

# Addressing HIV and AIDS in the workplace

Lessons Learnt from  
Civil Society Organisations  
and Donors

**STOP  
AIDS  
NOW!**

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AIDS in the workplace**  
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## Abbreviations

|               |  |
|---------------|--|
| <b>AIDS</b>   | Acquired Immunodeficiency Syndrome             |
| <b>CSO</b>    | Civil Society Organisation                     |
| <b>HIV</b>    | Human Immunodeficiency Virus                   |
| <b>ILO</b>    | International Labour Organisation              |
| <b>INTRAC</b> | International NGO Training and Research Centre |
| <b>PLHIV</b>  | People Living with HIV                         |
| <b>SADC</b>   | Southern African Development Community         |
| <b>VCT</b>    | Voluntary Counselling and Testing              |



# Introduction

## Why have we written this report?

STOP AIDS NOW! and its partners have been investing in stimulating workplace responses among CSOs to HIV and AIDS for a number of years now. Many experiences, both of what has and has not worked, have been written down, yet they are spread over more than 40 different documents. Even if you had access to all those documents, would you have time to read them, and then figure out what applies to your organisation? So we have written this report to benefit us all: an analysis of all those documents, pulling out the lessons learnt, with the addition of the verbal input of around 20 individuals with expertise relating to addressing HIV in the workplace. Our intention is to provide an efficient way for many people to learn from others' experiences, and so to improve responses to HIV and AIDS in the workplace.

Please note that the analysis is limited to the experiences of STOP AIDS NOW!, its partners (ICCO, Cordaid, Hivos, Oxfam Novib and Aids Fund), their civil society organisation (CSO)<sup>1</sup> partners, and other STOP AIDS NOW! partners such as INTRAC. The degree of research which lies behind each of the lessons varies from full evaluations to observations, so the findings are not equally substantiated. However, for each lesson we have listed the numbers of the source documents (which appear in the Annex), so it is easy to gauge which lessons are widely reported and which are more unusual. Finally, most of the lessons learnt come from organisations in Sub Saharan Africa. While there are several initiatives by STOP AIDS NOW! and its partners addressing HIV and AIDS in the workplace in Asia, these have not yet been documented extensively.

## How to use this report?

For a rapid overview, please go to the summary chart at the beginning of the document. We have grouped the lessons learnt in six categories, which should help you find the sections of most relevance to your organisation.

The text of the report follows the same structure as the summary. It begins with the whole point of the work: the positive impacts of workplace HIV policies and programmes on CSOs and their staff. Next are three sections of lessons learnt for local organisations, on the practical level of developing and implementing their own workplace policies and programmes. This is followed by lessons learnt for local capacity building providers seeking to support CSOs. The report ends with lesson learnt about the role of donors.

Throughout the report, the source documents are listed for each lesson learnt, so for more detail you can use the Annex to identify specific source documents for your further reading.

## Why address HIV and AIDS in CSOs' workplaces?

Worldwide in 2007 there were an estimated 33 million people living with HIV, 2.7 million newly infected people, and 2 million AIDS related deaths<sup>2</sup>. The majority of those living with HIV and AIDS live in Sub Saharan Africa, are employed and in their productive years, with skills and experiences that their families, workplaces and countries can ill afford to lose<sup>3</sup>. With these statistics it is not hard to imagine that the economic and social costs of HIV and AIDS are enormous. This is already evident in highly affected nations, but is likely to emerge in countries with low levels of HIV prevalence in years to come.

In both the South and North, development organisations are slowly waking up, like many international businesses before them, to the fact that HIV and AIDS are threatening their performance and effectiveness. In HIV-affected countries, HIV and AIDS are not only infecting and affecting a significant proportion of CSOs' beneficiary groups, but are also having an impact on their own organisations. CSOs struggle due to loss of staff through sickness, death, care for relatives, and funerals; reduced performance of staff because of sickness or distraction; and rising medical expenditures. This results in declining output and increasing overhead costs. In recent years many organisations have therefore started to manage HIV and AIDS in their own workplaces through HIV workplace policies and programmes, also referred to as internal mainstreaming.

<sup>1</sup> Civil society organisations (CSO) refers to organisations such as registered charities, development non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trades unions, self-help groups, social movements, coalitions and advocacy groups

<sup>2</sup> UNAIDS. (2008). UNAIDS Annual Report – Towards Universal Access. Retrieved from [http://data.unaids.org/pub/Report/2009/jc1736\\_2008\\_annual\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1736_2008_annual_report_en.pdf)

<sup>3</sup> ILO. (2009). Facts on HIV and Work. Retrieved from <http://www.ilo.org/public/english/protection/trav/aids/events/ilc09fs.pdf>, and UNAIDS. (2008). UNAIDS Annual Report – Towards Universal Access. Retrieved from [http://data.unaids.org/pub/Report/2009/jc1736\\_2008\\_annual\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1736_2008_annual_report_en.pdf)

In addition to protecting the organisation's ability to work, internal mainstreaming can protect human rights by breaking the silence around HIV and AIDS, and by reducing discrimination and stigma aimed at workers living with or affected by HIV and AIDS. It can also support individuals to claim their rights through providing information to make informed decisions, and by increasing access to treatment, care and support. Workplace policies and programmes should also attend to the way in which HIV and AIDS can widen gender inequalities.

Finally, another motivation for addressing HIV and AIDS internally is that it is likely to strengthen the way in which CSOs respond to HIV and AIDS in their work. This may be through AIDS-focussed work, such as HIV prevention or care, or through adapting the organisation's usual work.

Most responses to HIV and AIDS in CSOs' workplaces have come from high prevalence countries in Sub Saharan Africa. However HIV and AIDS should also be addressed in the workplace in low prevalence countries as absolute numbers can be high. India for example has just 0.36 per cent HIV prevalence, but this translates into 2.5 million HIV-positive people. Low prevalence contexts can cause complacency, but they also offer the opportunity to address HIV early. This reduces the likelihood that localized epidemics will become generalised<sup>4</sup>.

<sup>4</sup> See source document number 5 in Annex

**Addressing or managing HIV and AIDS in the workplace is also referred to as internal mainstreaming. It has to do with adjusting policy and practice to try and reduce the organisation's susceptibility to HIV and its vulnerability to the impacts of AIDS.**

**Mainstreaming can also be focussed at addressing the causes and effects of HIV and AIDS in an organisation's usual work with beneficiaries. This is called external mainstreaming.**

## Summary of Lessons Learnt: Addressing HIV and AIDS in CSOs' Workplaces

### Impacts of internal mainstreaming experienced by CSOs and their staff

- Increased knowledge, competence and awareness levels of HIV and AIDS.
- Increased openness in the workplace and ability to talk about HIV and AIDS.
- Reduction of stigma and discrimination.
- Promotion of normalisation of staff living with HIV.
- Increased intention and willingness to disclose status if found HIV positive, and more confidence in job security.
- Increased proportion of organisations with HIV prevention mechanisms in place.
- Organisations have increased interaction with HIV service providers.
- Increased access to HIV related services for staff.
- Improved service seeking behaviour by staff, with more staff getting HIV tested and more staff on anti retroviral treatment.
- Behaviour change, with staff reporting safer sexual behaviour and more staff taking condoms from the workplace.
- A more gender friendly workplace.
- A spill-over effect to family and community.
- Addressing HIV and AIDS in the workplace stimulates external mainstreaming.

### Lessons learnt for CSOs about making a start with internal mainstreaming

- Systems should be appropriate for the development stage an organisation is in.
- Organisational culture is a strong determinant in openness to address HIV.
- Conducting a risk assessment is important to identify the susceptibility and vulnerability of organisations to HIV and AIDS, and their capacity to deal with internal mainstreaming.
- 'Organisational stigma' of being affected by HIV and AIDS can prevent an organisation from revealing it is affected by HIV, and therefore from developing a policy.

- Importance of CSOs becoming aware of the organisational costs of HIV, and that not having an HIV policy means higher indirect costs.
- Type of organisation:
  - It should not be assumed that AIDS service organisations have an HIV workplace policy in place
  - A special approach is needed for those faith-based CSOs that do not approve of condom use
  - In one survey, older CSOs were least likely to have a workplace policy, and faith-based CSOs were less likely than secular organisations to have a workplace policy.

### Lessons learnt for CSOs about developing a workplace policy

- Having a written policy assists in ensuring fair and consistent treatment of staff.
- There is no one-size-fits-all policy, but there are some basic principles to follow.
- Ownership and participation are key in the success of addressing HIV and AIDS in the workplace.
  - Mutual trust, a shared vision and shared action between management and other staff is key
  - The policy should be available to all staff. For everyone to understand the policy, wording is important. To keep discussing the policy in routine meetings is a good way to keep staff informed and up to date, and increase understanding of the contents
  - A good way for staff consultation is to mix individual questionnaires with group discussions
  - A survey of staff views can be a useful tool
  - The atmosphere for discussion has to be safe, respectful and conducive
  - Consciousness about how HIV affects staff personally is important in the process.
- Commitment of top leadership/management is crucial to get internal mainstreaming prioritized, going and continuing.
- People living with HIV should be positively and meaningfully involved, without them becoming over-worked and over-involved.
- Gender issues affect susceptibility and vulnerability, so workplace policies and programmes must be gender sensitive.

- The development process should not drag on for too long; the initial policy does not have to be perfect, but should be monitored, reviewed and improved as time goes on.
- To be sustained, workplace policies and programmes need to be integrated in existing work plans, expected outputs and budgets. Those responsible need clear tasks in their job descriptions and time allocated for the work.
- The cost of providing care goes beyond the cost for medication.

## Lessons learnt for CSOs about implementing a workplace policy

- Unless stigma is addressed, effective implementation of an HIV and AIDS policy is impossible. A key objective is to create an open and supportive environment, through, improved understanding.
- People living with HIV should be positively and meaningfully involved, without them becoming over-worked and over-involved.
- Appointment of focal points for HIV can make HIV mainstreaming initiatives more effective. Important conditions are that:
  - The individuals hold a position in the organisation that enables them to influence management, programme and support staff
  - There is wider ownership, which gives them a better platform from which to play their role
  - There are at least two focal points, or a rotating focal committee/steering committee
  - Dedicated time is part of the job description of each focal point.
- Peer pressure can be used to good effect in HIV and AIDS programmes in the workplace.
- Extending workplace programmes to employees' immediate family members makes them more effective.
- Bringing VCT services to the workplace has been successful in reaching employees, their family members, and the wider community.
- Implementation does not have to be held up by budgetary constraints.
- Ensure all staff understand the policy, and keep it 'alive' through discussions at repeat trainings, refresher sessions, and HIV-related events.
- A workplace policy should be considered as a living document, which should be reviewed and updated regularly to make sure it keeps pace with the changing needs and context of the organisation.
- Organisations have to think creatively to provide systems and procedures to protect the

- confidentiality of staff who use HIV and AIDS related services while also providing financial oversight.
- A multi-cultural workforce requires a variety of teaching methods and approaches.
- Partnerships and co-operation are needed:
  - With service providers to increase access for staff
  - With other stakeholders to learn from each others' experiences and build upon these
  - For joint lobbying for all necessary services to become available freely.

## Lessons learnt for local capacity building providers about supporting others to do internal mainstreaming

- It is important to 'walk the talk'.
- Expertise is needed in HIV and in facilitating organisational change processes for proper support to effective HIV workplace policy development.
- Capacity building requires networking, collaboration and exchange of learning between different organisations and stakeholders.
- Follow-up is critical, as staff are highly mobile and awareness raising is a continuous process.
- Forming a good relationship with the individuals responsible for the policy in the CSO helps capacity builders to know how to support them, and to contextualise the interventions.
- A learning community of capacity builders in sub-Saharan Africa exists to stimulate reflection on practice, sharing of experiences, and learning from new tools. – see [http://www.intrac.org/pages/CB\\_Learning\\_Group.html](http://www.intrac.org/pages/CB_Learning_Group.html)

## Lessons learnt about the role of donors

### Perspective of local organisations

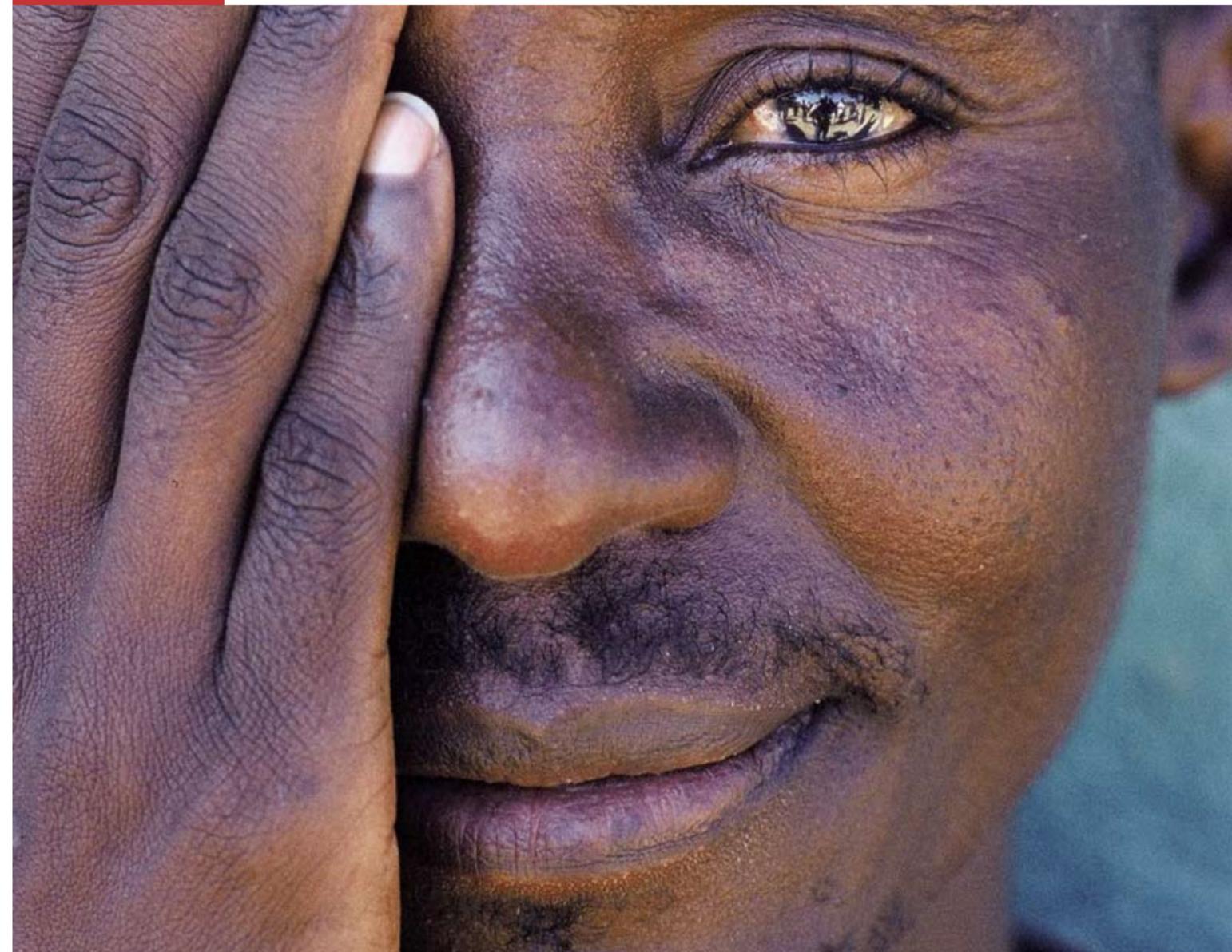
- Often, the reason for not implementing workplace policies is a lack of resources and the unwillingness of donors to fund this implementation.

### Donor perspective

- It's important to 'walk the talk', including donor organisations training their own staff as part of their own internal mainstreaming.
- Donors working in countries of high HIV prevalence need to incorporate the costs of HIV to partners in their plans.
- Supporting internal mainstreaming is more than one-off support for training or policy development.

- Ongoing donor support is essential for developing the pool of local capacity building providers with the ability to assist CSOs to mainstream HIV and AIDS.
- Ownership of the policy development by partners is believed to be crucial for the actual implementation.
- Local CSOs need to be more up front with donors about the need to address HIV and AIDS in their workplace.
- Donors can also take a more active approach in stimulating their partners to address HIV and AIDS in their workplaces.
- Clear roles and shared responsibilities between donor and partner lead to better commitment and results.

- Drawing in more donors is necessary.
- Donors need to use their influence, jointly lobbying with their partners, to increase access to necessary services in each country.
- Donors' focus on workplace policies needs to be complemented by recognising the role of informal responses too.
- The 4% funding by the STOP AIDS NOW! donors is in some cases insufficient to cover the costs, while in other cases less than 4% is required.



# 1 Impacts of internal mainstreaming, as experienced by local organisations and their staff



**1** An **increase in the AIDS knowledge, competence and awareness levels** within an organisation. For example, staff know that their organisation has a workplace policy in place, and understand the importance of developing such a policy and how this is done. Also, staff are more aware of the rights, responsibilities and services available to staff that come along with the HIV workplace policy. On a content level internal mainstreaming has increased competence and awareness on, for example, how HIV is spread and how it can be prevented, on a proper attitude towards people living with HIV (PLHIV) – not to stigmatize and discriminate them – and on the importance of voluntary counselling and testing (VCT) (1, 8, 16, 17, 24, 28, 34, 37, 43).

**2** **Increased openness in the workplace and greater ability to talk about HIV and AIDS** and how it affects staff personally and their organisation (1, 4, 8, 16, 24, 30, 37, 39, 43, 44). For example, in one case (1) staff reported that they can now discuss issues related to AIDS and how it affects their families with fellow staff during lunch breaks or duty travel, and that AIDS is no longer a taboo issue.

**3** **Reduction of stigma and discrimination** in the workplace concerning HIV and AIDS in general and towards PLHIV in particular. This has been achieved in part through the active implementation of a policy on inclusion, but also through the participatory process of developing the workplace policies. Furthermore, various workplace activities have promoted **the normalisation of staff living with HIV** instead of looking at PLHIV as an unusual and undesirable ‘problem’. Stigma reduction creates a more open and conducive environment, allowing PLHIV within an organisation to disclose their experiences to fellow staff if wanted (1, 4, 15, 16, 24, 28, 34, 39, 41, 43), which can also help other staff to seek testing (42).

**4** The above impacts also lead to an **increased intention and willingness among staff to disclose their status within the workplace** if they are HIV positive. Related to this, **staff have felt more confident that they would not lose their job** if found to be HIV positive (1, 4, 16, 30, 41, 42, 43).

**5** **Increased proportion of organisations with HIV prevention mechanisms in place.** For example by providing condoms at the workplace, having first aid kits, and sharing information through educational materials, behaviour change sessions, AIDS corners, emails, newsletters and notice boards (1, 4, 8, 15, 16, 44).

**6** **Organisations have increased interaction with HIV service providers,** for example for promotion of VCT. This has **increased access to these services for staff and lead to improved service seeking behaviour by staff.** In particular, creating a safe environment has led to more staff getting tested for HIV, and more staff on anti retroviral treatment (1, 4, 8, 16, 17, 24, 28, 34).

**7** **Behaviour change, mainly related to safer sexual behaviour.** Staff reported being more faithful to one partner and using condoms outside marriage or with casual partners (1, 24). Organisations also report that **more staff take condoms** provided by the organisation (1, 30).

**8** **A more gender friendly workplace** by bringing in gender awareness. Gender relations have changed. Some staff report that they are more open to talk with the other genders about HIV and AIDS (1).

**9** **A spill-over effect to family and community.** On the one hand because staff talk about workplace policy issues with friends and family outside the workplace. On the other hand because some organisations deliberately involve the family and the community in the workplace programme, through sharing information, education campaigns or VCT family days (1, 4, 8, 12, 15, 19, 24, 28, 42). There is also spill-over where staff take condoms from the workplace for others to use (1).

**10** **Stimulation of external mainstreaming.** Participatory development and implementation of a workplace policy has motivated some CSOs which do not have health or AIDS as their (core) business, to start talking about HIV and AIDS with their ‘beneficiaries’. Some organisations now try to mainstream HIV and AIDS in all their programmes (4, 24, 42).

## Lessons learnt for CSOs about making a start with internal mainstreaming

### 1

Systems for addressing HIV and AIDS in the workplace should be appropriate for the **development stage an organisation is in**. This means that for smaller, more informal CSOs, a less formal policy may be more suitable to promote appropriate action. Response should build on already existing (informal) structures (7, 26).

### 2

**Organisational culture is a strong determinant** of whether an organisation is open to develop a workplace policy or not. This culture is strongly related to values on gender and stigma, and leadership in an organisation. An effective response requires a culture of openness and responsibility (2, 7, 26, 32, 36, 41).

### 3

**Conducting a risk assessment is important to identify the susceptibility and vulnerability of organisations to HIV and AIDS, and their capacity to deal with internal mainstreaming.** For example, it leads to better understanding of how staff are susceptible to HIV infection, and of the impact of HIV and AIDS on the workplace (18, 26).

### 4

**'Organisational stigma' of being affected by HIV and AIDS can prevent an organisation from developing a policy.** Experience shows that organisations can have difficulties revealing to their donors that their performance might suffer as a result and perhaps jeopardise future support. There is an incentive therefore to deny the organisational impact of HIV (6, 32). **Creating awareness** of the need for internal mainstreaming is therefore key (15, 24, 32).

### 5

It is important for CSOs to **become aware of the organisational costs of HIV** to proactively start addressing HIV in the organisation. Often these costs are hidden in programme budget lines. Many CSOs do not have complementary systems in human resource management, finance and monitoring and evaluation to enable them to respond adequately (14, 26, 27). Yet **not having an HIV policy means having higher indirect costs** including absenteeism, loss of morale, underperformance, and management time (26).

### 6

With regard to the **type of organisation**

- **It should not be assumed that AIDS service CSOs have policies and processes in place to address HIV and AIDS in the workplace** (42)
- **A special approach might be needed towards faith-based CSOs** which have objections against discussing condom use and providing condoms in the workplace (1)
- Research among 29 CSOs in Malawi, Tanzania and Uganda showed that older CSOs were least likely to have a workplace policy, and faith-based organisations were less likely than secular organisations to have a workplace policy.



# 3 Lessons learnt for CSOs about developing a workplace policy

## 1 Experience shows that **having a written policy assists in ensuring that all staff are treated fairly and with consistency.**

It enhances the possibility of continuity in response. It encourages better planning and therefore budgeting of response. Having a written document also helps to integrate the HIV response with other systems and policies, and enables legal compliance with national legislation. It also provides an accountability framework for funds received from donors to finance HIV responses. A written document clearly demonstrates to staff that the organisation takes their welfare seriously. Yet having a written policy in itself is, of course, not sufficient and needs to be complemented by programmes (7, 13, 14, 26, 42).

## 2 There is **no one-size-fits-all policy.** Policy development has to be **contextualised** by the experience, needs and material conditions of individual organisations, and by the legal framework of the country in which the organisation operates, to be effective. Policies and action plans should be explicit and realistic: **practical and pragmatic policies that fit the CSOs resource base are more effective** than politically correct wish lists or vague principles (7, 13, 29, 31, 32, 33).

- Experience shows however that each workplace policy should be **based on the following basic principles** (33):

- national labour laws and international guidelines (also 11, 13, 21)
  - address the four major objectives of prevention, positive living, access and adherence to treatment, and mitigation of social and economic impact
  - a close link to other staff health/wellness policies
  - provision of basic services such as HIV and AIDS education, access to condoms, promotion of general wellness and positive living
  - ensure confidentiality, while seeking to reduce HIV and AIDS related stigma.
- Contextualisation of the policy also refers to whether the policy should be a **stand-alone** HIV and AIDS policy, **or** should be part of a broader **health or wellness policy** (33, 42).

## 3 **Ownership and participation of all staff are key.**

If all the staff, including management, are not involved from the beginning, and so do not own the process, less progress will be made. Involving everyone from the beginning helps them understand the need for everyone to do something about managing HIV and AIDS within their workplace and ensures everyone's views are taken into account: **acceptability, responsibility, accountability.** As internal mainstreaming is not a one-off event, it is important to sustain this involvement in the course of the implementation. This also enables the staff joining after the initial meeting to get on board. Using a participatory approach **encourages discussion of important issues** of disclosure, stigma and discrimination and can therefore help in demystifying these issues (1, 2, 10, 11, 12, 13, 14, 15, 16, 19, 23, 24, 25, 26, 28, 30, 33, 34, 36, 37, 41, 42, 43, 44).

- **Mutual trust, a shared vision and shared action between management and other staff is key** for internal mainstreaming (9, 11, 42).
- To increase effectiveness of the policy, it is good to **make the policy available and known to all staff** (irrespective of job category) in an organisation (therefore sometimes translation in local language is necessary). Though a policy is a formal document, **wording** should be simple enough for everyone within the workplace to understand it easily (11). To **keep discussing the policy** in routine meetings is a good way to keep staff informed and up to date, and increase understanding of the contents (1, 16, 19, 25).



- A good way for staff consultation is to **mix individual questionnaires with group discussions** to allow views to be expressed anonymously, as well as discussed with others (30).
- **A survey of staff views can be a useful tool** for internal advocacy purposes by demonstrating the level of support for the policy within the staff (30).
- As HIV and AIDS is linked to sexuality, stigma and discrimination, **the atmosphere** in which management, staff and volunteers discuss matters **has to be safe, respectful and conducive** (34).
- When staff are **conscious about how HIV affects them personally**, they are more likely to have the motivation to contribute to an organisational response and to take HIV into strategic planning processes (26, 32).

## 4 **Commitment of top leadership/management** is crucial to get internal mainstreaming prioritised, going and continuing (10, 11, 12, 15, 16, 18, 21, 23, 24, 26, 28, 29, 32, 33, 34, 37, 42, 45).

- **Evidence-based information** is important for convincing management on the need for a workplace policy (42).
- In order to ensure leadership buy-in, it is vital to **make sure that all staff are fully trained.** It should not be assumed that senior staff have more knowledge with regard of HIV and AIDS than other staff (28).
- Workplace policies and programmes can **contribute most in workplaces where the quality of work and a healthy lifestyle are valued and worked at.** In such workplaces, the push to improve worker performance is a visible and primary goal of leadership; it is central to the institution's planning, budgeting and personnel decisions (23).

## 5 **For effective workplace policies it is important to positively and meaningfully involve people living with HIV.**

This is not a natural process if there are no employees openly in the workplace with HIV. Where PLHIV are willing to take part in the response, their contribution should be recognised and rewarded, including reallocation of other duties as necessary. Responsibility should be shared and not 'dumped' at the feet of PLHIV. Over-working and 'over-involving' PLHIV undermines the policy aim of supporting them to protect their health and to work efficiently (14, 15, 28, 33, 39, 41, 42).

## 6 Gender is an important factor influencing susceptibility to HIV infection and vulnerability to the impacts of AIDS; as a result, HIV and AIDS affect men and women differently, so workplace policies need to be **gender sensitive** (16, 32, 45).

## 7 Experience shows that the **process** of developing an HIV workplace policy **should not drag on for too long as this can result in a loss of momentum.** Quick implementation also helps to **strengthen the confidence** of staff, which can support them to stay healthy and productive. The initial policy does not have to be perfect. After being put into action, it should be closely monitored, reviewed and improved when necessary (19, 33, 43).

## 8 To stop internal mainstreaming remaining at the level of good intentions, and to increase sustainability, it must be **integrated into existing work plans, expected outputs and budgets.** Making it a strategic issue like this also ensures that management can be held accountable for it in their overall performance (1, 16, 32, 33, 42, 43). Those responsible for implementing and monitoring the activities need to have the **tasks and objectives in their job descriptions with time allocated** and clear division of responsibilities (1, 8, 24, 25, 43).

## 9 The **cost of providing care goes beyond the cost for medication.** Other costs that should be taken into account when designing a workplace policy are for example nutrition and transport costs or counselling for staff (and dependants) (28).

## 4 Lessons learnt for CSOs about implementing a workplace policy

1

**Unless stigma is addressed, effective implementation of an HIV and AIDS policy is impossible.** A key objective is to **create an open and supportive environment**, through an improved understanding of HIV and AIDS among staff members. This can be done both formally and informally through trainings, sensitisation sessions, staff meetings and storytelling. Strategies for addressing stigma also need to address stigma in the external environment, which may restrict take-up of services such as VCT (9, 14, 16, 19, 21, 25, 26, 28, 30, 32, 36, 39, 41, 42).

- Building this capacity **takes time, understanding and knowledge** (28)
- Trainings need to be **tailor-made** to different staff (e.g. managers, implementing staff) (42).

2

**For effective workplace programmes it is important to positively and meaningfully involve people living with HIV** (14, 15, 33, 39, 41, 42). See lessons learnt for local organisation about developing a workplace policy nr 5.

3

Appointment of **HIV and AIDS focal point person(s)** can make HIV mainstreaming initiatives more effective (10, 16, 17, 42).

- If a focal person is expected to be the 'engine' for internal mainstreaming, they need to hold a **position** in the organisation that enables them to influence management, programme and support staff. The person's position will affect the 'power' they have to influence other staff, and their ability to: attend capacity building sessions; convince donors about the need for funding to implement the workplace policy; delegate some activities to other people to make their workload more manageable (10).
- **Ownership** among all staff, including management, **gives focal persons a better platform** to play their role (10).
- It is important to have **at least two people** as focal points (main and assistant) **or a rotating focal committee/steering committee** (in which management is also represented) directly and actively involved in the process. This provides backup in case one leaves the organisation. It also enlarges knowledge and ownership of the policy within an organisation (10, 11, 14, 42, 43).

- A focal point person/steering committee is more effective when dedicated time is **part of the job description** (10, 42, 43).

4

Senior staff members and other key persons with responsibility for HIV can lead by example, modelling good practices which other staff are then more likely to copy. **Peer pressure** can be used to good effect in the workplace (12, 15, 16, 42).

5

Experience shows that **extending workplace programmes to employees' immediate family members makes these programmes more effective.** For example when anti retroviral treatment is made available to immediate family members also, it can increase the uptake of treatment among employees. Involving family members also encourages discussion between staff and their sexual partners about safer sex and other relevant issues. However, issues of affordability and sustainability must be considered particularly as treatment and care programmes cannot be short-lived (8, 11, 25, 26, 28, 33, 42).

6

**Bringing VCT services to the workplace** has proven to be successful in reaching out to employees, their family members and the wider community (12):

- When **top managers (with their families) lead by example** in openly going for VCT it can **increase staff uptake**
- **Having CSOs to host the event** (the CSO in question or in partnership with other local CSOs) and to take a central role in the whole process increases ownership and motivates staff to give moral support during the post-VCT period
- Although there are challenges (such as predicting the number of technical staff that will be needed), **VCT family days are cost-effective.** They can reach a large number of people in a short time, using fewer technical staff and resources than normally needed for successful VCT. Experience from Uganda shows that testing at the event costs US\$1 per person, compared to a normal cost of US\$3.



7

Policy implementation does **not have to be held up by budgetary constraints.** Comparatively low cost elements of workplace policies, such as awareness raising, condom provision and addressing stigma, can be implemented without high costs (1, 16, 18, 21, 30, 32, 33, 37, 41). Organisations can partner with AIDS service organisations who can provide training and materials at low cost or for free (42). It does however **take time and good analysis** for organisations new to internal mainstreaming to identify and implement these activities (17).

8

To build on initial success and to cope with high turnover of staff, it is necessary to ensure that everyone has a copy of the policy, that everyone understands it, and that the policy is 'alive' in people's minds through discussions at, for example, **repeat trainings, refresher courses, and HIV-related events** (15, 16, 24). The impact of staff leaving can be reduced by having systems in place to **capture individual learning** for the organisation (26).

9

A workplace policy should be considered as a **living document**, which should be reviewed and updated regularly to make sure it keeps pace with the changing needs and context of the organisation. Experience shows that organisations benefit from **regular monitoring of the policy and its implementation**, potentially from someone outside the organisation who visits the organisations to discuss progress, to encourage, and to provide support to solve any problems arising (6, 13, 19, 23, 33, 37, 38, 41, 43).

10

A key challenge is to **develop systems and procedures to protect the identity of staff who use the policy to access HIV and AIDS related services** in ways that also allow for financial oversight and integrity. This may involve rethinking how financial and human resources policies, procedures and practices are implemented, and finding creative ways to ensure confidentiality (11, 25, 30, 33, 42, 44).

11

Providing services effectively to a **multi-cultural workforce requires a variety of teaching methods and approaches** (22).

12

**Need for partnering and co-operation**

- The development of partnerships and co-operation with other actors, such as **health service providers, counselling institutions providing VCT services and PLHIV organisations** is critical for the purposes of policy implementation (6, 9, 16, 25, 26, 29, 30, 33).
- Increased linking and learning between organisations and other stakeholders is necessary. Organisations can **learn from each other's experiences and best practices and build upon these** (1, 6, 16, 24, 25, 26, 42, 44).
- For an organisation to support its staff to reduce their susceptibility to HIV infection and vulnerability to AIDS, certain services, including access to condoms, VCT and anti retroviral treatment, need to be accessible. As this is often not the case, there is a **need for joint lobbying for all necessary services to become freely available** in each country. CSOs in the South and North should keep lobbying governments to provide these services and keep reporting when such services are not available. These initiatives should build on existing good practice of advocacy on lowering costs of generics, making the G8 keep their promises, and influencing the Global Fund (6, 26).

## 5 Lessons learnt for local capacity building providers about **supporting others** to do internal mainstreaming



In addition to all the previous lessons learnt, which also apply to local capacity builders as CSOs doing their own internal mainstreaming, there are also some practical lessons for them regarding their work supporting other CSOs.

### 1

It is important for organisations in capacity building to **walk the talk** or practice what they preach. This facilitates learning by the beneficiaries of their services, and means they are not attempting to support others to do things which they have not themselves done (14, 15, 17, 42, 44).

### 2

**Expertise is needed** to assist organisations to develop an HIV and AIDS policy. **HIV expertise** is needed to help organisations to identify and make decisions about the critical choices in policy development, which should be in line with national laws and international codes (SADC and ILO). Workplace policy development also needs **skilled organisational change facilitators** who can structure participatory processes which build trust, leadership commitment and staff ownership. This makes the organisational culture more open to change and addresses stigma (11, 26).

### 3

Capacity building requires **networking, collaboration and exchange of learning** between different organisations and stakeholders. They can build on each others' experiences and certain gaps in capacity building support can be mitigated by organisations working together (6, 11, 14, 26, 32).

### 4

In supporting local organisations in the development of workplace policies and programmes, **follow-up is critical**. Just an introductory training is not enough. CSO staff are highly mobile and awareness raising should be a continuous process. Many organisations need technical assistance in developing and implementing the policy (11, 32, 38, 42).

### 5

It is helpful if capacity builders take time to **form a good relationship with the focal person(s)** to understand their role in the organisation, their position, their work and challenges. This helps the capacity builders to know how to support them and to contextualise the interventions (10).

### 6

It is perceived that in some regions there is still a **lack of people skilled in HIV and AIDS mainstreaming** to provide support to local organisations. This results in organisations scrambling for the few there are which can **affect the pace and quality of the services provided** (17). However, a **learning community has been set up** in Sub Saharan Africa which stimulates learning and build capacity between experts in the field of addressing HIV and AIDS in the workplace through reflection on their practice, sharing of experiences, and learning from new tools (3). For more information see [http://www.intrac.org/pages/CB\\_Learning\\_Group.html](http://www.intrac.org/pages/CB_Learning_Group.html)

## Lessons learnt about the role of donors

### Perspective of local organisations

**1** Often, the reason given for not implementing a developed HIV workplace policy is **lack of resources** in an organisation. Many organisations perceive there is an **unwillingness among donors to fund their workplace policy** ('unnecessary or unacceptable overhead') and that donors are only interested in funding work that has a direct impact on poverty in the communities. Organisations fear that responding to HIV will considerably increase their overheads which will be unattractive to result-oriented donors (16, 21, 25, 26, 32, 35, 43, 45). Additionally, experience shows that organisations can have difficulties revealing to their donor that their performance might suffer because of HIV as they feel it jeopardises future support (32).

### Donor perspective

**1** For donors it is also important to **walk the talk**. It is difficult and less effective to attempt to support others in something which you have not yourselves dealt with (6, 14, 42). As part of their own internal mainstreaming, staff from donor organisations should receive training regarding awareness, stigma and so on. A side-effect of this is that they are then better able to discuss HIV and AIDS issues in a meaningful way with local partners (6).

**2** **Donors working in countries of high HIV prevalence, need to incorporate the costs of HIV to partners in their plans.** It requires some donors to shift their thinking from supporting projects (or even programmes) to supporting partners. This may mean accepting the higher 'overhead' costs and reduced outputs that working in contexts of high HIV prevalence entails. It will also mean making expected results and timeframes more realistic for an HIV context. It will require donors to invest, not just in capacity building, but even in simple capacity maintenance (6).

**3** Donor support for internal mainstreaming must be **more than one-off support for training or policy development to partner organisations.** Developing a strategic organisational response has significant budgetary implications for partners, which need to be addressed with structural, long-term support (15, 26, 32, 40, 42).

**4** Ongoing donor support is **essential for developing the pool of local capacity building providers with the ability to assist CSOs to mainstream HIV and AIDS.** Evidence has shown that this can be done among others through: training trajectories; exposure or exchange visits; facilitation of linking and learning between partners; conferences; producing and sharing tools, publications and materials; and by facilitating the linking of partners with AIDS specific organizations and health service deliverers in their locality (6, 32).

**5** **Ownership of the policy development by partners is believed to be crucial for the actual implementation.** Donors should be aware of this when setting their targets (e.g. 'percentage of partners with HIV policies') and when discussing workplace policies and programmes with their partners. Donors need to avoid a situation where partners feel under pressure to develop a policy just as a donor funding conditionality, as this severely reduces the likelihood of implementation (7, 13).

**6** **Local CSOs need to be more up front with donors.** Although many donors are still in denial, there are also many that are increasingly committed **in theory** to providing appropriate support to partners working in contexts of high HIV and AIDS prevalence. They however do not know how they to do this in the absence of specific requests from partners (6, 32).



**7** Just as partners need to be more upfront with donors, **donors can also take a more active approach in encouraging their partners to address HIV and AIDS in their workplaces.** For example, donors can emphasise that they see an internal response to HIV, including the costs, as a strength in a CSO and not a weakness. Successful methods for encouraging partners include consultations, research, training, exchange visits, partner workshops and dialogue during staff visits (6, 16, 20, 26, 34).

**8** **Clear roles and shared responsibilities between donor and partner** through for example face to face discussions, ongoing consultation and feedback, lead to better commitment and results (18, 42). Donors need to develop clear, open guidelines for support to partners in addressing HIV and AIDS in the workplace, including budgeting guidelines (26, 27).

**9** **Drawing in more donors is necessary.** Many donors remain silent with regard to the effects that HIV and AIDS have on their partners' workplaces. The experience of STOP AIDS NOW!s partners and their CSO partners shows, however, that it is possible to break the silence between donors and local partners. Those donors which are already responding are best placed to advocate and encourage others to take action. The likelihood of interest turning to action is much greater among those donors that fund recurrent costs such as salaries and institutional costs. Donors that do not cover these essential costs are unlikely to be persuaded to pay for workplace programmes (6, 14, 25).

**10** Donor organisations need to work with their partners in the South to **lobby for all the necessary services to become available** in each country, particularly as they are well-placed to influence G8 funding, and to run long-term campaigns on key issues such as lowering the costs of generics drugs (6, 26).

**11** **Donors' focus on workplace policies ('percentage of partners with HIV policies') needs to be complemented by recognising the role of informal responses too.** As there is no one-size-fits-all solution, CSOs have to be looked at on a case-by-case basis. Because workplace policies and programmes are the most easily measured response, there is a danger that they will become the only way to measure whether CSOs have strategies to cope with the realities of HIV. Many CSOs are too small, young or informal to have written policies, let alone an HIV policy. Often however, they do have certain coping mechanisms in place. An organisation's response to HIV is not only determined by a policy, but to a large extent also by organisational culture. Donors therefore need to use their judgement alongside their checklists (7).

**12** STOP AIDS NOW! and its partners generally fund up to **4%** of the total payroll for workplace policies (27). Experience has shown that **in some cases it is not sufficient to cover the costs for workplace policy development and implementation, while in others less than 4% is required** (1, 6).

# Annex: resources

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## Consultations

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## For more information

Visit our website for a wide range of downloadable resources on HIV and AIDS in the workplace, including many of the documents mentioned in this report: <http://www.stopaidsnow.org/downloads>

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STOP AIDS NOW! aims to expand and improve the Dutch contribution to the global response to HIV and AIDS. In STOP AIDS NOW! five organisations, the Aids Fonds, Hivos, ICCO, Cordaid and Oxfam Novib have joined forces.

STOP AIDS NOW! aims to:

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



