Network for the workshop	March 28	
	George & Molly	Make preparations including promoting the workshop to staff	April 10	
Provide staff with information on counselling & testing services	Peter	Research existing options, (including ask XYZ as they have a leaflet on this for their staff)	April 28	Peter presents findings to Molly

> 66 **For dissemination, everybody got a copy - we discussed it together, we revised it, and everybody got a copy as well. So that is in everybody's heart."**
>
> Ugandan CSO, STOP AIDS NOW! Applied research (unpublished interview).

Step 7: Learn from what happens

Learning from what happens is important for two reasons.

First, if you learn and respond to what you find out, you'll get better at managing HIV. This means your organisation will benefit more from the policy and its activities.

Second, you are more likely to sustain activities if you know they are helping the organisation. If you have no evidence then staff may become fed-up, and donors are less likely to want to help.

How will you do this learning? Well, how does your organisation usually learn? Do you already have a monitoring and evaluation system, which you can add to? Or will you need some new steps? Here are some ideas of the kinds of things you might do:

Table C: monitoring and evaluation ideas

Learning about...	Ways of finding out
...if the policy is being implemented.	- Check if activities are carried out as planned. - Track expenditure against what was budgeted.
... changes in staff members' knowledge, attitudes, and behaviour in relation to HIV and to the policy.	- Do a confidential survey once a year (there's one you could use on the CD which came with this guide).
... whether staff know about the policy, and how satisfied they are with its implementation.	- Do a confidential survey.
... changes in staff sick leave and staff turnover.	- Keep records, and analyse the results each year.
...if the activities are effective.	- Ask participants the same questions before and after an education session, to see if their knowledge or attitudes have changed. - Monitor the number of condoms taken. - Keep track of staff use of HIV services – but only if it's possible to do this without revealing who was involved.
... if the organisation is supporting HIV-positive staff effectively.	- Anonymous feedback forms, where staff rate the services they are using. - Where possible, get feedback from HIV-positive employees about their experiences.

If your organisation has enough staff, it's useful to look at the data for different groups of people. For example, there may be interesting differences if you compare the data for male and female staff, or for senior and junior staff.

Of course, the important part about this step is to make good use of what you learn. What changes can you make to deal with any problems, or to get further improvements? For example, if stigma has reduced but testing has not gone up much, could you run a special event to encourage staff to test?

Your policy should be in force for a time period; towards the end of it you can use your learning to make any changes that may be needed. You can also check if anything has changed – such as the availability or costs of services - which mean you should change the policy. For example, if free ART is

newly available locally, you may decide to change what's in your policy.

Finally, on the topic of learning, remember that you can learn from others' experiences, and they can learn from yours.

Look out for updates about the 'linking and learning' part of STOP AIDS NOW!'s project supporting CSOs to manage HIV in the workplace at www.stopaidsnow.org/our_work_article/workplace

> 66 **In our organisation we managers take an active role. Rather than thinking "I cannot say anything unless he comes to me to talk" we approach employees who are showing signs of not being well. We also encourage staff to tell each other their HIV status. Instead of total confidentiality we have shared confidentiality - the information is known within the organisation, but not spoken of (without permission) outside."**

Director of a Zimbabwean CSO, personal communication with the author, May 2009.

Chapter 3:
What will your organisation do to manage HIV?

Policy options

Just as there's no single way to develop your policy, there is no single way to manage HIV.

In Figure 2 we've set out some of the things that your organisation could put in its policy concerning prevention, treatment and care. We've also listed changes in human resource management that help to reduce the impacts of AIDS on organisations.

You may decide to only do some of these things. You might also use a phased approach. For example, beginning with awareness raising and addressing stigma, and bringing in other elements later.

Figure 2: Possible features of your organisation's policy

Prevention: set out how the organisation will:
- tackle stigma in the workplace;
- inform staff about HIV prevention, **HIV counselling & testing**, positive living, care and treatment;
- create a safe and supportive environment;
- support staff to change their sexual behaviour to reduce their likelihood of HIV infection;
- motivate and help staff to get male and female condoms, counselling & testing, treatment for sexually transmitted infections, and treatment to prevent HIV transmission from mother to child;
- enable medical (and other) staff to get **HIV-PEP** if the need arises;
- reduce and deal with cases of sexual harassment and sexual trading;
- encourage a culture of safer sexual behaviour and staff taking care of their health.

Treatment and care: set out how the organisation will:
- motivate staff to seek treatment;
- help them to get treatment and to continue with it;
- help them to get support and care, such as counselling and legal advice;
- if needed, adjust the working conditions of HIV-positive staff members.

Reducing impacts: commit to human resource management changes which will reduce the effects of AIDS on the organisation:
- make sure that new staff learn about HIV and the workplace policy;
- set out and enforce how much leave staff are allowed;
- alter ways of working to reduce the effect when someone is off work;
- find ways to speed up recruitment and on the job training of new staff.

HIV counselling & testing (HCT) is a step on from VCT (voluntary counselling and testing). It emphasises risk reduction plans for those who test HIV-negative. For people who test HIV-positive, HCT makes the necessary referrals e.g. to TB screening, a CD4 test, treatment for opportunistic infections, pre-ART management and on-going counselling.

HIV-PEP is a four week course of anti-retroviral treatment, taken when someone has been exposed to HIV. It can only be taken by people who are HIV-negative, and may not prevent them from becoming HIV-positive.

HIV-PEP's effectiveness is related to how soon after the event the ART drugs are taken, and whether the person takes the drugs (which have severe side effects for 1 in 4 people) correctly.

HIV-PEP is mainly recommended for health workers, but some organisations make PEP available when a staff member has been raped, or had a one-off exposure to HIV-infected blood.

Staff can support each other, and use outside services to get support

Ideas for activities, and their relative costs

The activities you do will be shaped by the commitments in your policy. Here are some ideas, and a very rough sense of the relative costs of different activities.

Figure 3: activities to manage HIV and their relative costs
Prevention

< lower cost   **higher cost >**

give out leaflets on HIV & AIDS	run education sessions for staff	train some staff as peer educators
keep updating staff on HIV	have same-sex discussion groups for staff to talk over issues	run family HIV testing days
tell staff and family members where they can get condoms, counselling & testing, HIV-PEP, and treatment for STIs	run workshops about stigma	run education sessions for family members
tell staff how they can prevent mother to child transmission of HIV	provide condoms	pay or share the costs for staff and family member to get counselling & testing, HIV-PEP, treatment for STIs and treatment to prevent mother to child transmission
	set rules to stop sexual harassment and sexual trading in the workplace	

66 **You can have a policy without having to spend much money, because you can link up and build networks with service organizations that do not require money, or only little for lunch."**

Ugandan CSO, Addressing HIV and AIDS in Ugandan CSOs, 2009, www.stopaidsnow.org/downloads

Treatment & care

< lower cost   **higher cost >**

put-up anti-stigma posters

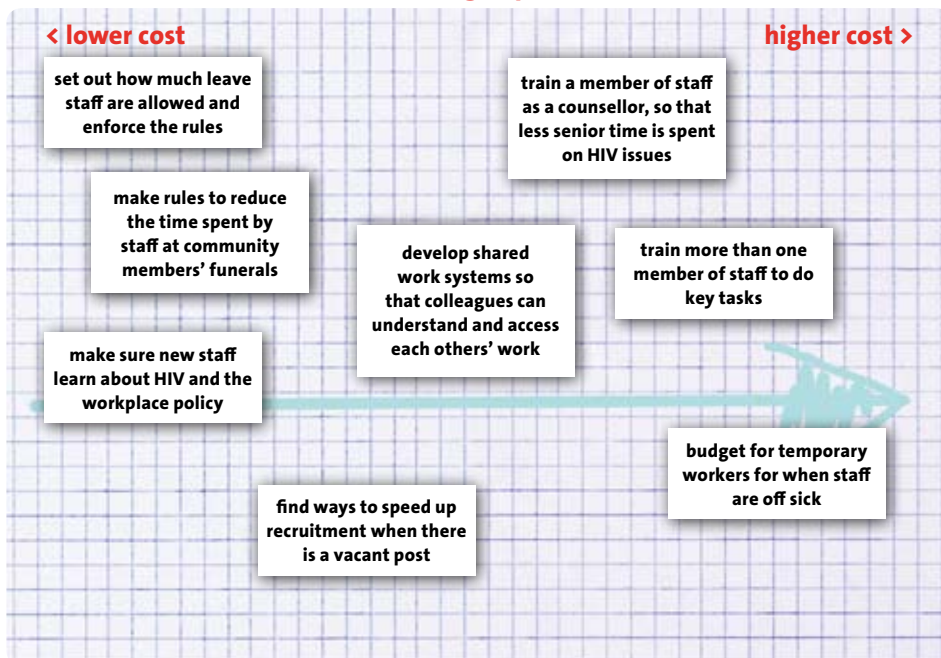make rules about non-discrimination and enforce them

hire staff who are HIV-positive

run workshops about positive living

help staff to get support such as counselling and legal advice

alter workloads if needed for HIV-positive staff

motivate staff to seek help for health problems

provide a healthy work environment, including food

tell staff and family members where they can get free treatment

pay for, or share costs with, staff to get treatment for opportunistic infections

pay for, or share costs with, staff to get private ART

Reducing impacts

< lower cost   **higher cost >**

set out how much leave staff are allowed and enforce the rules

train a member of staff as a counsellor, so that less senior time is spent on HIV issues

make rules to reduce the time spent by staff at community members' funerals

develop shared work systems so that colleagues can understand and access each others' work

train more than one member of staff to do key tasks

make sure new staff learn about HIV and the workplace policy

budget for temporary workers for when staff are off sick

find ways to speed up recruitment when there is a vacant post

For all these activities, please be alert to the gender issues. In general, female members of staff are likely to be more affected. However, male gender roles may lead male staff members to take risks. Men who have sex with men and transgendered people are especially likely to be stigmatised, and to lack relevant information and access to services.

Many people, including CSO employees, discriminate against people with alternative sexualities. To learn more about this issue and its link to HIV, read Oxfam's *Break Another Silence: Understanding Sexual Minorities and Taking Action for Human Rights in Africa*. It's on this guide's CD and at www.stopaidsnow.org/cso-tool

Creating health seeking behaviour

We will not, in this short guide, go into detail about each of the above activities. Instead, we focus here on the overall goal of encouraging staff to know their HIV status and to seek HIV treatment when they need it. In particular, we look at reducing stigma and HIV testing initiatives.

To manage HIV in the workplace, we all ideally need to:

- understand and accept the basic facts about HIV transmission and AIDS;

- know that condoms give protection against HIV infection;

- reject myths about HIV and AIDS;

- know our HIV status;

- believe that ART is the most effective medical treatment (compared to e.g. herbal therapies, charms and spiritual responses);

- be motivated to stay HIV-negative if we are HIV-negative;

- be motivated to stay healthy if we are HIV-positive, to start treatment when necessary, and to take the drugs correctly.

We all also need a work environment in which we:

- can talk about HIV without fear of stigma;

- will be supported if we or our family members are HIV-positive;

- believe that our HIV status can be kept confidential, if that is what we want;

- can get HIV services including treatment;

- are supported to keep working, including altering our tasks if necessary if our health deteriorates.

Addressing stigma in the workplace

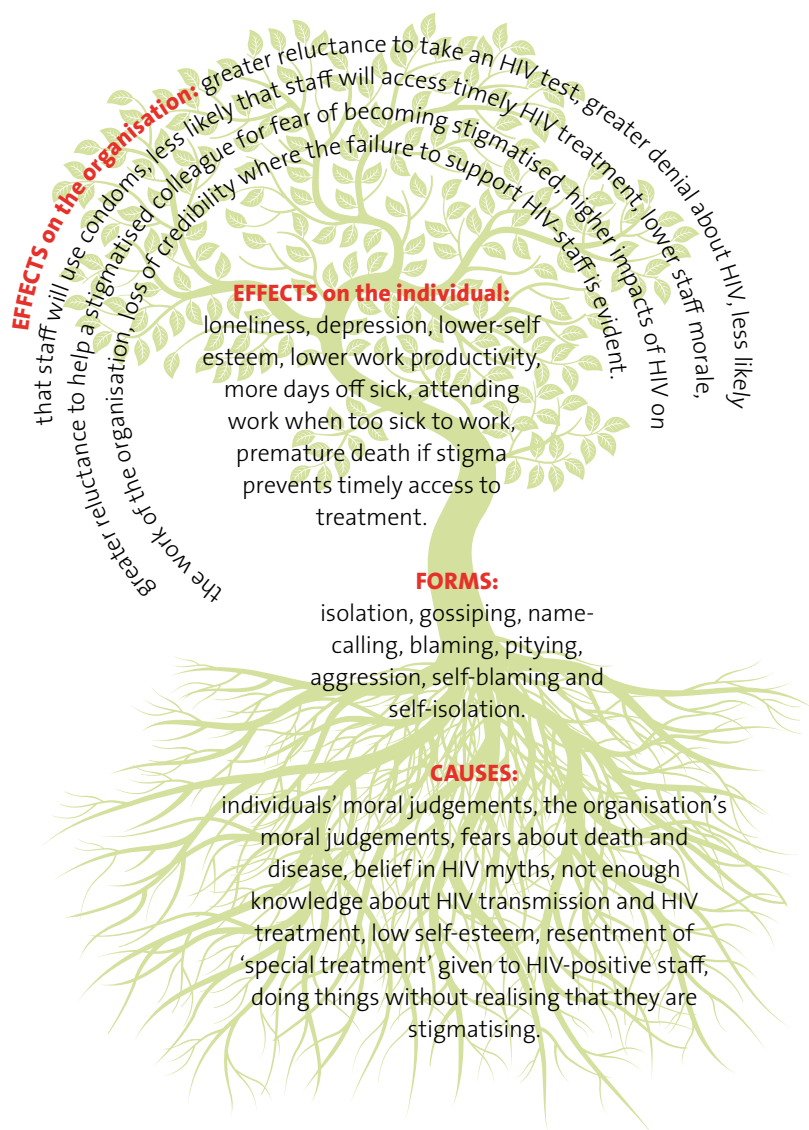We often talk of stigma, but what does it mean?

- Stigma is an invisible label which we attach to someone, and which discredits them.

- There's also self-stigma. This refers to the negative labels that we attach to ourselves.

- Finally there is fear of stigma. The fear may or may not be well founded.

Stigma devalues people. It is often followed by discrimination, where people are treated unfairly based on their real or perceived HIV status.

Figure 4: the causes and effects of stigma in the workplace.

EFFECTS on the organisation: greater reluctance to take an HIV test, greater denial about HIV, less likely that staff will access timely HIV treatment, lower staff morale, higher impacts of HIV on the work of the organisation, loss of credibility where the failure to support HIV staff is evident. greater reluctance to help a stigmatised colleague for fear of becoming stigmatised, less likely that staff will use condoms,

EFFECTS on the individual:
loneliness, depression, lower-self esteem, lower work productivity, more days off sick, attending work when too sick to work, premature death if stigma prevents timely access to treatment.

FORMS:
isolation, gossiping, name-calling, blaming, pitying, aggression, self-blaming and self-isolation.

CAUSES:
individuals' moral judgements, the organisation's moral judgements, fears about death and disease, belief in HIV myths, not enough knowledge about HIV transmission and HIV treatment, low self-esteem, resentment of 'special treatment' given to HIV-positive staff, doing things without realising that they are stigmatising.

Why manage?

How to develop?

What to do?

Stigma in its different forms is very powerful. Powerful enough to stop many of us from going for an HIV test. Powerful enough to prevent people from seeking treatment, and so dying, for fear of being identified as HIV-positive. And powerful enough to block our efforts to manage HIV the workplace, as shown by the following case study:

Stigma blocking the take-up of HIV testing and treatment
At a time when ART was not available through public services, ACORD's Northern Uganda Project implemented a workplace policy. Among other things, it included free counselling and HIV testing, and paying for 80% of the cost of ART. There was strong evidence that several members of staff were HIV-positive. Yet in the first year, no one used the policy to test or to get treatment. Indeed, one member of staff died of AIDS.

A survey and staff discussions revealed that fear of stigmatisation was the main reason that staff would not take up the policy's benefits. Their fear was well grounded. Of the survey's respondents:

- One third thought new staff should be tested for HIV;

- 12% thought staff who were HIV-positive should be retired;

- 55% believed AIDS to be the result of immoral behaviour;

- Half disapproved of married couples using condoms;

- Half had witnessed discrimination against people living with HIV, and all had heard very negative conversations about them.

Significantly, as policy implementation had not been happening for long, two thirds of the respondents had not been to awareness raising sessions on HIV.

ACORD responded by first making sure that all staff attended sessions about HIV transmission, treatment and care. They also brought in a system where staff could ask a question anonymously, for discussion at the weekly staff meeting. These actions were aimed at dealing with stigma based on inaccurate information. They then made HIV testing available to their staff in the main part of the hospital, rather than at the HIV unit, as this was more acceptable to them.
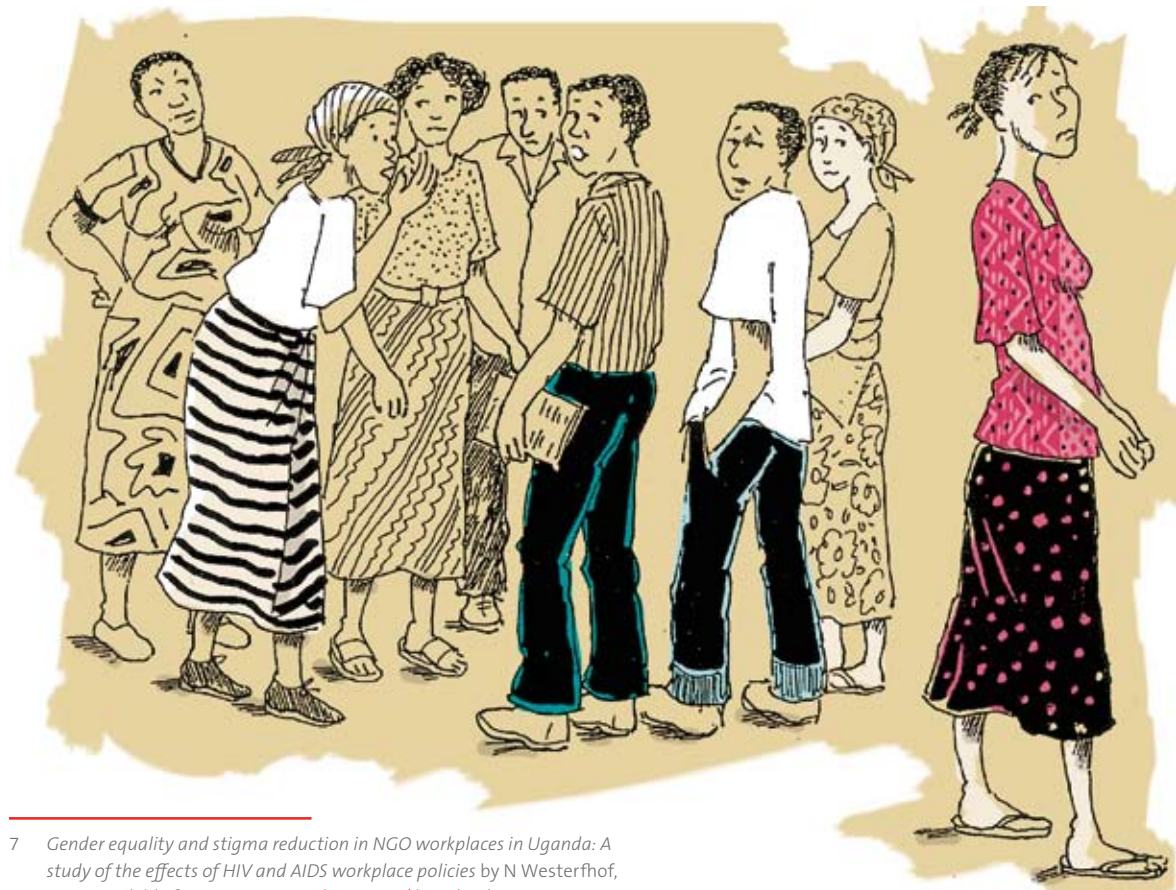
7   *Gender equality and stigma reduction in NGO workplaces in Uganda: A study of the effects of HIV and AIDS workplace policies* by N Westerfhof, 2009, available from www.stopaidsnow.org/downloads

These measures soon led to two staff testing and disclosing their status, and one beginning ART. The rate of condom use also rose, and staff became able to talk about HIV and AIDS more openly.

Stigma is present in our communities, but it can also be generated within our organisations. For example, within CSOs dedicated to doing AIDS work in the community, it is easy for staff to stigmatise HIV-positive colleagues. Because the staff are experts on HIV, people can be judgemental on the basis that "they should have known better".

The values of some faith based organisations can cause stigma. Many do not recommend use of condoms to their staff, believing that doing so would 'encourage immoral behaviour'. This logic links having HIV with sinful behaviour. Other faith based organisations use a different logic which allows them to talk about condom use and to give out condoms within discussions of all the options for HIV prevention.

Another example: one Ugandan CSO had a code of conduct which stated that any employee who has sex outside of marriage will be sacked[7]. This indirectly conflicted with the same CSO's workplace policy of supporting and giving job security to HIV-positive staff. In Uganda HIV is mostly transmitted through sex, so the organisation's values stigmatised HIV-positive people, and probably reduced the willingness of employees to disclose their status.

What can we do to address stigma? A research project in Ethiopia, Tanzania and Zambia found that these five actions are important:

- Get everyone to recognise what stigma is, and to develop a shared language for talking about stigma.

- Get everyone to understand that its effects are bad not only for particular staff members, but for everyone and the organisation itself.

- Help everyone to really understand the facts about HIV and HIV treatment, and so reduce fear among staff.

- Create safe spaces where staff can discuss the values and beliefs about sex and death which are among the roots of stigma. Some of these may be held as organisational values.

- Involve people with HIV in the process.

To do these actions, use the modules from *Understanding and Challenging Stigma: A Toolkit for Action* which are on this guide's CD, or you can download them from www.icrw.org/html/projects/stigma.html. You can also order a free hard copy of the toolkit from www.aidsalliance.org/Pagedetails.aspx?id=217

Workplace initiatives to know your status

Many of us are reluctant to take an HIV test, so the majority of people who are infected with HIV do not know.

Yet it's much better if we know our HIV status, particularly if treatment is available. With the right support, the knowledge can empower us to look after our health better, and so be more productive in the workplace.

■ If we find ourselves to be HIV-negative we can develop more determination to try and stay negative.

■ If we are HIV-positive but without symptoms, we can take steps to minimise future illnesses, reduce side effects of medication, and extend our life expectancy. We can do this by taking drugs which reduce the likelihood of opportunistic infections, by eating healthily, and by having regular blood tests, so that we begin ART before HIV badly damages our immune systems. We can also take care not to transmit HIV to our sexual partners or our future children.

■ If we find ourselves to be HIV-positive and with symptoms we can begin ART if medically required and/ or treatment for opportunistic infections. We can also be careful not to transmit the infection to others.

With regard to costs, it's much cheaper to treat HIV-positive employees who have tested for HIV compared to those who do not have the diagnosis. Research with companies in Zambia found that it cost on average seven times more to treat the opportunistic infections of employees who should have been on ART[10] .

So, what can your organisation do? It could encourage its staff to go for testing simply through information – give them a leaflet. It could do a little more by having a session on why it's worth getting tested. This is fine. (It may also be the most suitable response in low-prevalence settings where only a fraction of a percentage of staff members are likely to be HIV-positive.) But a more effective method is to offer counselling and testing in your workplace.

> **ART certainly extends lives on average, but people on ART can still die. A review of ART programmes in 13 sub-Saharan countries found that 10 months after starting treatment, around 10% of the patients had died[8].**
> **However, the risk of dying is much higher among people who begin ART in the clinically advanced stages of HIV infection with low CD4 cell counts, compared with those who begin ART earlier[9].**
> **It's better if we find out our HIV status before HIV infection is advanced.**

Your organisation can help its staff to know their status

The benefits of on-site counselling & testing

A study involved 22 Zimbabwean businesses. They promoted HIV testing in two different ways, but with all businesses offering the same package of HIV care to anyone testing positive.

Half of the businesses offered all their staff a voucher to use at a chain of counselling & testing clinics. 19% of the staff took a voucher, but only a minority reported using them. Just over 4% of the workforce tested.
In the other half of the businesses, staff were told they could visit their company's own clinic for counselling & testing. 51% of them did this!

On average for all the businesses, around 19 people in every 100 were HIV-positive. With the voucher method only one of those 19 discovered their status, and so got care, while with on-site testing half of them did[11].

Of course, unless you work for a medical institution, your organisation will not have an on-site clinic. Instead you can hold a one-day event where the testing clinic comes to your workplace. In Uganda ACORD has been running family testing days:

- One organisation hosts the event, but staff and their families from several nearby NGOs are invited. Sometimes community members come too.
- An approved counselling & testing provider is responsible for the technicalities.
- The day begins with music, a drama performance, and testimonies from people who have taken an HIV test. Stewards organise games for the children.
- People split into peer groups by age and sex for knowledge sessions, pre-test counselling, and clarification on the process.
- During the day participants can have food, pick up condoms and information materials, and go for an HIV test if they choose to.
- They get their result and post-test counselling – individually or as a couple, depending on their preference - later in the day.
- Between about 55% and 85% of adults who attend the events take an HIV test.
- The total cost per participant (including HIV testing technical inputs, refreshments, drama performance, speakers, transport, and hire of chairs, tents and public address system) is around $10.

> 66 **It is very interesting to see the overwhelming turn up of fellow staff family members at this event. We have all the time known that such services are provided at the hospital (which is a stone throw away), but few of us have ever bothered to attend."**
>
> Ugandan CSO staff member, Praxis Note 44, www.intrac.org

8   *Patient Retention in Antiretroviral Therapy Programs in Sub-Saharan Africa: A Systematic Review*, www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0040298

9   *Mortality of HIV-Infected Patients Starting Antiretroviral Therapy in Sub-Saharan Africa: Comparison with HIV-Unrelated Mortality*, www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000066

10 *The Costs and Benefits of HIV Workplace Programmes in Zambia*, HLSP Insititute, 2009, free download from www.hlspinstitute.org

11 *Uptake of Workplace HIV Counselling and Testing: A Cluster-Randomised Trial in Zimbabwe*, www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030238

We note that the cost in relation to the benefits of family testing days depends partly on the prevalence of HIV in the locality. In all settings the participants benefit from learning about HIV and HIV testing. Those that test also find out their status. But the benefits are greater in high prevalence settings in two ways. First, a greater proportion of participants discover they are HIV-positive. Second, the participants who test negative are at greater risk of getting HIV in the future, compared to people in a low-prevalence setting. In terms of managing HIV, it's very useful that they get post-test counselling about how to prevent HIV infection and to stay HIV-negative.

You can find out about running a workplace testing day in Praxis Note 44 *Customised Family Testing Events*, which is on this guide's CD and at www.stopaidsnow.org/cso-tool

Family events include testimonies and drama

A different approach is to make it compulsory for staff to attend an awareness raising session, and to go for counselling about testing. The final step – whether or not to actually get tested – is for each individual to decide. When used by organisations which provide HIV treatment, this method leads to around 80% of staff opting to take an HIV test. This high level is achieved because when people have the correct information and have had time to discuss the issues, they generally see the value in knowing their status[12].

12 www.careafrica.info/care4/presentations/Monday/ Harry_Lake_-_Workplace_programmes.ppt#285,63

Financial considerations

A low-cost response

All the activity options in Figure 3 need at least some staff time, but many of them need little or no money.

For a low-cost approach, be sure to:

- address stigma, so that people are more likely to use HIV services;
- use free resources – for example, leaflets, posters, male and female condoms;
- use free or low-cost services – for example, counselling & testing, treatment for sexually transmitted infections, and ART;
- swap services with AIDS-specialist CSOs – for example, they run a session about stigma for you, and you help them with something your organisation is good at;
- motivate staff to protect themselves and to seek counselling & testing and treatment;
- give staff good up-to-date information about where they can go for services;
- create a supportive atmosphere in your workplace.

Budgeting for your policy

It's important to be thinking about the costs and what your organisation can afford from the start. This will help avoid raising unrealistic expectations among staff. You'll also be less likely to waste time developing plans for activities which are unlikely to happen.

While budgets focus on financial costs, you should also think about staff time. Your employees need to have enough time to implement and take part in the activities.

Many of the activities and items in Figure 3 are easy to budget for. This is because they are one of the following:

- free (for example, giving out free condoms, or making a rule about employees attending community members' funerals);
- low-cost (such as counselling and testing, where it won't matter much if you over- or under-budget for them);
- familiar (for example, you already know how to budget for workshops);
- have a fixed price (for example, to budget for health insurance, multiply the price by the number of people).

The item which is trickiest to budget for is paying for private treatment, because this is both difficult to estimate and expensive. Under-budgeting for this item also has serious consequences for staff who need to start or to continue treatment.

❝ In STOP AIDS NOW!'s Uganda project, 89% of CSO staff knew where to get ART. When asked where they would prefer to get ART, only 15% preferred private services. 48% preferred free ART from other CSOs, while 35% preferred free government services.❞

Implementation and Effects of HIV and AIDS Workplace Policies in Ugandan NGOs in the STOP AIDS NOW! project, 2009, www.stopaidsnow.org/downloads

You can learn about how other CSOs have managed to keep their costs low form the Praxis Note Low Cost HIV and AIDS Workplace Responses: Experiences form Ethiopia, India and Uganda. You can find it at www.intrac.org/pages/en/praxis-notes.html

To roughly budget for private treatment costs, you'll need to:

■ Decide what percentage of the workforce (and family members, if you are including them) is likely to be HIV-positive. You could use the national HIV prevalence rate, the rate for urban or rural areas, or another rate. It will depend on your sense of how susceptible your staff are to HIV infection compared to the general population.

■ Estimate how many of those people are likely to need ART. A general rule is that 13% of those who are HIV-positive need to begin treatment each year[13] . However, you might use a higher figure, say 25%, to avoid under-budgeting[14] . There might be a rush of people taking up treatment in the first year or two of the policy, particularly if you are successful in encouraging staff to find out their HIV status.

■ Estimate the cost per person of treatment for opportunistic infections such as TB, and of ART.

■ Include a bit extra (a 'contingency') to cover unforeseen expenses.

■ Remember that the costs will build up. If you assume that 25% of the HIV-positive people start treatment in the first year, you must then add in another 25% in the second year, and so on.

Table D, below, gives an example of a very rough calculation. You could make it more sophisticated. For example, include a 'treatment take up' rate, because not everyone who needs treatment will necessarily access it through your organisation's policy. You could factor in the costs of other illnesses, if your organisation's policy is not limited to HIV-related illnesses.

Table D: Estimating HIV treatment costs over three years

	Year 1	Year 2	Year 3
Number of people eligible for assistance	40	40	40
% of them who are likely to be HIV+	10%	10%	10%
Estimate of number of HIV+ people	4	4	4
% of HIV+ people likely to need treatment	25%	25%	25%
Estimate of number needing to begin treatment	1	1	1
Plus those on treatment in previous year	0	1	2
Total people needing treatment	1	2	3
Estimated annual cost of treatment per person	500	500	500
Estimated total annual cost of treatment	500	1000	1500
Plus contingency of 20%	100	200	300
Total	**600**	**1200**	**1800**

13 In developing nations the average time from getting infected with HIV to needing treatment is 8 years. In any one year, then, the likely proportion of HIV-positive people who need to begin treatment is 100% divided by 8, which is 13%. However, the best time to begin treatment is still being researched. If earlier treatment becomes standard practice then the proportion will be higher than 13%.

14 The percentage is likely to be higher if very few staff have tested, and then they do as a result of the policy, so that a high proportion start treatment in a particular year. It is also sensible to use a higher proportion if the actual number of people you are dealing with is small. For example, with 100 people and an HIV infection rate of 10%, you would estimate that there are 10 HIV-positive people. 13% of them are likely to need start treatment each year – which is 1.3 people. If you only budget for 1 person and then 2 need treatment you have under-budgeted by 100%!

Different ways of helping staff to access health care

Informal methods: In many organisations staff organise their own schemes, such as savings and credit groups, or condolences funds. These can be very important in terms of giving staff practical financial help, as well as building morale among staff through acting together. Organisations can support these self-help groups by, for example, deducting payments through the payroll, matching contributions, and allowing groups to use meeting rooms.

Formal methods: Table E sets out nine different methods and their advantages and disadvantages, including the budgeting implications. It is based on the strategies used by CSOs in Uganda, and on the insurance options there. The best solution for your organisation may involve a combination of methods, as Table F shows. What fits your organisation best will depend on: the HIV prevalence and availability of services in your locality; the culture of expectations regarding benefits which CSOs generally give their staff; how your staff are spread geographically; and your organisation's budget size and its financial security.

Table E: Different methods for supporting staff to get health care

Method	Advantages	Disadvantages
1. No health care costs paid for by the organisation. Staff use public services or pay for private services from their own pockets. The organisation gives them information on where to get counselling & testing, treatment for opportunistic infections, ART, and encourages them to go.	✔ No health care cost to the organisation. ✔ No health care to budget for. ✔ No extra work on administering a health scheme. ✔ Fewer worries about funding and sustaining the workplace policy. ✔ Staff choose where they get health care.	✘ Free or low-cost services may not be available locally, especially ART. ✘ Private services may be too expensive for staff. ✘ Services may be of lower-quality, less confidential and less effective than private health care. ✘ Staff may have to wait more, and therefore miss more work, to get treatment. ✘ Staff may postpone starting treatment, or be unable to sustain treatment, leading to sickness and higher mortality.
2. Organisation gives each staff member a sum of money for their health care.	✔ Very easy to budget for: no of staff x sum. ✔ Confidential. ✔ The limit can be set at a level which the organisation can afford. ✔ Easy to administer e.g. 1/12th of the sum added into each month's salary. ✔ No potential for abuse of the scheme. ✔ Staff choose where they get health care. ✔ Likely to be popular with staff if they prefer to have the money in their pockets, and so have control over how they spend it.	✘ The organisation has no control over how staff use the money. The effect on staff members' health may be very small if they spend it all on dependants' health care, on ineffective 'treatments', or on things unrelated to health. The effect might even be negative if the sum is spent on unhealthy practices e.g. alcohol, illegal drugs, buying unsafe sex. ✘ The sum is likely to be too small to cover treatment for chronic illnesses. ✘ Likely to be unpopular with donors, who want to be sure that funding is well spent on protecting the organisation's ability to deliver its outputs despite the effects of HIV and AIDS. ✘ Some of the sum may be lost to tax if it is paid through the payroll.
3. Organisation refunds health care expenses up to a limit. Organisation sets an annual limit for each member of staff. Staff pay for medical expenses, hand in their receipts, and are then paid back.	✔ Budgeting is relatively easy: no of staff x sum x % they are likely to claim. ✔ Easy to monitor trends in average expenditure per staff member. ✔ The limit can be set at a level which the organisation can afford. ✔ The policy can allow staff dependants to be included. ✔ Staff choose where they get health care.	✘ Not confidential as receipts must be linked to staff members. ✘ If the sum is spread between too many dependants, the positive effect on the staff member's health may be very small. ✘ A lot of administration work, collecting receipts and refunding staff. ✘ Open to abuse: staff bring in receipts for health care they have not received.

Method	Advantages	Disadvantages
4. Organisation **sets aside a sum of money per staff member**, and uses it to refund health care expenses. Same as **3**, only at the end of the year, if a member of staff has not used all their sum, then they are given what is left.	✔ Budgeting is very easy: no of staff x sum. ✔ The limit can be set at a level which the organisation can afford. ✔ The policy can allow staff dependants to be included. ✔ No potential for abuse of the scheme. ✔ Staff choose where they get health care.	✘ Not confidential as receipts must be linked to staff members. ✘ The sum is likely to be too small to cover chronic illnesses. ✘ If the sum is spread between too many dependants, the positive effect on the staff member's health may be very small. ✘ A lot of administration work, collecting receipts and refunding staff.
5. Organisation **buys basic health insurance** for staff members.	✔ Very easy to budget for: no of staff x insurance premium. ✔ Confidential - staff have ID cards and get treatment without having to get approval from the organisation. ✔ Staff get private health services, which are likely to be of higher quality than public health services. ✔ Cover includes unlimited **outpatients**, and limited inpatients. ✔ ID cards mean that organisation's investment is focused on the staff members' health, rather than being spread among dependants. ✔ Easy for the organisation to include dependants with their own insurance cover. ✔ Can give staff the options of: buying cover for dependants; cost-sharing cover for dependants; or paying to upgrade their own health insurance.	✘ Cover excludes chronic conditions including HIV infection, and the **inpatients** limit might be exceeded. So this insurance would only help staff to get basic health care. ✘ Staff have to use the facilities which the insurance company is linked to. ✘ Costs may be too high for some organisations. ✘ Monitoring is not possible because organisation gets no feedback from the insurer - has no way of knowing whether or not staff are making claims, and what their actual costs are. ✘ If organisation offers cover for dependants with cost-sharing, this makes budgeting harder, as it will not know how many staff will take up the offer.
6. Organisation **buys standard health insurance** for staff members.	✔ As for **5**, but with higher cover for expenses as an inpatient.	✘ As for **5**, though the inpatients limit is less likely to be exceeded. ✘ Costs are higher.
7. Organisation **buys comprehensive health insurance** for staff members.	✔ As for **5**, but with chronic illnesses including HIV included, and even higher cover for expenses as an inpatient. ✔ Can pay an additional premium to buy cover for staff with pre-existing conditions e.g. if already known to be HIV-positive.	✘ As for **5**, except that chronic illnesses including HIV infection are included. ✘ Second line ART may be excluded. ✘ Cover for people known to be HIV-positive before taking out insurance may be expensive.
8. Organisation **has a health (or emergency) fund.** Staff members in need of money can ask for assistance. The organisation determines rules for the fund e.g. what needs are eligible, whether there is a maximum payout per staff member, whether the staff member must pay a percentage of costs.	✔ Can be used as a top-up to other methods i.e. in combination with any of **2** to **7**. ✔ A combination (e.g. with **3** or **5**) is likely to be cheaper than **7**, comprehensive health insurance. This is because relatively few staff will claim for chronic illnesses and HIV. ✔ Very flexible in terms of what emergencies are eligible and how much to give each person who applies (can favour most vulnerable staff). ✔ Easy to do cost-sharing e.g. staff contribute % of salary which organisation then matches.	✘ Budgeting is difficult: no of staff x likely % applying for emergency funding x likely average cost of emergency. ✘ Not confidential - staff must approach the manager with their problems. ✘ Puts stress on the manager responsible for the fund. ✘ Possibility that the fund runs out. ✘ Demands on the fund will rise over time, assuming that 'for life' treatment such as ART work. On-going costs will accumulate, as more staff draw on the fund. ✘ Need arrangement with donor(s) if the fund is under spent. ✘ Staff applying to the fund may not be treated equally - likely that manager will show favouritism and discrimination.
9. The organisation **sets up a third party fund for chronic illnesses** including HIV infection. Another organisation e.g. an insurer or service provider, holds the fund and draws on it when eligible people get treatment for chronic illnesses.	✔ As for **8**. ✔ Confidential if combined with **5** or **6**, as staff members will already have ID cards. ✔ Easy to include dependants if combined with **5** or **6**. ✔ Decisions rest with third party so managers are not faced with extra work or stress. ✔ Flexible e.g. organisation can specify what conditions and treatments are eligible - could include second line ART. ✔ Organisation receives information as to how many staff are using the fund, and expenditure per person (but not the identities of the people). This is useful for monitoring the workplace policy.	✘ Budgeting is difficult, but easier than 8 because the fund can only be used for chronic illnesses: no of staff x likely % having a chronic illness x cost of treatment. The third party can advise based on their experience. ✘ Not confidential if combined with **2**, **3** or **4**, as the third party needs to check with the organisation that the person is eligible (or organisation needs to give approval of person to third party). ✘ Have to trust that the third party will act honestly. ✘ Possibility that the fund runs out. ✘ Demands on the fund will rise over time, assuming that 'for life' treatment such as ART work. On-going costs will accumulate, as more staff draw on the fund.

*Table F: examples of combinations of methods
to support staff to get health care*

One method...	...plus another	Comments
3. The organisation **refunds health care expenses up to a limit** for staff members only.	**8.** The organisation has a **health (or emergency) fund** for staff only.	A low-cost option. The organisation has excluded dependants from health care, but may still involve them in awareness-raising and workshops.
5. The organisation **buys basic health insurance** for staff members only.	**9.** The organisation **sets up a third party fund for chronic illnesses** including HIV infection for staff members and a specified number of dependants.	Staff members' health is taken care of, as are chronic conditions for a number of their dependants. Staff are left to cover their dependants' day-to-day health care costs.
7. Organisation **buys comprehensive health insurance** for staff members.	**7.** Organisation **cost-shares** the purchase of **comprehensive health insurance** for up to a specified number of dependants per staff member.	The high cost of comprehensive insurance for dependants is shared with staff members. The proportion paid by the staff member could vary according to salary. Staff can decide whether or not to opt to buy for insurance for their dependants. For budgeting, the organisation would need to find out what staff intend to do.

The outpatients limit on health insurance refers to treatment which does not need the patient to stay overnight in the hospital. The inpatients limit is for treatment which does require staying at least one night.

Finding the resources to respond to HIV

This is an extremely important issue for many CSOs. It's not unusual for CSOs to struggle to find the money to pay salaries, let alone additional activities and benefits.

The safest approach is only to plan for activities which your organisation is confident it can do. This means you will not spend time planning activities you cannot afford, or chasing funds which never arrive.

An alternative is to try and get funds for a more comprehensive response, with a back-up plan of activities to run if you don't get extra funding. The back-up plan is very important. Without it you might spend more time and achieve less than if you had opted only to do what you can afford.

If you need extra money to fully implement your workplace policy, be sure to start the dialogue with your donors early on (see Step 5 in Chapter 2). You may need to explain how spending money on managing HIV will save money by avoiding bigger impacts, and how it will protect your organisation's productivity (see Chapter 1). Your donors give your organisation funds to achieve certain things; you need to convince them that managing HIV is a good investment, which will help you achieve those things. So be ready to justify the items in your budget for managing HIV.

Your donors are more likely to fund costs which directly link to protecting staff members from HIV infection, addressing stigma, supporting staff to find out their HIV status, and keeping HIV-positive staff members productive.

They may be less persuaded by other costs, such as expenses relating to staff members who have died (funerals, death benefits, care for former employees' orphans).

Note also that donors usually prefer you to keep the costs of managing HIV in the workplace separate from the cost of HIV activities for the community.

You might ask donors to specifically fund your HIV workplace policy. But it is better to integrate the costs of managing HIV into project proposals. Most donors would prefer this. It also means that the costs are spread between all your projects and all your donors. Each time you apply for funding you include part of the cost of managing HIV, just as you include something for your offices or for your staff costs. Table G suggests some ways you might integrate the costs in your organisation's overall budget.

> **What is affordable varies a lot between CSOs. Some international NGOs are able to pay for staff and their dependents to have health insurance, while smaller CSOs simply direct staff to free public health services.**

Table G: integrating the costs of managing HIV

Activity or item in a workplace policy	Possible budget lines to include them in
Education sessions, workshops	• Training • Capacity building • For programme staff, allocate to their programmes (learning about HIV and AIDS so as to be better able to respond and not stigmatise in the field)
Condoms	• Health and safety • Staff costs (part of the benefits package)
Health costs	• Staff costs (part of the benefits package) • For programme staff, allocate to their programmes (they need to be healthy to run the projects)
All activities	Take the total budget for managing HIV in the workplace and include it • as an extra percentage on all salary budgets • or as an extra cost per employee in all salary budgets

You may decide to vary your strategy depending on the donor. For some donors it will strengthen your application if they know you are managing HIV in your workplace. Others may be less interested.

Conclusion

More information and learning

If you would like to know more, have a look at the great tools, workshop ideas and other materials on the CD which came with this guide, or go to **www.stopaidsnow.org/cso-tool**

You could also stimulate dialogue by putting one of our e-banners on your organisation's website or intranet, or your own Facebook page. Download them from **www.stopaidsnow.org/about_article_wide/banners**
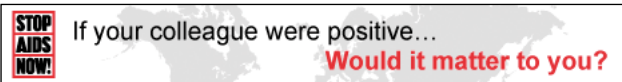
STOP AIDS NOW! is now scaling up its Managing HIV and AIDS in the Workplace project in at least 10 countries worldwide. The 'linking and learning' element of the project will connect people who are managing HIV, or helping others to do so, and enable them to learn from each other and outside resources. Look out for updates on our website **www.stopaidsnow.org/our_work_article/workplace** Remember also that this guide is for CSOs in many different countries. For information which fits your context, why not link-up with CSOs and other organisations in your country?

Final thoughts

We produced and distributed this guide to help CSOs. Our organisations already face so many challenges, and now we need to face-up to HIV too. We hope that this guide has given you practical information and ideas which you can use.

What happens next is in your hands.

Can you convince others that your organisation should manage HIV?

Will you use your influence to reduce stigma, and so make an important difference to your work environment?

Will you take the opportunity to extend your own or others' lives through early testing for HIV and accessing treatment?

Will your organisation let HIV do its worst, or resolve to manage HIV?

"We very much hope that your organisation is able to take action, for the good of you and your colleagues, and for your organisation's work."

HIV affects many families and communities. Instead of ignoring HIV in the workplace, we can take action to manage it, for the benefit of our staff and our work. This guide sets out why Civil Society Organisations need to manage HIV in their workplaces, in order to reduce the damage which HIV causes to their staff and their productivity. It addresses common emotional blocks to managing HIV in the workplace, and presents seven steps to developing a response. It also provides ideas for activities to manage HIV, and help on budgeting and financial issues.

The guide comes with a CD containing tools, workshop ideas and supporting documents. It is also available in a short version, which can be downloaded from **www.stopaidsnow.org/cso-tool**

STOP AIDS NOW!