Good Donorship in a time of AIDS

Guidelines on Support to Partners to Manage HIV/AIDS in the Workplace

to be used in pilot projects in Uganda and India

Colophon:

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Setting an example....

With a HIV prevalence rate of around 25% still some NGO's say they do not think they have any HIV-positive employees. It is obvious that a lot still needs to be done to make our partners aware of the enormous impact of hiv/aids on their (and our) work. Important goal as it is, 'getting our heads out of the sand' is just one of the reasons STOP AIDS NOW! has decided to develop guidelines to support partners to manage hiv/aids in the workplace. We have committed ourselves to setting a good example, becoming better donors in the context of aids, and to assist our partners in their efforts to develop and implement their own workplace policies.

The guidelines informs us why they are needed, why local NGO's should have a workplace policy, and why within this policy special attention should be paid to hiv/aids. Sue Holden who researched and wrote the guidelines does this so very convincingly, with great skill and insight.

The guidelines themselves are based on key principles for a workplace policy and the components of an ideal hiv/aids workplace policy. Naturally, for our partners and us, the ideal situation is often very far away. Rather than stressing this, the guidelines offers a framework to help our partners establish what, given their context, their specific needs are in dealing with hiv/aids in the workplace. We hope to stimulate them to address a number of vital questions, regarding ways of delivering health care, the security of funding, and capacity building. But also: who should be included in treatment? In our pilot projects in India and Uganda, first line ARV treatment is available and accessible. Sadly, this is a 'luxury', compared to many countries in the developing world.

Although not every measure to be taken in managing hiv/aids in the workplace calls for additional financing, it is fair to expect a, albeit modest, rise in the overhead costs of the projects. STOP AIDS NOW! has committed itself to address these extra costs in the pilots. I strongly believe that the positive effects of a hiv/aids workplace policy exceed by far these extra costs. Both in terms of an improvement of the situation of individual employees and the continuity of the projects they carry, as an improved accountability. But, as Sue Holden rightly puts it: accountability cuts both ways, and we as donor community should (and will!) be hold accountable to the commitments we have made.

I believe that these guidelines will be of interest not only to its two main target groups, programme officers and partners organizations that will use the guidelines, but also to policymakers dealing with the issues mentioned.

Sjoera Dikkers, director STOP AIDS NOW!

1 Introduction

Let us start with the obvious: HIV/AIDS is with us, and it is a serious global problem. A problem for our own organizations and for the partners[1] that we work with; a problem which affects both individual staff members and how effectively our organizations and our partners can work. A problem which is very evident in highly affected nations and which, in countries with low levels of HIV prevalence, is likely to emerge in years to come. A problem which is not about to go away.

These guidelines are a tiny contribution to the response to the problem of HIV/AIDS. They have been developed by four Dutch co-funding agencies or NGO donors[2] - Cordaid, Hivos, ICCO and Novib - who, along with the Dutch Aids Fund, form the collaborative organization STOP AIDS NOW! The guidelines are one element of a STOP AIDS NOW! project called 'managing HIV/AIDS in the workplace, including access to treatment'. As such, they are part of a larger process of learning through pilot projects in India and Uganda which aim to improve how local NGOs manage HIV/AIDS within their workplaces. These pilot projects include bringing the partners together to learn about workplace policies, to take part in capacity building exercises, to share experiences, and to develop strategies. Whilst we donors will initially use the guidelines in the pilot projects with our partners in Uganda and India, when we have learned from and evaluated that work, we hope to improve the guidelines, and to use them with all our partners in the future.

This project wants to set a good example, to re-think 'business as usual'. Talking is not enough: the new business should be in writing. This document is a first attempt to set out what 'good donorship' means in a time of AIDS. It contains clear principles and commitments which are presented as separate text in boxes throughout the document, and which are also all listed together in Section 3.

1.1 Objectives

So what do we - the four Dutch co-funding agencies who support the work of partner organizations in the South - hope to achieve by producing these guidelines?

The first objective is connected to achieving the idea of 'good donorship': the guidelines are part of a process of us becoming better donors in the context of AIDS. In order to produce them we have been through a process of developing and deciding upon our position with regard to our partners, their workplace policies, and our responsibilities. And by jointly committing ourselves to the contents of these guidelines, we aim to set out and clearly communicate that position.

This leads to a second objective concerning managing HIV/AIDS in the workplace: that by clarifying and communicating our position, along with the country level support we are providing, we hope to assist our partners in their efforts to develop and implement their own workplace policies.

All of this leads to an overarching aim, of supporting our partners to reduce the impacts which HIV/AIDS has on their work, and so to protect their performance and effectiveness.

[1] Or, as Novib calls them, 'counterparts'.

[2] We, and other organizations who work in partnership with Southern organizations, are more than just 'donors'. However, it becomes confusing to refer to NGOs in the North and South as 'partners', and alternatives such as 'co-financing agencies' are no better than the label 'donor'.

1.2 Why have we developed these guidelines?

In addition to the above objectives, we have many reasons for wanting to develop these guidelines, as this section will outline.

Breaking the silence: in many partnerships between Northern and Southern NGOs, HIV/AIDS is not discussed, or is discussed only in terms of the effects at community level. We want HIV/AIDS to be part of our dialogue with partners, and hope that these guidelines will lead to it being on the agenda, for both donors and partners. The guidelines may also help stimulate discussion within partner organizations.

Acting in solidarity: we are now in the late stages of developing and implementing workplace programs for our own staff, but are funding local partners which lack such programs. We believe we should actively open up dialogue and provide support to our partners, rather than be 'concerned bystanders', watching the impacts of HIV/AIDS on our partners but doing little to assist.

Getting our 'heads out of the sand': a recent CARE survey[3] of 42 NGOs in Southern Africa found that, despite a HIV prevalence rate of around 25%, two thirds of the respondents said they did not think they had any HIV-positive employees! This vividly illustrates how managers may act like ostriches by ignoring difficult realities, a costly habit in the case of HIV/AIDS. These guidelines are about raising our heads, stating our commitments, communicating them to our partners, and helping them also to raise their heads.

Responding to demands from local NGOs: some donors expect better results from NGOs in high prevalence settings, or lower costs, as if HIV/AIDS does not exist. Research with local NGOs shows that instead of that lack of understanding, they want more openness, more support, and more clarity from their donors with regard to managing HIV/AIDS[4]. These guidelines should go some way to meeting those demands.

Responding to demands from Program Officers: our Program Officers sometimes get requests from partners to fund their workplace policies. Some of them feel ill-equipped to deal with this new topic, and have asked for guidance. These guidelines should help them make decisions, and should ensure that partners' requests are dealt with consistently within each of the Dutch donor NGOs.

Influencing others: other NGOs who work through partnership with organizations in the South are facing the same issues, but none have 'grasped the nettle' and developed guidelines on good donorship in a time of AIDS. We can share these guidelines with those development agencies, and so use them to stimulate their response. We expect that partners may also use these guidelines to influence their other donors towards 'good donorship' with regard to HIV/AIDS.

Greater accountability: where local NGOs do not have budgets to cover employees' health care costs, managers may cover the costs with money from other parts of their budgets. They are unlikely to tell their donors about this. These guidelines should increase communication and so accountability between us by providing clarity on what costs we are willing to fund, and

3 Connelly P (2005): An analysis of the Impact of HIV/AIDS on NGOs and CBOs in South Africa, CARE

4 James R with Katundu B (2005): Draft of Counting the Organisational Cost of HIV/AIDS on CSOs, INTRAC, and Novib (2004): Managing HIV/AIDS in the Workplace: Examples of Nine Non-governmental Organizations in South Africa, Zambia and Zimbabwe.

by initiating dialogue between donors and partners, so that we can agree budgets to cover the financial costs of HIV/AIDS and other chronic diseases.

Please note that these guidelines are only a part of what we are doing with respect to HIV/AIDS. In addition to the wider work in the pilot projects in Uganda and India, we are also involved in other activities. For example: supporting partners who are implementing AIDS projects; advocacy and campaigning about patents, generic drugs, and access to treatment; tracking the actual allocation, use, and effectiveness of funds such as the Global Fund; and organizing coordination between donors with regard to HIV/AIDS policies and supporting strategies. The commitments expressed in these guidelines are not our sole commitments - just those that relate to supporting partners to develop and implement ways of managing HIV/AIDS in the workplace.

1.3 Why should NGOs have a workplace policy?

1.3.1 Different kinds of workplace policy

Before going on to look at the arguments for having a workplace policy, we should briefly note that "workplace policies" come in different forms. First, there are distinct HIV/AIDS workplace policies. Some people think that HIV/AIDS is such a special issue, it needs to be dealt with separately, in a very focused way, though the policy may in time be integrated within a general health policy.

An alternative is to develop a chronic illness workplace policy which covers all chronic health problems, including HIV/AIDS. This avoids the problem of, for example, an employee with cancer who is does not have HIV getting lesser treatment than an employee with cancer who is HIV-positive. It may also reduce stigma because HIV/AIDS is dealt with along other less controversial diseases.

A third option is to develop a staff health and wellness workplace policy. This is the most holistic approach, focusing on promoting health, as well as dealing with all forms of ill health, including mental health and issues such as alcoholism and domestic violence. In such a policy, however, great care must be taken to ensure that HIV/AIDS is not forgotten, and that issues of stigma and confidentiality are still closely attended to.

For a more detailed discussion of the advantages and disadvantages of different kinds of policy, see the CARE briefing papers, listed in Section 4.1. For simplicity, in these guidelines we shall use the cover-all term of "workplace policies".

1.3.2 Reasons for having a workplace policy

Why should partners bother developing and then implementing a workplace policy? The reasons fall into two categories. You could see these as those of the heart, which are values-based ('it's our duty to assist our employees with their needs') and those of the head, which are instrumental ('it makes sense for us to help them because doing so leads to other benefits').

The values-based reasons are to do with being a socially responsible employer, or one which meets its moral obligations to attend to its employees' well being. They are also grounded in rights; if we as donor organizations believe that everyone should have the right to health care, we should do what we can to help partners to secure that right for their employees.

The instrumental reasons are more varied, and include the following:
The costs of doing nothing can be substantial: where employees and their relations are falling ill due to HIV, the costs to organizations quickly build up. These include direct costs such as more expenditure on health care, funeral costs, recruitment, and training, along with indirect costs in

terms of reduced productivity, increased absenteeism and presenteeism[5], and managers' time and effort in responding to workplace impacts. There are also intangible costs such as loss of morale and of skills. The costs may be particularly high in NGOs, where the 'caring culture' means that managers are likely to be more generous towards, or less strict about, issues such as paying for medical care, leave allowances, and use of vehicles for personal business. The costs may also escalate over time, with, for example, erosion of workplace discipline, motivation, and cohesion becoming more acute as time goes by. Whilst most of the costs of HIV/AIDS in the workplace cannot be avoided altogether, many of them can be reduced through proper management.

Invest now to save later: many profit making organizations such as Heineken and some NGOs such as Oxfam GB have looked carefully at the costs of not having workplace policies, and at the likely benefits of different policies. They have concluded that it makes economic sense to invest in their employees' health, including providing antiretrovirals (ARVs) to prolong the life and productivity of those who are HIV-positive. In other words, they estimate that the costs of having workplace policies are worth it, given the benefits which they should lead to, and that the costs of having policies are lower than the costs of doing nothing. In Oxfam GB's assessment, undertaken in 2003, 10-year projections indicated that for every pound invested in ARV treatment made available to all employees and one dependant each, there would be savings worth £1.50.

Clear and fair handling of cases: workplace policies set things out clearly by stating what the organization will do and what it will not do. This means that managers do not have to make decisions on a case-by-case basis, which can be extremely stressful and disruptive, particularly where budget lines do not exist for AIDS-related expenditure. Having a clear policy also avoids the pitfall of unintentionally setting standards by setting a precedent. This happens when a manager decides to provide certain benefits or treatment for one member of staff, and must then provide the same for all others, because in some countries the precedent has the force of law. For employees and their families, having a clear policy means that they know in advance what allowances and benefits they are entitled to, free from the risk of discrimination which may occur where matters are left to a manager's discretion.

Managing rather than 'fire fighting': with clear policies and funding in place, organizations are more able to accommodate HIV/AIDS, dealing with it and trying to minimize its impacts as an on-going issue, rather than sporadically having to suffer its disruptive effects and the crises which it causes for individuals and the organization.

Increasing credibility: at least in high HIV prevalence settings, organizations which are proactively managing HIV/AIDS within their workplaces, and which are able to talk about HIV/AIDS openly, are likely to achieve greater credibility in the eyes of others. This will be more so for NGOs which are engaged in work to do with AIDS, or supporting partners who are responding to AIDS.

Increasing competitiveness: those NGOs which manage HIV/AIDS in the workplace, and so reduce its impacts, should also find that their effectiveness compares well with those NGOs which have kept their heads in the sand. In this sense, having successful policies in place may help NGOs to become more attractive to funders, despite the additional costs of having such policies. They are also likely to become more attractive to prospective employees, a significant advantage when there are skills shortages.

[5] This recently invented word describes the phenomenon of people who are too sick to work nevertheless turning up to work but achieving very little.

More effective work: by managing HIV/AIDS in the workplace, NGOs can reduce the impacts which it has on their work. Furthermore, they are likely to respond to HIV/AIDS more effectively through their work, because their staff are likely to be more able to face up to AIDS, and to be able to open up discussion about HIV/AIDS with partner organizations and at community level.

1.4 Why pay special attention to HIV/AIDS?

In many nations, HIV infection has become endemic - in other words, it is always present. And, in the absence of a cure or vaccine, it is going to be with us for a long time to come. In this sense, HIV infection is similar to other endemic and debilitating health problems such as malaria, tuberculosis, and cancer which also affect NGO employees. So why should we and our partners pay special attention to managing HIV/AIDS in the workplace?

First, HIV/AIDS is highly stigmatized. This is mainly because HIV can be transmitted through the taboo practice of sex, and the criminal practice of injecting drug use. It has become associated with stigmatized groups such as sex workers, men who have sex with men, and injecting drug users. And the main mode of transmission, sex, raises a lot of uncomfortable issues, including sexual infidelity and sexual abuse, and links AIDS to discussion of morality and notions of wrongdoing. Furthermore, compared to other sexually transmitted infections, the stigma of HIV is magnified by the fact that HIV leads to AIDS, which, without treatment, is fatal. In the workplace, stigma makes employees reluctant to find out their HIV status, and to seek treatment and support when needed. A stigmatizing culture also disables a supportive response in the workplace, may undermine confidentiality, and can also lead to discrimination. So, unlike judgments-free illnesses such as malaria or diabetes, to manage HIV/AIDS in the workplace, we must first deal with the powerful causes and effects of stigma.

Second, HIV is special because infection is concentrated among people of working age. Whereas in the past it was unusual for a NGO employee to die of natural causes, in high prevalence nations this is no longer the case. And HIV infection is often not confined to the employee but is also present in the spouse and young child, multiplying the impacts on the NGO.

Third, in high prevalence settings, the scale of HIV infection means that there are consequences in the workplace stemming from all employees being affected by AIDS. For example, disruptions caused by staff having sick family members, by staff caring for relatives' orphans, and by the amount of time staff spend on attending the funerals of relatives and colleagues and community members.

Fourth, and in a different vein, HIV/AIDS also affect community members and the prospects for development. It is beneficial to pay special attention to HIV/AIDS within development organizations because workplace policies not only help employees and their organizations, they also build staff capacity to address HIV/AIDS through their work at community level.

The good news is that if NGOs do take action to manage HIV/AIDS in the workplace, they can reduce the impacts that it has for both individuals and the organization. But that action will only be effective if the special nature of HIV/AIDS, and in particular the issue of stigma, is addressed.

2 Guidelines

We have written these donor guidelines with our Program Officers in mind, but will also be sharing them with our partners in India and Uganda, so that they have a clear understanding of our commitments.

Please note, this is not a detailed 'how to' document; partners will have access to ideas,

information, and training about how to manage HIV/AIDS in the workplace through the pilot projects. Section 4.1 in the appendices also lists some key documents. Instead, these guidelines set out our key principles and commitments as donors, which are written as separate text in boxes, to aid clarity. A summary of them all appears as Section 3.

Our overall guiding principles are as follows:

- We believe that all donors should fund a share of their partners' overheads, including the cost of workplace policies, in addition to funding projects or activities.
- We recognize that the impacts of HIV/AIDS can cause partners to produce lower levels of outputs for the same investment.
- We believe that the cost of inaction is greater than the cost of action to manage the impacts of HIV/AIDS. Workplace policies are a cost-effective method which all organizations can use to reduce the impacts of HIV/AIDS on their work.
- We note that, as autonomous organizations, partners are responsible for developing, implementing, monitoring, and evaluating their own workplace policies. However, we will support them as set out by our commitments in these guidelines.
- We believe that donors and partners need to communicate openly about the challenges brought about by HIV/AIDS, and are committed to doing so.

2.1 Key principles for a workplace policy

Various organizations have developed codes of practice to guide their members in developing workplace policies. They generally share the key principles which are listed overleaf in Table A, and which are mainly taken from the ILO Code of Practice.

We commit to following these key principles in our workplace policies, and expect that partners will also be guided by them.

Table A: The key principles for workplace policies

Adapted from Rau (2002:37), mainly based on ILO guidelines

Recognition of HIV/AIDS as a Workplace Issue

HIV/AIDS is a workplace issue because it threatens productivity, profitability and the welfare of all employees and their families. The workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.

Non-discrimination

Discrimination against workers on the basis of real or perceived HIV status is to be actively discouraged. Discrimination against and stigmatization of people living with HIV/AIDS inhibits efforts to promote HIV/AIDS prevention and can easily lead to disruptions in the workplace. In short, HIV/AIDS should encourage businesses to examine their policies regarding long-term illnesses.

Gender Equality

Discrimination against and exploitation of women promotes the spread of HIV/AIDS. Also, women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than are men, due to biological, sociocultural and economic factors. Proactive efforts by companies and workers' organizations to prevent gender discrimination and sexual coercion and abuse greatly aid prevention efforts.

Healthy Work Environment

The work environment should be healthy and safe, in line with national regulations and negotiated agreements, to reduce the risk of on-the-job transmission of HIV. A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.

Social Dialogue

The successful implementation of an HIV/AIDS policy and program requires co-operation and trust among government, employers and workers and their representatives, with, where appropriate, the active involvement of workers infected and affected by HIV/AIDS.

Communication and Leadership

Employers, unions and workers' representatives must communicate HIV/AIDS policies to employees in simple, clear and unambiguous terms and continue to demonstrate their support for HIV/AIDS prevention and care efforts. Communication of clear messages will reinforce established business practices, assure consistent implementation of the policy and reinforce low-risk worker (including sexual) behaviors.

Screening for Purposes of Exclusion From Employment or Work Processes

Mandatory HIV/AIDS screening is unnecessary and inappropriate for either job applicants or persons already employed. Companies and unions should encourage employees to obtain a voluntary and confidential HIV test and pre- and post-test counseling off-site.

Confidentiality

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should workers be obliged to reveal such personal information about themselves or fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality. Breaches of confidentiality erode employee morale, can disrupt production and can lead to legal action.

Continuation of Employment Relationship

HIV infection is not a cause for termination of employment. As with many chronic conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work. This can be many years.

Prevention

HIV infection is preventable. Prevention can be furthered through changes in behavior, knowledge, and treatment, and the creation of a non-discriminatory work environment. Unions and business managers are in a unique position to promote effective prevention efforts, including changing attitudes and behaviors through providing information and education, setting non-coercive sexual standards and addressing socioeconomic factors that increase the risk of HIV/AIDS transmission.

Care and Support

Solidarity, care and support for HIV-positive individuals and their family members should guide the response to HIV/AIDS in the world of work. This should include support for positive living, and, for those taking antiretroviral drugs, crucial support in helping them to adhere to treatment, to maximize its efficacy and reduce the likelihood of drug resistance. There should be no discrimination against HIV-positive employees and their dependants regarding access to and receipt of benefits from social security programs and occupational schemes. Company and union policies should encourage the formation of support groups for HIV-positive individuals, caregivers and other concerned workers

2.2 The components of an ideal HIV/AIDS workplace policy

Table B, below, outlines the components of an ideal comprehensive workplace policy, as it relates to HIV/AIDS. (Clearly there would be more components if the partner organization were devising a wider health and wellness policy).

Please note, in cases where an organization lacks clear human resources policies regarding terms and conditions for staff (for example, leave allowances, sickness payments, insurance and pension arrangements, death benefits) then those policies would also need to be created. If employees with HIV/AIDS or other chronic illnesses have special benefits - for example, different leave allowances, or the right to early retirement - then they need to be clearly stated.

Table B: Components of an ideal comprehensive workplace policy

Theme	Wording which states...
Policies, procedures, and objectives	• the objectives of the policy; • how the policy is to be implemented, including how the contents will be shared with all employees; • how the policy relates to other health and human resources policies within the NGO and to national law.
Confidentiality	• employees' right to confidentiality, and how the NGO will ensure that confidentiality is maintained; • that employees are under no obligation to inform anyone of their HIV status; • that there will be no compulsory HIV testing.
Non-discrimination and reasonable accommodation	• there is to be no discrimination, from recruitment to retirement, on the basis of or suspicion of HIV infection; • how the NGO will guard against discrimination, including clear disciplinary procedures in cases of discrimination or stigmatization; • that the NGO is willing to make reasonable accommodations (such as less rigorous work, or a different work environment) for employees who request them.
Education and environment	• how the NGO will work to: - address stigma within the workplace; - inform and motivate employees about prevention of HIV infection, VCT, positive living, care, and treatment; - create a safe and supportive environment in which employees can talk about HIV/AIDS, and be HIV-positive, free from judgment, stigma, and discrimination; - engage employees in wider issues of well-being relevant to HIV such as women's rights, alcohol use, and self-esteem; - motivate employees to take proactive steps to reduce their vulnerability to the impacts of AIDS e.g. encourage them to build-up assets, and to write wills. • how the NGO will similarly work with employees' families and partner organizations.

Theme	Wording which states...
Gender issues	• the measures to be undertaken to address gender discrimination with the NGO, and to promote greater gender equity.
Prevention measures	• what is considered to be acceptable sexual behavior, including disciplinary measures in cases of prohibited behavior, such as sexual coercion, or the use of NGO resources to gain sexual favors • the first aid and health & safety procedures to be followed to minimize the risk of HIV infection • how the NGO will secure access for employees and their dependants to - male and female condoms - post-exposure prophylaxis - voluntary, informed, and confidential counseling and testing - treatment of sexually transmitted infections (STIs) - treatment to prevent HIV transmission from mother to child • any changes to how the NGO operates which may help reduce its employees' susceptibility to HIV infection (see Section 4.2 for examples)
Treatment and care	• how the NGO will secure access for HIV-positive employees and their dependants to - nutritional supplements - treatment for opportunistic infections - antiretroviral treatment, including support to adhere to treatment - support systems such as counseling or support groups to encourage positive living - legal advice, for example in writing a will or in securing the transfer of property
Reducing organizational vulnerability	.• changes to be made in how the organization functions in order to reduce the impact of HIV/AIDS (see Section 4.2 for more detail), including - reviewing and enforcing leave allocations - establishing ways of reducing the effects of staff being absent - streamlining recruitment processes
Monitoring and evaluation	• how the NGO will monitor the implementation of the policy and evaluate its use • that the NGO will adapt the policy as necessary in the light of experience, and will consult with and communicate any changes to employees

2.3 Adapting the ideal

Table A set out key principles which we believe all organizations should try to adhere to in their workplace policies. But Table B set out the components of an ideal, comprehensive workplace policy, and we are not expecting all our partners to attain this standard. This is because partners' policies need to fit their context. This section outlines five interrelated variables which can affect the contents of partners' workplace policies.

2.3.1 Capacity

NGOs need to consider their capacity to research, devise, implement, monitor, and account for a workplace policy. This capacity is determined by a variety of factors including: what skills are available; how much staff time is available; and what systems the organization can sustain (e.g. to maintain confidentiality). In general, capacity is likely to increase with the size of the organization, and as the capacity of the organization rises, so does its ability to develop and manage a more comprehensive workplace policy.

We hope that one benefit of collaboration in the pilot projects is that partners will be able to develop better workplace policies than if they were working alone. This should happen because the project will involve capacity building through workshops. Furthermore, some of the research and negotiation - which low-capacity NGOs would struggle to do - will be done collaboratively or on their behalf.

2.3.2 Funding security

Very few local NGOs are 'financially secure', but the degree of security does vary, and this is likely to affect managers' ability to commit to different components of a workplace policy.

We must note, though, that many activities within a workplace program need not involve financial outlay, although they do require staff time. Setting up systems to ensure confidentiality, and to stop discrimination, can be done 'in-house' without using consultants. Seminars or discussion groups or displays of the latest information about HIV/AIDS need not be expensive. Even ARV treatment is gradually being made available through the public health system, providing an alternative to private provision.

Furthermore, the low-cost components are fundamental to having an effective comprehensive policy in the future. As an illustration, it is common for organizations to offer access to ARVs, and to find that few if any employees take them up, despite obvious need. This apparently irrational behavior among employees is due in large part to their rational fears about stigma, lack of confidentiality, and discrimination in the workplace. The 'top level' and most expensive components of workplace policies only achieve their potential if the fundamental and least costly components have been fully and effectively implemented. So in some cases it may make sense initially to develop and implement a low-cost program, whilst pursuing the funds to expand the program to include more complex education, prevention, and treatment components in the future.

2.3.3 Starting point

Another variable is where the organization is starting from - its level of 'AIDS competence'. An organization which lacks human resource policies, which provides no benefits for staff beyond payment for their time, and where AIDS is taboo, will not be able to leap straight to the point of having a full comprehensive workplace policy. But stepping towards the ideal may be achievable for an NGO which, for example, already has well developed human resource policies, openness around talking about HIV/AIDS, and systems which can be adapted to manage the workplace policy.

UNAIDS has developed a framework that might be helpful in dialogue with partners to assess their level of 'AIDS competence'. An adapted version appears in Section 4.3.

2.3.4 Local resources

When NGOs implement their workplace policies they commonly use resources from outside of their own organizations. For example, trainers and people who are living with HIV/AIDS who assist with the aspect of education and creating a supportive environment; government departments and other NGOs who provide informative materials and condoms; and services providing VCT and treatment. The availability and cost of local resources will have some influence on what an organization can include in its workplace policy.

2.3.5 HIV prevalence

Workplace policies are relevant in all contexts, regardless of HIV prevalence. NGOs in low prevalence settings have the great advantage of being able to act in advance; of, for example, being able to erode stigma and encourage healthier lifestyles at a time when their capacity to devise and implement a workplace policy is unaffected by HIV/AIDS.

The contextual effect of HIV prevalence mainly concerns the best approach to take. Strategically, in low prevalence settings, a chronic illness policy, or a health and well being policy, is probably preferable. Employees are unlikely to see HIV as relevant to them, and are more likely to engage with a process concerning wider health issues, which can include HIV-relevant topics such as STIs, alcohol use, and sexual abuse.

> We recognize that partners need to create workplace policies to fit their context, if they are to have effective policies which they can keep-up.

As donors we should take account of each partner's context, taking care not to pressurize them to do too much too quickly. We do not want them to spend a lot of time on workplace policies which are ineffective because they did get the fundamentals right, or which they cannot implement for lack of funds[6], or which are unlikely to be funded because their overheads have risen massively.

> Through the pilot projects, we will liase with insurance companies and health management organizations, with the aim of securing affordable means of health provision for partners in the pilot projects.
>
> We are not, in the pilot projects, making funding conditional upon partners demonstrating that they are actively trying to manage HIV/AIDS in their workplaces. We will, however, adjust our own grant assessment processes to include attention to the issue, and will favorably view an organization's efforts to manage the risk that HIV/AIDS presents to its work.

2.4 The process of developing and implementing a workplace policy

Just as organizations vary, so will the processes which they follow in order to develop and implement their workplace policies. There's no exact recipe to follow. However, the key ingredients for developing a policy are a mix of participation, research, consultation, mathematics, and communication. For implementing, we must add the need to adapt systems, to monitor, to

[6] For example, Novib (2004:20): Managing HIV/AIDS in the Workplace: Examples of Nine Non-governmental Organizations in South Africa, Zambia and Zimbabwe, cites a partner NGO which has a policy to provide general health coverage (not including AIDS treatment) but does not have the funds to do so.

keep going with the process, and to keep communicating. Section 4.4 provides an outline. More detailed guidance can be found in the resources listed in Section 4.1.

Each organization's workplace policy budget should be integrated within its overall budget, because the costs involved with implementing the policy are part of on-going overheads. The policy's elements will, however, need to be presented as separate budget lines to allow it to be visible, and for monitoring purposes. Having an integrated budget may be possible from the outset for a partner which is due to commence a new 3-year funding agreement with its donor; the new application includes the workplace policy costs and planned activities. However, for organizations which are part of the way through a 3-year funding agreement, the workplace policy will initially need to be considered as a separate budget, and then integrated when applying for a new grant.

2.4.1 Ways of delivering health care

Section 4.5, in the appendices, compares five ways in which NGOs provide access to health care for their employees and family members. The most preferable methods are through insurance and through direct provision (paying for treatment when it is needed).

> Through the pilot projects, we will liase with insurance companies and health management organizations, with the aim of securing affordable means of health provision for partners in the pilot projects.

Section 4.5 also looks at the idea of cost sharing as a way of reducing the cost to the NGO of providing health care, and of securing greater ownership from employees.

In terms of who provides the treatment, note that in both India and Uganda there is some availability of first line ARVs at low or no cost through the public health system. However, just as NGOs generally pay for private health care for their staff because it is perceived to be of higher quality, more confidential, more reliable, and with less waiting than that available in the public system, so they may also opt for private provision with regard to ARVs.

The 'how' and 'who' of delivering health care have important implications for confidentiality. For a very useful summary of the issues and options with regard to protecting confidentiality whilst also retaining financial oversight, see CARE's fourth briefing paper, listed in Section 4.1.

2.4.2 Who is included in the workplace policy?

Alongside the issue of what a policy includes, there is the issue of who is covered by the policy, and for which benefits. Most organizations exclude employees who are on probation or on short-term contracts - for example, less than six months - from treatment, unless they were or on ARVs on joining the organization. However, those employees and volunteers (who are not salaried) can be included in some parts of the policy, such as information and motivation sessions, VCT, and support groups for those who are HIV-positive.

For all other employees, organizations should treat the staff equally. For example, if a Dutch NGO funds a project within a local NGO, it would not be fair to develop a policy which covers and benefits only the staff who are working on that project. It would also be inequitable to offer better treatment to senior staff.

NGOs sometimes extend employee benefits to their family members. For example, involving their employees' spouses and children in education activities, because it is also important to tackle the stigma which exists in employees' homes, and to encourage family members to find out their HIV status, to live positively, and to access timely and effective treatment. Some organizations' policies

also include treatment for family members, such as one or more named spouses and up to a certain number of named children being able to access health care.

The need, ideally, to include family members becomes particularly interesting where NGOs are offering access to ARVs as part of the workplace policy. Where employees cannot get ARVs for their HIV-positive spouse or child they are likely to share their own pills. This makes the treatment not only ineffective for the employee, spouse, and child alike, but also encourages resistance to the drug (as does any way of taking ARVs which is not as directed, such as missing doses). If resistance develops it is bad news for the individuals concerned and the NGO, because they will fall sick despite the investment in ARVs, and if they are to be treated they must switch to more expensive 'second line' ARVs.

The likelihood of pill-sharing can be reduced by ensuring that there is much greater 'treatment literacy' among staff in general and staff accessing ARVs in particular. They need to understand that sharing pills is harmful rather than helpful and to be supported to adhere to treatment. But it is harder to tackle the way in which the lack of ARVs for dependants undermines openness and so the effectiveness of the policy. The employee who is getting ARVs is likely, out of guilt, to keep his or her HIV status a secret from family members. This means that the likelihood of not adhering to the drug regimen is increased (more likely to miss doses, as s/he is having to hide them), raising the risk of drug resistance. Furthermore, the employee gets no emotional support from family members, and is less likely to practice positive living, including taking care not to transmit HIV to anyone else.

Partners must decide who to include in their workplace policies. We expect that their policies will attend to gender issues, and that they will not discriminate between different cadres of employees. We also prefer that direct family members are covered including, where relevant, access to antiretroviral treatment.

2.4.3 Calculating costs

Large businesses and NGOs usually do some kind of cost-benefit study to estimate the financial costs of the impact of HIV/AIDS on their organizations, both now and in the future, and the likely effect of their workplace policy. Having estimates of the 'costs of doing nothing' can be a powerful way of motivating managers to take action, as Oxfam GB found. However, cost-benefit studies can be quite complex and expensive to do (though there are more simple ways of doing them too) and we are not, in the pilot projects, expecting the partners to do them. Instead, we are taking the position that we know that in medium to high HIV-prevalence settings, HIV/AIDS is having an impact: the important thing is to get on with trying to reduce it.

Not surprisingly, there is no single way of calculating the costs involved in workplace policies. Just as organisations have different ways of doing their project budgets, so will their methods for calculating their workplace policies. However, we will be providing technical support at the country level in the pilot projects to assist with the issue of calculating the costs. *Section 4.6* presents the basics.

2.5 Covering the cost of the workplace policy

2.5.1 Our financial commitments

We know that motivation to devise a workplace policy can be easily undermined by the fear of not securing funding to implement the policy. This section sets out our financial commitments to our partners in the pilot projects.

We undertake to provide technical, and sometimes financial, support to partners through the pilot projects as they develop their workplace policies.

We want partners to integrate their workplace policies within their overall budgets, to form part of their ordinary applications for 3-years funding. We will positively consider all such applications as part of usual assessment procedures, including funding our share of the costs of prevention, care, support, and treatment. We expect that the costs of workplace policies will be up to about 4% of the total payroll (salaries plus benefits).

In the interim – where partners need resources to begin workplace policies but are not due to reapply for a new 3-year grant – we will provide short-term funding through the pilot projects.

If a partner's 3-year grant finishes and we have not approved a new grant, we will, if necessary, continue to provide funding for ARVs for up to 6 months. We would hope that partners will provide a similar treatment safety-net for employees on ARVs who leave the organization.

In addition to this framework to aid their decision making, we recognized that our Program Officers will also need information concerning what treatment is available through the public health system, what services are available in the country, and what those services cost. We will channel this information to them from the pilot projects.

2.5.2 Where partners have more than one funder

In some cases the Dutch donor NGOs fund all of a partner's costs, or all of their overheads or core costs. In these instances the dialogue about funding the workplace policy may be conducted between just the two parties. However, in the majority of cases, other funders are involved, so if the whole workplace policy is to be funded then the other donors will also need to agree to pay for it. We hope we can achieve this together with our partners. These guidelines are an attempt to coordinate the donor response.

First, partners can advocate on their own behalf. This may be both collaborative - the group of partners approaching donors - and individual, where a NGO talks directly with its current funders. We hope that these guidelines will be a useful resource for them to show other donors and to convince them to make similar commitments.

Second, we donors must talk with and advocate the idea of 'good donorship' to the other donor agencies. This may be particularly effective if we focus on other donors who tend to fund the same kinds of projects, or on whom we may expect to have a lot of influence. For example, many of the partners which Cordaid and ICCO fund also receive funding from other Christian organizations; Hivos finds that its partners often receive funding from DANIDA, NORAD and the Ford Foundation; and Novib might initially concentrate on influencing the other branches of the Oxfam family.

We commit to advocating good donorship among the wider community of donor agencies, with the aim of increasing the proportion of donors who are willing to support partners' efforts to manage HIV/AIDS through workplace policies. We expect that partners will also engage in advocacy to influence their donors.

In situations where we and the partner have tried but failed to secure the support of all their donors to share the costs of the workplace policy, we will ensure there is sufficient funding for at least some activities to proceed.

2.6 Accountability

We already have arrangements for financial accountability with our partners. This takes the form of narrative reports on activities against plans, and financial accounts of expenditure against the budget. Funding for workplace policies will need to be similarly accounted for, either separately, where separate interim funding is given, or as part of overall reporting if the workplace policy costs are fully integrated within on-going overheads. The timing and format of reporting should fit in with each donor's existing systems, though there may, during the pilot projects, be a case for having a standardized reporting system for all the participating partners. Certainly during and after the pilot project it will be necessary to compile data, to get an overall picture of the progress which partners are making or have made.

It is important, though, to see accountability as more than a mundane requirement: being able to show the impacts of effective workplace programmes is a powerful form of advocacy, particularly if costs are set against estimated savings in terms of absenteeism, death benefits, and so on. Section 4.7 presents some ideas for monitoring and evaluation.

Of course, accountability cuts both ways, and our partners and other stakeholders should be able to hold us accountable to the commitments we have made in these guidelines. The pilot project evaluation will include assessing how we as donors perform against the commitments we have made.

We undertake to monitor and evaluate the process and outcomes of the pilot projects, and expect to be held accountable to the commitments that we have made to good donorship in these guidelines

3 Summary of our principles and commitments

By way of a conclusion, we here re-present the principles and commitments which we have set out in these guidelines.

3.1 Principles

a) We believe that all donors should fund a share of their partners' overheads, including the cost of workplace policies, in addition to funding projects or activities.

b) We recognize that the impacts of HIV/AIDS can cause partners to produce lower levels of outputs for the same investment.

c) We believe that the cost of inaction is greater than the cost of action to manage the impacts of HIV/AIDS. Workplace policies are a cost-effective method which all organizations can use to reduce the impacts of HIV/AIDS on their work.

d) We note that, as autonomous organizations, partners are responsible for developing, implementing, monitoring, and evaluating their own workplace policies. However, we will support them as set out by our commitments in these guidelines.

e) We believe that donors and partners need to communicate openly about the challenges brought about by HIV/AIDS, and are committed to doing so.

f) We recognize that partners need to create workplace policies to fit their context, if they are to have effective policies which they can keep-up.

g) Partners must decide who to include in their workplace policies. We expect that their policies will attend to gender issues, and that they will not discriminate between different cadres of employees. We also prefer that direct family members are covered including, where relevant, access to antiretroviral treatment.

3.2 Commitments

h) We commit to following the ILO key principles in our workplace policies, and expect that partners will also be guided by them.

i) We are not, in the pilot projects, making funding conditional upon partners demonstrating that they are actively trying to manage HIV/AIDS in their workplaces. We will, however, adjust our own grant assessment processes to include attention to the issue, and will favorably view an organization's efforts to manage the risks that HIV/AIDS presents to its work.

j) Through the pilot projects, we will liase with insurance companies and health management organizations, with the aim of securing affordable means of health provision for partners in the pilot projects.

k) We undertake to provide technical, and sometimes financial, support to partners through the pilot projects as they develop their workplace policies.

l) We want partners to integrate their workplace policies within their overall budgets, to form part of their ordinary applications for 3 years funding. We will positively consider all such applications as part of usual assessment procedures, including funding our share of the costs of prevention, care, support, and treatment. We expect that the net? costs of workplace policies will be up to about 4% of the total payroll (salaries plus benefits).

m) In the interim - where partners need resources to begin workplace policies but are not due to reapply for a new 3 year grant - we will provide short-term funding through the pilot projects.

n) If a partner's 3-year grant finishes and we have not approved a new grant, we will, if necessary, continue to provide funding for ARVs for up to 6 months. We would hope that partners will provide a similar treatment safety-net for employees on ARVs who leave the organization.

o) We commit to advocating good donorship among the wider community of donor agencies, with the aim of increasing the proportion of donors who are willing to support partners' efforts to manage HIV/AIDS through workplace policies. We expect that partners will also engage in advocacy to influence their donors.

p) In situations where we and the partner have tried but failed to secure the support of all their donors to share the costs of the workplace policy, we will ensure there is sufficient funding for at least some activities to proceed.

q) We undertake to monitor and evaluate the process and outcomes of the pilot projects, and expect to be held accountable to the commitments that we have made to good donorship in these guidelines.

4 Appendices

4.1 Resources

The following are key references and all available for free download from the websites listed here.

Lessons on Addressing HIV/AIDS in the Workplace Briefing Papers: CARE, 2005

Each one-page brief looks at a different issue, based on the experiences of CARE offices from around the world. The series comprises: Executive Summary; 1) Making Responses Fit the Context; 2) From HIV/AIDS Policies to Wellness Policies; 3) Addressing the Full Continuum of Needs; and 4) Protecting Confidentiality While Accessing Services.

http://www.careinternational.org.uk/

Working Positively: A Guide for NGOs Managing HIV/AIDS in the Workplace: UK Consortium on AIDS and International Development, 2003

A concise overview of the why and how of workplace policies, including the experiences of NGOs.

http://www.aidsconsortium.org.uk/

Action against AIDS in the workplace: UNAIDS, 2002

Contains sections on: 1) Workplace policy: key components and sample language; 2) 10 steps for implementation; 3) ILO Code of Practice: key principles; 4) Trade union action against AIDS. There are different versions of the document for Africa, Asia-Pacific, Latin America and the Caribbean, and global.

http://www.unaids.org

HIV/AIDS and the World of Work: An ILO code of practice: ILO, 2002

Adopted by organizations around the world, the code focuses on tackling discrimination and prevention.

http://www.ilo.org/public/english/support/publ/online.htm

Developing workplace and medical benefits policies to support staff with HIV: International HIV/AIDS Alliance, 2004

Outlines the experiences of partners in Burkina Faso, Cambodia, and Senegal. It includes a sample technical support program, workshop sessions plans, and sample policies.

http://www.aidsalliance.org/sw7444.asp

Workplace HIV/AIDS Programs: An Action Guide for Managers: by Bill Rau, for Family Health international, 2002

A practical guide advising managers on how to create workplace programs in the developing world - and how not to. Includes case studies, but mainly focuses on large businesses.

http://www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/Workplace_HIV_program_guide.htm

Workplace Policy Builder for HIV/AIDS: The Futures Group, no date

This is a computer program which is designed to lead organizations through the process of creating a first draft of their workplace policy. It is very detailed and includes resources such as other organizations' policies, but is mainly aimed at large organizations.

http://www.futuresgroup.com/Resources.cfm?area=2

4.2 Responding to HIV/AIDS by changing how an organization functions

Workplace policies mostly focus on people - the employees and their family members. The measures are mainly do to with reducing the likelihood that employees and their family members become infected with HIV, and helping reduce the impacts on those who are infected, and so on the organization. Another part of workplace policies, though, is to think about the organization itself and what changes it might make to help reduce its employees' susceptibility to HIV infection, and to reduce how vulnerable it is to the impacts of AIDS.

In this appendix we present two questions which NGOs might ask, and some examples of how they might respond.

Are our staff and their families made more susceptible to HIV infection by working for us?	
Possibly yes, because...	**Possible responses....**
Our staff have to travel a lot, and are likely to have sex when away from home	Invest more in education efforts for employees and their spouses. Enable single-sex groups to come up with their own solutions e.g. masturbation as an alternative to intercourse, and condoms as a sign of responsibility. Encourage VCT. If possible, reduce the need for travel e.g. by investing in better communications between offices.
We pay staff per diems in cash, so they go to the field with full pockets	See if employees would prefer an alternative e.g. half in cash, and half in their salary, or time to drop cash to their homes before going to the field.
To be part of the team, you need to join in with boozing and so on.	Use sessions to reflect upon the work culture, its strengths and weaknesses. Try to generate new inclusive norms e.g. mutual respect and support, healthier ways of team building, attention to gender issues, buddies who support each other in positive living.
There is the unspoken practice of trade in sexual favors, which helps junior women to get on in the organization, or sex may be demanded in return for keeping their jobs.	Bring the issue out into the open. Provide formal and transparent means by which employees can progress on the basis of merit. Institute disciplinary measures for staff abusing their position, and means of reporting breaches.
Some of our emergencies staff work away from home for long periods in stressful situations, and may use sex partly as a way of coping.	Ensure all emergency staff have undergone education around HIV and the organization's code of conduct. Provide condoms. Give them respite breaks and opportunities to debrief.

Does how we run our organization make it more vulnerable to the effects of AIDS?	
Yes, it's more vulnerable because...	**Possible responses....**
We don't have, or we don't enforce, leave allocations. Rates of absenteeism are getting out of hand, particularly for attending funerals.	Establish allowances for sickness leave, holiday leave, and compassionate leave. Communicate these and the systems to be followed clearly with staff. Enforce them. Days taken in excess to be deducted from annual leave, or taken as unpaid. Allow overtime to be accumulated to a limit and taken off as time in lieu. Also, devise a policy with regard to employees attending funerals within the community, to put a cap on days of work lost in this way.
When key members of staff are off work things go wrong, or work stops. We don't have any back-up systems.	Establish shared systems and records, so that colleagues can access each others' work, and information is not only carried in people's heads. Train staff to cover each others' work. Budget for hiring temporary cover, Work out which are the key posts: Drivers? Financial controller? Technical specialists? 'Over-employ' key staff, or have other staff shadowing them and learning on-the-job. Promote VCT and work to create a supportive environment. Encourage communication about likely absences for whatever reason. It is easier to plan for absences if managers know that certain employees will be absent.
When someone leaves, it takes ages to fill the post.	Review and speed up recruitment processes.

4.3 A self-assessment framework for AIDS competence

Theme	1 Basic	2	3	4	5 High
Acknowledgement and recognition	We know the basic facts about HIV/AIDS, how it spreads and its effects	We recognize that HIV/AIDS is more than a health problem alone	We recognize that HIV/AIDS is affecting us as a group/community and we discuss it amongst ourselves. Some of us get tested	We acknowledge openly our concerns and challenges of HIV/AIDS. We seek others for mutual support and learning.	We go for testing consciously. We recognize our own strength to deal with the challenges and anticipate a better future
Inclusion	We don't involve those affected by the problem	We cooperate with some people who are useful to resolve common issues	We in our separate groups meet to resolve common issues (e.g. PLWAs, youth, women)	Separate groups share common goals and define each member's contribution	Because we work together on HIV/AIDS we can address and resolve challenges facing us
Care and prevention	We relay externally provided messages about care and prevention	We look after those who are unable to care for themselves (sick, elderly). We discuss the need to change behavior	We take action because we need to and we have a process to care for others long term	As a community we initiate care and prevention activities, and work in partnership with external services	Through care we see changes in behavior which improve the quality of life for all.
Access to treatment	Other than existing medicines treatment is not available to us	Some of us get access to treatment	We can get treatment for infections but not ARVs	We know how and where to access ARVs	ARV drugs are available to all who need them, are successfully procured and effectively used
Identify and address vulnerability	We are aware of the general factors of vulnerability and the risks affecting us	We have identified our area of vulnerability and risk e.g. using mapping as a tool	We have a clear approach to address vulnerability and risk, and we have assessed the impact of the approach	We implement our approach using accessible resources and capacities	We are addressing vulnerability in other aspects of the life of our group
Learning and transfer	We learn from our actions	We share learning from our successes but not our mistakes. We adopt good practice from outside	We are willing to try out and adopt what works elsewhere. We share willingly with those who ask.	We learn, share and apply what we learn regularly, and seek people with relevant experience to help us.	We continuously learn how we can respond better to HIV/AIDS and share it with those we think will benefit

Theme	1 Basic	2	3	4	5 High
Measuring change	We are changing because we think it is the right thing to do but do not measure the change	We begin consciously to self measure	We occasionally measure our own group's change and set targets for improvement	We measure our change continuously and can demonstrate measurable improvement	We invite other ideas about how to measure change and share learning and results
Adapting our response	We see no need to adapt because we are doing something useful	We are changing our response as a result of external influence and groups	We are aware of the change around us and we take the decision to adapt because we need to.	We recognize that we continually need to adapt.	We see implications for the future and adapt to meet them
Ways of working	We wait for others to tell us what to do and provide the resources to do so.	We work as individuals attempting to control the situation, even when we feel helpless	We work as teams to solve problems as we recognize them. If someone needs help we share what we can.	We find our own solutions and access help to others where we can	We believe in our own and others' capacities to succeed. We share ways of working that help others to succeed.
Mobilizing resources	We know what we want to achieve but don't have the means to do it	We can demonstrate some progress by our own resources	We have prepared project proposals and identified sources of support	We access resources to address the problem of our community because others want to support us	We use our own resources , access other resources to achieve more and have planned for the future
Human Resource	Staff have no knowledge of HIV/ AIDS	Staff have attended sensitization workshops on HIV/AIDS	We recognize the importance of training staff in HIV/AIDS	We are in the process of training staff on HIV/AIDS issues	We have trained staff and continue to update them with information on HIV/AIDS
Organization policy	No organization policy on HIV/ AIDS	We have no policy but realize the need to develop one	No policy yet but we are already engaged in HIV/ AIDS sensitization in the organization	Draft policy in place and we are addressing issues of prevention, care and support	We have a policy in place and a workplace HIV/ AIDS program is already being implemented
Level of openness	Staff do not discuss HIV/AIDS	Staff discuss HIV/AIDS issues informally	HIV/AIDS issues are part of the agenda for meeting	Special sessions on HIV/AIDS are held in the organization	Staff are sensitive to HIV/AIDS language and culture within the organization

Adapted from the UNAIDS framework for assessing HIV/AIDS competence, taken from Acord HASAP (2004): Report of Workshop on Mainstreaming HIV/AIDS in Programmes and the Workplace, for CDRN, TTP and TRACE

4.4 The process of developing and implementing a workplace policy

The key ingredients for the process of developing and implementing a policy are outlined here. These are the kinds of things which Program Officers might be looking for, or discussing with partners, when considering workplace policies.

Process

Have the participation of...

a range of people working for the NGO on the committee which is responsible for the process, representing different functions.

Do research into....

- legal requirements (can be done collectively)
- costs of different activities
- availability, cost, and quality of different services - public and private sector (can be done collectively)
- other NGOs' experiences (can be done collectively)
- current and future estimated impacts of HIV/AIDS on the organization (a useful exercise, but one which we are not expecting our partners to do in the pilot projects)

Consult with.....

- employees - the impacts of HIV/AIDS on them, their needs and preferences
- funders - how they feel about funding a part of the policy
- other organizations - how they may be able to help
- employees again - to get comments on the draft policy

Create a baseline...

so that you can better measure the impact of the policy, and make adjustments in the future. A baseline might include: an anonymous survey of employee's knowledge, attitudes and behaviors; assessing how much leave is taken and for what; and calculating current medical costs.

Do the maths....(see section 4.6)

- for likely uptake of benefits, particularly treatment
- for different options for implementing the policy e.g. the effect of including dependants
- plan who will implement which elements of the policy, and at what cost
- devise budgets and a plan for implementation, and seek funding if necessary

Keep communicating...

- ensure that all stakeholders are kept informed during the process
- explain decisions
- fully disseminate the final policy

Implementation

Start implementing...

even if not all the funding is in place, proceed with some activities.

Adapt systems...

to integrate the policy and its activities, e.g. make any changes to the health scheme to ensure

confidentiality, or make HIV/AIDS training part of the induction process, or write non-discrimination into employees' terms and conditions.

Monitor what happens...

for the purposes of accountability, but also to learn about what is happening, so that you can spot problems and try and solve them.

Keep on going....

Persevere to increase the impact of the policy, and so decrease the impact of HIV/AIDS.

Keep communicating..

without breaching confidence, share feedback and changes to the policy with all employees and with other NGOs.

4.5 Ways of delivering access to health care

This section briefly reviews the ways in which partners may deliver access to health care for their employees. Table C below presents a comparison of five methods.

Table C: Comparison of ways to deliver access to health care

Method	Advantages	Disadvantages
No provision: employees use public services	No cost to organization Does not increase the dependency of partners on external funding	Likely to be unable to access some services May be time-consuming e.g. long waiting times Services may be lower quality Employees will still have to pay fees, and may want org to cover those costs.
Give employees a cash lump sum or % of salaries to spend on health	Easy to administer Easy to budget for May be preferred by some, especially low-salary support staff	Employees may spend on other things e.g. new roof for a house, or faith healer. If they do not spend it on effective health care, the organization does not reap the benefit of its 'investment'. Sum likely to be too low to cover treatment of chronic illnesses

Method	Advantages	Disadvantages
'Home-grown' safety-nets, such as staff paying into a fund which is used to help employees as and when needed	High sense of ownership May encourage openness among staff Funds could be augmented by contributions from donors No problems with budgeting or carrying funds over from one year to another	Potentially divisive, if the terms for accessing funds are not very clear and adhered to Individuals within the NGO would have to manage the fund, and make difficult decisions Claimants would have to share medical problems with colleagues who manage the fund. Wider confidentiality in the workplace may be difficult to maintain. Likely to involve judgments of the relative merits of individuals' claims ('innocent' vs. 'guilty' 'victims' of HIV) Unsustainable in the case of ARVs (as costs are on-going) without on going top-ups from the NGO or donors. Unfair, if funds are allocated on a 'first come first served' basis.
Direct provision: pay for employees to use private health services as required, up to a maximum expenditure per employee or family	Should provide full range of services May be more efficient May be higher quality Organization only pays for actual costs incurred	Difficult to budget for, especially in a small organization. Uncertainty regarding actual costs may be off-putting for donors. Issue of what to do about underspending (many donors do not like funds to be carried over) and overspending (how to meet the shortfall).
Insurance: pay for cover which will meet some or all of private health costs when incurred	Easy to budget for Predictable/known costs, therefore may be easier to get donors to support Should provide full range of services May be more efficient May be higher quality Collaboration between partners should make it possible to negotiate good range of good value insurance options	May be underused e.g. paying for 30 employees to be covered for ARVs, but only 2 need them, and neither of them are accessing them. Insurance terms will be inflexible and may be damaging e.g. some companies only pay for ARVs once the claimant is AIDS-sick, rather than when the CD4 count drops. Dependent on existence of competent insurers in whom staff have confidence. Likely to look expensive, but cannot be compared with direct provision, as insurance covers all health problems, not only ARVs.

Note also that these methods can be mixed. For example, lower-paid staff might opt to have a lump-sum which boosts their income, whilst others might prefer to contribute to the cost of insurance cover.

4.5.1 Cost sharing

The idea of cost sharing can be incorporated in the methods above. Some people believe this is a good practice because it encourages employees to have greater ownership of the medical scheme, and to commit to the treatment which they receive, so promoting their compliance. Psychologically, an individual may be more likely to attend an appointment, to take a drug regularly, or to follow nutritional advice if they are contributing towards the cost of the service they are receiving. Of course, cost sharing also has the practical advantage for the organization that its costs are reduced.

However, great care must be taken to ensure that cost sharing does not exclude employees and their families from getting treatment because the proportion set is too high. The way costs are shared also needs to be considered. For example, cost-sharing ARV treatment with the employee making a 5% contribution sounds fair, but would not be. For low-paid employees the 5% would be a much larger proportion of their income than for more highly-paid employees. A fairer method would be to contribute a percentage of salary. However, cost-sharing actual costs undermines confidentiality, as the organization's administration must be able to link actual health expenditure to individuals in order to deduct their share of their costs from their salaries. One way around this would be for the employee to pay its share to the health care provider. An alternative is cost-sharing through a fixed contribution for each member of staff - for example, a 2% deduction from salaries - which allows confidentiality to be maintained and is easy to administer. However, that method weakens the psychological link between contributing to and adhering to treatment.

4.6 Calculating costs

When looking at budgets for workplace policies, most of the calculations are similar to those which NGOs already make. For example, the cost of running a half-day session on HIV/AIDS for staff every six months will involve the same kinds of items which any training day involves: perhaps the cost of a facilitator, tea and snacks, possibly room hire, maybe travel costs (or maybe none of these, if it is to be done in-house).

Some of the other costs will be more novel, and will require some guesswork. For example, how many condoms might an average employee take each week? How many employees might go for voluntary counseling and testing? Such costs might be omitted if good quality condoms and VCT are available and affordable locally; in such cases the only costs to the organization will be to do with reducing stigma among employees and motivating them to want to access condoms and VCT.

The most significant costs are to do with treatment, death benefits, and any other elements of the policy which concern how many people may be HIV-positive, how many may be sick, and how many may die. Again, though, some of these may not apply if there is good access to treatment through the public health system. Table D sets out how an NGO might estimate the costs of treatment through private provision. For India the price of treatment is similar, but the adult HIV prevalence rate is around 1%, so the costs are around one quarter of those in Table D.

Table D: Estimating the cost of treatment for a NGO in Uganda

Estimating the cost of treatment for a Year 1 NGO in Uganda		Notes
a No of eligible staff	25	
b Plus eligible partners & dependants	75	1 spouse + 2 dependants
a+b = c no of eligible people	100	
d assumed proportion who are HIV+	4%	National prevalence is 6% of 15 to 49 year olds: use lower % as some dependants will be under 15.
c x d = e estimated no of eligible people who are HIV+	4	
e x 12.5% = f estimated no needing ARV treatment	0.5	Assume 25% of HIV+ need treatment: assume half of those need ARV treatment
e x 12.5% = g estimated no needing treatment for opportunistic infections	0.5	The other half of 25% do not yet need ARVs, but need treatment for O.I.s
f x 40% = h estimated no accessing ARV treatment	0.2	Of those who need ARVs, not all will access them
f + g - h = j estimated no accessing treatment for O.I.s	0.8	All of those who do not need ARVs, plus those who need them but are not accessing them
Treatment costs		
k price of 1st line ARV treatment per person per year in $ (as at end 2005)	400	Price rises to $1,250 in 15% of cases where 2nd line treatment is needed
l estimated cost of treatment for O.I.s per person per year in $	300	Costs vary from $10 to $2,000, depending on the problem, so difficult to estimate
(h x k) + (j x l) = estimated cost of all treatment	320	
Cost per eligible person per year	3.20	

Please note also that:

- The estimates should be extended to cover 3 to 5 years because ARV costs accumulate so long as ARV treatment is successful and staff remain with the NGO.

- Treatment costs will rise if there is a rise in the proportion of people needing second line treatment due to drug resistance, for example, a person accessing treatment in Year 1, who needs second line ARVs by Year 3.

- The calculations show how difficult it is to budget for treatment, particularly for small organizations and in situations of lower HIV prevalence. In reality, it will not be 0.2 of a person who accesses ARV - it will be zero, or one, or more. The important thing for us as donors is to emphasize the need to be open; to ask about how things are turning out, and to encourage partners to talk about what is happening.

- To budget a whole workplace policy, partners would need to also add in other assumptions and calculations as appropriate to their organization. For example, if the policy includes funeral costs and death benefits, estimates for these should be included, along with the aforementioned costs of education, VCT, condoms, and so on. We intend to provide support to partners to help them to budget for workplace policies though the pilot projects.

An alternative way of providing access to health care is through insurance. Through the pilot projects we are already talking with insurance providers, and are hopeful that we will be able to negotiate a good deal (against the current price of around $160 per person per year to cover all illnesses including HIV/AIDS and access to ARVs).

4.7 Ideas for monitoring and evaluation

Monitoring and evaluation is, of course, a weak area for many NGOs (big and small, local and international). In the case of workplace policies it is made a bit more difficult by the need to maintain confidentiality about some components. Nonetheless, it is possible to find appropriate ways of gathering feedback and monitoring change. For example, in conjunction with its contracted service provider, CARE South Africa-Lesotho is tracking whether its employees are engaging in four key desirable actions through these indicators:

1. the extent to which staff are participating in education sessions;
2. the number who are going for VCT (self-reported, and as logged by the service provider);
3. the number who register with the service provider's positive living support group;
4. the number accessing treatment for opportunistic infections and ARVs through the service provider.

Table E provides some further suggestions, using a combination of an annual anonymous staff survey (including whether a respondent is male or female) and management indicators. These measures would be in addition to the overall monitoring of actual costs against budgeted costs. Clearly each NGO should devise indicators which are relevant to what its policy contains, and should try to balance the need for sufficient indicators against the costs of gathering and analyzing the data. There is also the issue of the size of the organization to consider with regard to methodology; for example, an annual anonymous survey would not be appropriate for an organization with only 5 employees.

Table E: Possible methods for monitoring and evaluating a workplace policy

Note, as far as possible, all measures should be disaggregated by gender.

Theme	Means of monitoring
Is the policy in place and being implemented?	• Staff and family members' survey: test them on their knowledge of the policy's contents. • Check activities against plans e.g. whether education & motivation sessions have been held.
Confidentiality	• Staff and family members' survey: ask for their perceptions and experiences.
Non-discrimination and reasonable accommodation	• Staff survey: ask for their perceptions and experiences. • Record how instances of discrimination or breaches in confidentiality have been dealt with. • Record any cases of reasonable accommodation.
Education and environment	• Staff and family members' survey: assess knowledge, attitudes, and practice with regard to stigma, means of prevention, VCT, positive living, care, treatment, the workplace environment, and any other issues covered in the sessions. • Number of sessions held, attended by whom (gender, status). • Results of 'before' and 'after' evaluation measures taken at education sessions. • Record anecdotes illustrating positive and negative aspects of knowledge, attitudes, and behavior in the workplace.
Gender issues	• Monitor any measures undertaken to address gender discrimination with the NGO, and to promote greater gender equity.
Prevention measures	• Log cases of sexual behavior which breach the organization's code of what is acceptable, including the disciplinary action taken. • Staff survey: where staff risk HIV infection at work e.g. health workers, ask if they have access to means of universal precautions, and if they use them. • Monitor distribution of male and female condoms. • If possible without compromising confidentiality, log numbers of people accessing post-exposure prophylaxis, VCT, STI treatment, and treatment to prevent HIV transmission from mother to child.
Treatment and care	• If possible without compromising confidentiality, monitor number of HIV-positive people accessing treatment for opportunistic infections, antiretroviral treatment, support systems for positive living, and legal advice. • Monitor costs of treatment against budget. • Where possible, get feedback from HIV-positive employees and family members about their experiences of the treatment and care provisions, as well as their insights into the workplace environment and thoughts about the overall policy.

In terms of tracking the effects of HIV/AIDS, and of the workplace policy, it would also be useful to have indicators for things such as the rate of staff turnover, the amounts of the different types of leave taken, and expenditure on death benefits.

STOP AIDS NOW! aims to expand and improve the Dutch contribution to the global fight against AIDS. In STOP AIDS NOW! five organizations, Aids Fonds, Hivos, ICCO, Memisa (Cordaid), and Novib have joined forces.

STOP AIDS NOW! aims to:

* Raise funds in order to contribute to more AIDS projects in developing countries.
* Obtain political and public support for the battle against AIDS, both nationally and internationally.
* Innovate or redefine existing strategies and to establish new forms of cooperation in order to improve the response to HIV/AIDS and to meet the needs of people affected by HIV/AIDS

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