Starting implementation of HIV and AIDS workplace policies by SAN! partner organisatations in Uganda

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Abbreviations

ABC	Abstinence, being faithful, condom use
AIDS	Acquired Immunodeficiency Syndrome
AR	Applied research
ART	Anti-retroviral therapy
FGD	Focus group discussion(s)
FP	HIV and AIDS focal person
GDG	Good Donorship Guidelines
HE	Health education
HIV	Human Immunodeficiency Virus
HRP	Human resources policy
IDI	In-depth interview(s)
IEC	Information, education and communication
JCRC	Joint Christian Research Council
LPG	Local project group
M&E	Monitoring and evaluation
MOU	Memorandum of understanding
PC	Project coordinator
SAN!	STOP AIDS NOW!
UAC	Uganda AIDS Commission
VCT	Voluntary counselling and testing
WPP	HIV and AIDS workplace policy/policies (and other ways of addressing HIV and AIDS in the workplace)

Executive summary

This report presents the findings of Phase Two of the applied research component of the Ugandan part of the STOP AIDS NOW! Project 'Managing HIV and AIDS in the Workplace'. Data for the report were collected through 24 focus group discussions (FGDs) and 92 in-depth interviews with staff of 72 STOP AIDS NOW! (SAN!) partner organisations in the period April to July 2007. The objectives of this phase were to describe the process of implementation of HIV and AIDS workplace policies in the partner organisations; document the promising practices; and identify enhancing factors and challenges for implementation. In this report 'WPP' stands for 'addressing HIV and AIDS in the workplace' which can be done either through a stand alone HIV and AIDS workplace policy, or as a part of the organisation's health scheme or the human resources policy.

Summary of findings

Development of a WPP

Presence of a WPP: The 72 organisations visited were at different levels of WPP development and implementation. Twenty-four had a final policy (or addressing HIV and AIDS in their human resources or health policy), 23 had draft policies, while 25 had no policy in place as yet. Fourteen of those without a policy were interested to start the process, 4 have already started, whereas 2 are not interested, and others are not sure. The number of organisations with final and draft policies have increased as have organisations that have started implementation of activities

Reasons reported for having a final or draft WPP were, recognising HIV as a problem in the organisation, the need to address stigma and discrimination at workplace, to create HIV and AIDS awareness among workers, and need for guidelines to care for and support infected staff.

Reasons for lack of a workplace policy included financial constraints, lack of technical guidance, labour turn over especially for the key staff involved in the policy, and having the idea that staff members were too few. These were reasons for the ten who were interested, but had not started yet. The two organisations that were not interested gave as reasons that they will start at their own time, not in the SAN! project, and that it is not in the interest in HIV+ staff to disclose their status in the office.

Staff involvement in the development of the WPP: Near to all organisations developed the policy in a participatory manner, most by internal meetings to discuss opinions and needs of staff. Others constituted a drafting committee, with other staff commented on the drafts in staff meetings, group discussions and sensitization workshops. Some organisations organized training programmes, facilitated by outsiders, during which staff members were mobilized to come up with their views regarding the implication of the policy. These workshops were to enable the staff to know what they were required to do and address.

Issues of contention during the discussions of the content of the policies included whether support should be extended to family members, inclusion of ARV treatment for staff, monetary contributions by staff, and whether to provide condoms at the workplace.

Basic elements of the policies: All the organisations contained almost similar elements which included - Promote a non-discriminating environment, encourage disclosure, awareness raising, education and prevention, care and support, access to treatment, focus on gender equality. Some included condom promotion and provision, and First Aid kit provision

SAN! Good Donorship Guidelines (GDG): Respondents in IDIs of 27 organisations said they had access to the SAN! GDG, 23 of them reported that these were resourceful and contributed to their success in developing their HIV and AIDS workplace policies. Some 11 organisations had not seen or heard about the GDG. (Others were not asked).

Activity plans: Of the 47 who either had final or draft policies 27 reported having put in place activity plans to guide them implement the activities stipulated in their work place policies. Those without argued that they had not developed their activity plans because they either had no budget for the item or the draft policy had not been tabled or it had not been approved by the board or were first waiting for the policy to be launched.

Implementation and effects of WPP

Status of implementation: 36 organisations (also some without activity plans) reported having started at least some activities, 3 of them reported full implementation.

Main activities implemented were: Awareness raising and sensitization of staff through routine discussions or special training; preventative measures by provision of a First Aid Kit and condoms; provision of information and education materials in an AIDS Corner, through posters, leaflets, or a newsletter; access to VCT and/or ART services either by the organisation paying, insurance or establishing referral systems by linking to specific service providers.

Effects of activities: Noticeable results reported by staff in FGDs included - increased awareness, increased uptake of HIV counselling and testing, increased staff members' openness, reduced stigma and discrimination, condom use, increased confidence of staff in job security, even if HIV+, and visibility of lead organisations.

Promising practices: Many organisations have taken the recommendations of the AR Phase One report to start activities that do not cost much money. **I**n this stage all implemented activities are considered promising practice, especially if no fund have been received yet. Specific promising practices include awareness-raising by technical staff training support staff, routine feedback to all staff by staff members who attended training/meetings on HIV and AIDS, senior staff living by example, networking with other agencies for free services including IEC, condoms, ART, putting in place sustainability measures, writing guidelines against discrimination of HIV-positive persons during recruitment procedures, continuing capacity building by SAN! and associates in training and during support visits.

Facilitating factors in the implementation of activities were: Presence and commitment of a HIV focal person, participatory approaches during development of the WPP which breeds commitment of staff, management and board, technical guidance from SAN! and CDRN, networking and information sharing, financial support by donors or having an internal fund, and the GDG.

Perceived challenges in the implementation of WPP were limited skills to implement also caused by high staff turnover, financial constraints, lack of time also because staff often works in the field, continued feared stigma and therefore hesitance to disclose HIV-positive status, negative stand on condoms and hesitance to open discussion of sexuality, especially among FBOs.

Recommendations

To partner organisations:

- Start implementing some of those components/activities within the WPP regardless of whether the policy is in draft or final stage. They could phase the implementation by starting with activities which do not require much money like advocacy and awareness raising activities.
- Continue to write proposals for funding to broaden the implementation instead of waiting for donor funds to begin implementation
- Disseminate WPP documents to all staff to internalise – and translate in the local language if appropriate, i.e. if some staff members are not able to read English.
- Establish relations with free HIV and AIDS services.
- Develop a policy in a participatory process. This approach makes staff members to open up and helps to raise their level of satisfaction early enough to obtain a better method of policy implementation.
- Internal awareness for staff needs to be undertaken to popularize the policies.

- Look at the promising practices of other organisations and discuss with all staff whether these can be replicated

To LPG, PC and Lead organisations

- Make a deliberate effort to assist those organisations who have communicated willingness to have a WPP but do not have it yet because of lack of technical competence or information on the project. Provide them with the GDG.
- Recognise and acknowledge different ways in which organisations can address HIV and AIDS at the place of work such as in the human resources policy (HRP), health scheme etc., and support them accordingly.
- Facilitate linking and learning between partner organisations by sharing promising practices. Organisations that have shown exemplary practices could be invited as resource persons in some of the SAN! workshop to share their experiences or/and organisations that need to learn from those promising practices could be advised to visit and learn from them.

To donors

- Timely funding of the organisation WPP budget, for activities to be implemented and not to lose the momentum
- Since partners are at different levels of development, donors need to think of possible extension of funding.

1 Introduction

This report presents the findings of Phase Two of the applied research component of the Ugandan part of the STOP AIDS NOW! (SAN!) project 'Managing HIV and AIDS in the Workplace'. Data for the report were collected through focus group discussions (FGDs) and in-depth interviews (IDI) with staff of SAN! partner organisations. Data collection took place between April and July 2007. The aim of this phase was to:

- describe the activities of implementation of HIV and AIDS workplace policies (WPP),
- document promising practices of implementation,
- identify facilitating factors and challenges for implementation

Although this phase was originally meant to describe the process of implementation only, it also described the processes of WPP development (as was done in the applied research Phase One), because some organisations were still at that phase.

When referring to 'WPP' we mean all policies, guidelines and other ways of addressing HIV and AIDS in the place of work. This may for instance also be through the human resources or health policies.

1.1 Progress in the SAN! project in Uganda in the second phase

In Phase Two of the SAN! Uganda project from January to July 2007, quarterly Local Project Group (LPG) meetings have continued, as have regular support visits by the Project coordinator and Lead organisations. TPO was selected lead organisation for the central region, besides FURA for the Southwest and Health Need in the Northeast. The focal persons of the lead organisations took part in a 3-days training to build their supporting capacities. Another training of five days was of 24 HIV focal persons in the 12-box model (a self assessment tool for organisations to measure their HIV and gender sensitivity and measures in place). In March a meeting of the review committee took place, and ten draft WPP were reviewed.

1.2 Methodology

Two qualitative methods of data collection, FGDs and in-depth interviews were used for this phase. This involved groups and individuals from 72 partner organisations, out of a total of 76 in the project (See annex 1). The four remaining organisations, located in Karamoja region (Northern Uganda) could not be reached because of insecurity in the area at the time of the study.

1.2.1 In-depth Interviews

In-depth interviews targeted all heads of organisations regardless of whether or not they had workplace HIV and AIDS policies. In organisations with these policies (draft or final), an HIV focal person and/or executive director (head of the organisation) were interviewed. Interviews involved a discussion with a topic list with open-ended questions (see Annex 2). The aim was to obtain ideas, insights and critical appraisals on WPP development, contents, and implementation. In organisations without WPP or those with draft policies but not yet submitted to the SAN! Local Project Coordinator in Uganda, only one respondent was considered. The focus here was mainly on the head of organisation purposely to establish reasons for not developing a WPP and possible future plans for developing one. A total of 92 in-depth interviews were conducted that mainly included directors and focal point persons.

1.2.2 Focus group discussions

In total 24 Focus Group Discussions were conducted with members of staff of the various organisations which

have draft or final HIV and AIDS workplace policies, using a topic guide. This was aimed at obtaining information in relation to staff experiences with, expectations, fears and attitudes towards the policy. Selection of FGD respondents considered both the lower and middle level staff members and paying special attention to include both male and female members of staff. In each of the above organisations, 5 –12 respondents were considered for the FGD. Discussions were facilitated by a moderator who directed the questions and a recorder who took notes and operated the tape recorder. Focus Group discussion lasted for between 1 and $1^{1}/_{2}$ hours. A FGD was also conducted with the Local Project Group. (The FGD guides are in Annex 2)

1.2.3 Variables and study themes

The study investigated key aspects that were considered vital for this phase. Focus was mainly laid on the status of the policy; the key actors in the policy development; the major components/elements of the policies; the implementation activities; special consideration of gender, stigma and discrimination as well as the factors that contributed to the success of the accomplished activities, challenges, sustainability measures, benefits realized from the programme, promising practices, and suggestions for better development and implementation of HIV and AIDS workplace policies.

1.2.4 Data analysis

Most discussions/interviews were tape recorded with consent from participants and later transcribed and typed. Answers to open questions were grouped in themes and categorized after reading through the transcripts by the AR team. All data were later logged in and displayed in master sheets for analysis and write up. Content analysis was employed to make meaning of the data.

1.3 Study limitations

Compared to the first phase of the applied research, the second phase was positively embraced by the majority of the respondents. In Phase One, busy schedules of staff in organisations delayed the process of data collection. However, a number of limitations, as listed below, were experienced in the second phase. Four organisations in Karamoja region could not be studied due to insecurity in the region. During the study when the applied research team was preparing to travel to the region, an official of the World Food Program was murdered. This created fear and anxiety among the research team leading to the cancellation of the trip to the region. Secondly, the means of transport to upcountry organisations was a big challenge. The research team had to rely on the SAN! project vehicle which was not always readily available. They therefore had to reschedule their travel as per the Project Coordinator's field monitoring program. This invariably delayed the process of data collection.

The open and exploratory nature of the FGDs and IDIs and later transcribing of the interviews and FGDs, made that sometimes there was no time to cross check answers in FGDs and IDIs that had transpired in previous FGDs and IDIs. The impression is that there are even more activities and changes within organisations because of the WPP than reflected here.

1.4 Structure of the report

After this introductory chapter, Chapter Two, Three and Four present the study findings. Chapter Two highlights the development of WPP and motivations for starting and barriers for not starting the process. Chapter Three provides the findings on activities of implementing of WPP including some effects, and measures for sustainability. Chapter Four highlights some promising practices and also analyses the facilitating factors and perceived challenges in implementation. The concluding Chapter Five presents an assessment of progress since the first phase and provides recommendations to partner organisations and project management.

2 Development of a workplace HIV and AIDS policy

2.1 Presence of a workplace policy

The 72 organisations visited were at different levels of WPP development and implementation. Twenty-three organisations had a final policy (one organisation had the policy developed through GTZ), 23 had draft policies, while 25 had no policy in place as yet (See annex 1). One organization, Raising Voices, addressed HIV and AIDS in their human resource policy and had activities implemented – this organisation will be counted as having a final policy.

2.2 Motivations to start the WPP process

Participants in the FGDs of organisations with final or draft WPP gave the following reasons for starting up the policy in order of importance.

Recognizing HIV as problem for staff

Most of the organisations noted that HIV and AIDS were problems in their area of operations and in their organisations which needed combating so they felt the need to "clean" their houses by coming up with a WPP. Because HIV and AIDS were affecting everyone in one way or another, they felt their organisations were no exception which called for immediate attention and action to combat it. Organisations like ACORD, DETREC and NORRACOL felt that if they help people outside the organisations, they should also assist their own staff, who are equally vulnerable to HIV and AIDS.

> *Well we have decided to come up with a policy because we feel that since HIV and AIDS is now becoming a cross-cutting issue, we felt that we should also have a policy which will help some members of our staff and associates in case they become infected and also affected with HIV and AIDS (FGD, DETREC).*

Some of the respondents expressed concern over the fact that many of their clients whom they interacted with in the field had HIV and AIDS, which called for the workers' protection. In addition, it was reported that some of the staff members had HIV and AIDS, which had a bearing on their activities. This strengthened the need for a WPP.

> *Most of our staff members working in the community are in contact with people who are HIV-positive. And besides that, maybe doing activities for only people outside the organisation we have to do something for the staff. That is why we talk about HIV and AIDS and it is cross cutting. So even at the workplace you find that people can be HIV-positive (FGD, Health Need)*

The need to address stigma and discrimination at workplace

Respondents argued that by developing a WPP, staff members who were HIV-positive would not suffer stigma and discrimination as a result of the actions of their workmates. Organisations such as ACCORD HASAP carried out research which showed the presence of much stigma and discrimination of HIV-positive people at their work places. Based on those findings, it was noted that leaving out these people would be denying them the right to live and work as well as look after their families. Therefore, developing WPP would forge a way forward and make everybody feel part of the organisation he/she worked for. The policy also meant that workers would be able to retain their jobs regardless of their HIV status.

> *Yeah, basically one of the reasons why we developed a policy is to help people; that is in disclosure, helping them come up in the open. And also to avoid stigmatisation and discrimination because we realised that such people in most cases feel offended or feel they are undermined and despised by the society. So we developed that to help them live by – fit in society. (FGD, DETREC)*

Create HIV and AIDS awareness among workers

It was also noted that developing a WPP became of great necessity after different organisations realised that they too had lost key staff members to HIV and AIDS. There was therefore urgent need to create awareness about HIV spread and prevention as well as helping those already infected to live longer and positively. In this way, it was hoped that absenteeism from work as a result of HIV and AIDS would be reduced. It was hoped that the policy would encourage HIV-positive staff members to disclose their HIV status to enable them easy access to HIV and AIDS related services which would keep them healthy and productive. This would also ensure that HIV-positive workers would live longer and look after their families well.

> *We have HIV victims and we need protection. HIV and AIDS have a bearing on our activities and some of the people you are implementing it with are suffering from HIV. It is important that all the implementers are knowledgeable. At the workplace HIV causes absenteeism and with time this increases the rate of turnover for the organisation. (FGD, NORRACOL)*

Guidelines for management in care of HIV-positive staff

Some organisations based on their experiences of losing their staff to AIDS, developed WPP since they faced many challenges following the deaths. For instance the IDI respondent in Soroti COU Education department recounted how they lost two staff and had to act ad hoc. This can cost a lot of money, as also other organisations experienced.

> *One of the staff was infected and the organisation spent a lot of money during her sickness and burial. A problem was realized because HIV and AIDS affect everybody. (FGD, CDRN).*

Through sharing of experiences like the one above, other organisations said they felt they needed to emulate such examples thus developing their work place policy.

> *We went for a meeting in CDRN and they presented a case of a secretary who got AIDS and the organisation spent a lot of money and time on her. This story strengthened the idea. (FGD, EASSI)*

2.3 Reasons for lack of a HIV and AIDS workplace policy

Only two of the 25 organisations without a WPP said they were not interested in developing a WPP now; one because they would develop a policy at their own time, not in the SAN! project (Kabale Diocese), the other opined that HIV status is something personal and does not have to be shared in the workplace (AMAKULA). Fourteen of the 25 organisations which did not have a WPP, said they were interested to develop a policy; this was expressed thus:

> *The level of interest is very high because we have already lost some of our staff in the past because of HIV. (IDI, CPA)*

> *We are so much interested in the program, we even reported this to OXFAM i.e. investing in staff before he or she dies. (IDI, UMWA)*

Four other organisations, namely Uganda Land Alliance, UWONET, CEEWA, and UCRNN had already started the process, but were waiting for discussion and approval by their Institutional Boards.

Several reasons, usually in combination, were forwarded in the in-depth interviews as to why the organisations did not have WPPs, including:

Lack of technical guidance

Most of the organisations expressed lack of information and technical guidance as the reason for not having a

WPP in place, some because they have not attended SAN! project workshops, as illustrated by the quotes below:

We need external expertise first because we feel the workplace policy has gaps that need filling. (IDI, USDC)

We lack guidance and enough information between TOCINET and SAN (IDI, TOCINET)

First of all we did not understand the relationship between us and SAN!. So we have not been paying attention to the project. We have never attended SAN! work shops to get the insight of what it is and how we can go about developing our workplace HIV and AIDS policy. As a result, we need a formal discussion with SAN!." (IDI, FOWODE).

Financial constraints
Organisations reported that they could not develop the policy due to financial constraints, for instance to pay for ART. Therefore, though conscious of it, they argued that HIV and AIDS could not be a priority yet and did not need to be handled immediately as a stand alone policy, but maybe as a section within the personnel manual. Related to his was that some organisations, have very few (paid) staff and thought funding a policy would not be possible. UWFT for instance has only three staff. Also Akika Embuga has very few paid staff.

Because NOVIB ceased funding us, we had to lay off all salaried staff. We now only depend on volunteers. We thus stopped developing the policy on grounds that it would serve no purpose. (IDI, Akika Embuka)

Some organisations were afraid that developing a policy and implementing activities would cost too much time, and thus money. Other organisations such as ACFODE, and RUCREF argued that while having a WPP was good, implementing its activities had a direct financial (and time) implication for them.

The dilemma is time for running this programme. It is not there, otherwise we are interested but that is if it has to be funded continuously. (IDI, RUCREF)

High staff turn-over
The high labour turnover of Focal Point Persons who were the link to the SAN! project was a problem for some organisations; when the focal point person left an organisation, it takes them back because the replacement has to be trained afresh. This was reflected for instance in TOCINET, Concern, RUCRAF, ACFODE.

HIV and AIDS addressed in other policies
A few organisations felt that they did not need a WPP because their medical schemes covered and integrated the HIV and AIDS issues very well in their Human Resource Manuals so they saw no need of a stand alone HIV and AIDS workplace policy.

We have no HIV and AIDS policy in place but issues are included in the organisational human resource policy. (IDI, Raising Voices)

2.4 Involvement in the development of the workplace HIV and AIDS policy

From the IDIs and FGDs it appeared that in near to all organisations the process of WPP development was participatory; organisations first held staff meetings where a common understanding was reached, some constituted HIV and AIDS workplace policy committees, held group discussions or sensitization workshops.

Participation in drafting of all staff
In some organisations staff members were involved in group discussions in a participatory manner. Each one's

ideas were taken and respected to come up with the policy. Some organisations used questionnaires to get the different opinions after which the ideas were shared among the participants. In other organisations like FAPAD, staff members had meetings where several questions were asked regarding what could happen to staff infected with and affected by HIV, after which they came up with facts to be included in the draft policy.

> *After the SAN! workshop I acted immediately, called staff members and all participated. We sat several days and finally came up with the draft. Even during budgeting it was a collective effort. (IDI, LABE)*

> *All 24 staff members were interviewed and each reasoned out why this policy is necessary. We came together and compiled the various views that made up the draft. (FGD, CEFORD)*

> *Questionnaires were drafted and distributed and we gave our input as a group and that is how this policy was developed. (FGD, NOGAMU)*

> *There was collection of information and literature from different actors on HIV and AIDS. Then each person was assigned a specific activity, inputs were reviewed and then the policy was developed. (FGD, COU-TEDDO)*

Contributing ideas on draft designed by committee

Other organisations reported that staff committees were formed to design the policy, which was then circulated to all staff for review. Their ideas and opinions were incorporated in the already existing drafts.

> *Staff views were gathered through several meetings. A draft was developed by some 4 staff, reviewed, and all staff came together to cross-check whether workplace policy content is all staff agreed on. Finally we came up with the final draft. (FGD, LABE)*

Participatory development in training by outsiders

Several organisations participated in SAN! and CDRN training workshops and this created capacity to handle drafting of the policy. Some organisations such as TTP and UFFCA went ahead to organize training programmes for their staff regarding the WPP. During these workshops, staff members were mobilized to come up with their views regarding the implication of the policy. These workshops were to enable the staff to know what they were required to do and address. KARUDEC indicated TTP came and sensitized the staff members and then the staff was mobilised and all came up with views regarding the implication of the policy. It was "participatory from bottom to top".

2.5 Issues of contention

Main contentious issues during the development of the policies were reported. There was debate of whether to include some of the issues outlined below:

Scope of the policy

Inclusion of treatment was seen as expensive and some organisations were not ready to include it in the policy. Other organisations discussed whether care and support should be extended to family members or not. Most of the staff wanted their family members included. An argument raised against including family was that this would impinge on the budget especially since the number of family members to be considered for the support was not specified. However, it was also reasoned in favour of including family, for instance in TPO, that if family members of staff were infected or affected, this would impinge on the performance of staff and therefore it was important to include family in the policy provisions concerning treatment.

Condom provision

In some organisations it was thought condoms would encourage people to be promiscuous. This was mostly echoed by FBOs, including COU-TEDDO, but also by staff in secular NGOs referring to their moral

convictions. They found it difficult to consolidate the policy because of the religious and moral stand on condom use.

Many of the staff did not support the use of condoms. Some were querying. Some said they were religiously inclined. Therefore there is no need to use a condom. Suppose you are a married person, there is no need to get a condom. (IDI, FAPAD)

The nature of the organisation; it is church based (Catholic) we cannot preach about condom use say in workshops, we cannot freely hang information concerning condom use in our offices. (IDI, JIDDECO)

This is more of a Christian organisation and some members think staff are not promiscuous so why the policy? This at times puts us down. (IDI, IRDI)

Other issues

Isolated other contentious issues included whether to have a clause on occupational safety for women, since they are viewed to be more susceptible to infection; whether or not staff members should contribute a certain percentage as a sustainability measure; whether or not a monetary package be given to a member of HIV-positive staff in case he/she leaves work and how much this should be; whether to make the HIV and AIDS workplace policy a stand alone policy versus incorporating it in Human Resource policy.

... Then there was also another debate on whether the workplace policy should be put in the HR policy, or it should be left as a stand alone policy. The fear was that if you included it in the HR policy, what would happen is that it would be ignored and not seen as a major policy. We decided we preferred to have it as a stand alone policy so that when it comes to raising funds for it, it is much easer that way. (FGD, EASSI)

2.6 Basic elements contained in the WPP

All the organisations' WPP contained almost similar elements, which is not surprising because most were involved in the training by SAN! and their draft policies were reviewed and commented on by the SAN! WPP review committee. IDI and FGD respondents reported the contents of their WPP.

Awareness raising and education

Continuous sensitization of staff and provision of HIV and AIDS information was considered a big necessity. Thus, awareness and education programmes would be put in place to inform employees about HIV and AIDS and help them to protect themselves and others against infection. Furthermore, the provision of information, education and communication (IEC) materials such as posters for creating and raising awareness as well as psychosocial support through information provision and sharing were outlined. Information about how to get to the clinic in case of emergency would be availed and accessed more easily.

Promotion of non-discriminating environment

All organisations expressed the importance of non-discrimination and stigma control for both those infected with and affected by HIV and AIDS to be addressed by the policy. This would be done by creating a good working environment under good health conditions, creating affection and avoiding discrimination and stigmatisation right from recruitment to retirement. It was noted that there should be no screening of employees for purposes of employment and that HIV testing should not be a prerequisite for recruitment, training or promotion. Also there should be punishment for those stigmatising HIV-positive staff.

.....Nobody socially is supposed to harass. When I say harass, it is through abuse, through pointing fingers, through this and that to anybody living with HIV and AIDS. ...... The punishment that we've put in place is related to our code of conduct. So anybody breaching some of these is supposed to go to the committee. The personnel committee is in charge of disciplinary affairs. So it is that committee which is supposed to decide on what can be

done to the breach of that nature. (IDI, TPO)

Disclosure and confidentiality
Confidentiality was to be maintained and disclosure of status only voluntary. Confidentiality was thought to enhance a good working environment for the HIV-infected staffs because they would not have to fear stigmatization, if they did not want to disclose. However, policies emphasized that disclosure of HIV positive status may increase understanding between staff members and enhance care and support for infected and affected staff including their immediate families. To facilitate disclosure, counselling facilities within or outside the organisations should be made accessible as it was also part of psycho-social therapy and rehabilitation for them.

Prevention
Many policies included a provision for training of staff in universal precautions. First aid kit provision was one of the policy elements although most organisations did not bring it out. The kits contained gloves, gauze, scissors, and materials to help heal wounds, which were viewed as precautions to prevent HIV transmission. In 19 organisations such as NOGAMU, BUSO Foundation, KALI, UFFCA and FAPAD, it was stated that condoms would be provided in the workplace for their staff, as this would help to reduce the spread of HIV.

Care and support, access to treatment
In some 20 organisations access to treatment was mentioned, including access to health care for opportunistic infections, VCT and anti-retroviral drugs. By developing a WPP, staff members wanted to ensure that their workmates suffering from HIV and AIDS received enough support and treatment, but on condition that the employee disclosed his/her HIV sero-status. In addition, staff members wanted the policy to extend the treatment to their families. Other issues included extension of sick leave and tolerance of those who are sick.

AAR and Micro-Care were frequently mentioned as service providers for the organisations with a WPP. They had staff and client insurance whereby if an employee fell sick, he/she could be treated using an identity card. Furthermore, arrangements were in place to include immediate family members of the infected staff member. Other respondents wanted the medical care to be extended only to the infected staff member and their biological children. CEFORD in Arua made an arrangement to bring in an external doctor to treat their staff. However, some organisations like FIDA had excluded ART for infected staff members because they did not have a budget for it. They were nevertheless planning to collaborate with JCRC to have their infected staff members in need of their service referred there. Other organisations also indicated in their policy they would facilitate staff to access free treatment institutions.

Another aspect of care was the attention to accommodation of duties for HIV-positive staff. They would adjust their workload, so that a too heavy workload would not be the cause of deterioration of their health.

Focus on gender equality
Gender concerns were high on the agenda of the policies. Respondents argued that the policy should be designed to address gender issues to cater for both male and female staff since HIV and AIDS affected them differently. Furthermore, they said the policies should take into account the general unequal gender relations, which make women more susceptible and vulnerable to HIV infection. However, it was usually not clearly spelt out how this would be implemented.

Gender equality, this is where we say that there should be equal opportunities to both men and women at the workplace. If they both test to be HIV positive, there should be no discrimination against either sex or regional or tribes but they should all access equal opportunities. If it is health scheme, they should all access the ARVs, if it is support in a certain point they should all access it, there should be no discrimination generally (IDI, FURA)

2.7 SAN! Good Donorship Guidelines

Of those 38 organisations who were asked about the Good Donorship Guidelines, 27 organisations reported to have received the GDG, whereas 11 said not to have seen them. Out of the 27, 23 said to have used them in the development of their policies. They reported that the GDG were resourceful and contributed to their success in developing their HIV and AIDS workplace policies as the quotes below illustrate. The four who had received the GDG, but not used them said they had no time to read them yet.

> *I think in developing the policy, the whole thing is that it guides you what to consider to put in the policy. Like I would say that when we were drafting the first draft, you could see it was so bad. Any way we are blending this because we had those guidelines. We included more material. So I think even it's really important that we have those guidelines so teamwork is put in the policy. When you are packaging it, you know what to package in. It's like when you are telling me that those people don't know, like the other organizations, how do they actually come to a draft? Maybe they haven't had access. The examples in the GDG really made us think; there are some things which you may think you need money to do, but you do not necessarily need it (IDI, WOUGNET)*

> *It is a good document that helped us and we still refer to it but I think it depends on resources available for each organisation. ... . And we also used them to enrich our current policy…. Yes. When we were updating the policy, we used all those materials. We were borrowing what we think would work within our framework (IDI, TPO)*

> *I think this policy has been beneficial because before I didn't have any idea at all after being charged the task of spearheading that process in the organisation, I had to rely on this tool of the sponsors (IDI, Health Need).*

There was also some critique on the GDG by EASSI and CEREDO related to unrealistic assumptions and unfairness of the budget of four-percent of the salaries guideline

> *When the development of WPP started, we had not seen it (guidelines) but later on we accessed it but some things in the guideline were not realistic e.g. the donor expects us to get condoms from the Ministry of Health. A lot of expenses are incurred which the donor does not know (IDI, EASSI)*

> *There is one I am not happy about. ..... That is the condition of the donors funding 4 percent of the total of all these. I think that is not fair for all the sections. Our organisation pays very low wages. Our wages are low so the four percent cannot uphold anything substantial you see that. In other organisations a man like me could be highly paid. So, six people alone can raise a big bill. Isn't it? (IDI, CEREDO)*

2.8 Activity plans

According to the informants in IDIs, of the 47 who either had a final or a draft policy, 27 reported having put in place activity plans to guide them implement the activities stipulated in their work place policies. Those without argued that they had not developed their activity plans because they either had no budget for the item, or the draft policy had not been tabled, or it had not been approved by the board, or they were first waiting for the policy to be launched.

3 Implementation and effects of the HIV and AIDS workplace policies

Thirty-six organisations (out of 47 with a draft or final WPP), had started implementing activities related to their WPP. Since only 27 had work plans, it is obvious some organisations with draft or final WPP but without a work plan had started activities without it, especially those activities that did not need a lot of funding. Only two organisations with a work plan said not to have started anything because the policy was not funded yet, including FAPAD and LOFP. It was interesting to find that normally in FGDs more activities would be mentioned than in IDIs, pointing at that the WPP and its activities are noticeable among staff. Box 1 below first gives a case of EASSI as example of how organisations were implementing their WPP activities, after that a summary of activities in other organisations will be given

Box 1: Implementation of WPP in EASSI

Okay, you know we just started the policy last year, by the close of the year, it was still being drafted. This year in February (2007) it was presented to the board, who also asked many questions but eventually approved of it. Also having submitted to the donors they had not approved and they had not even issued us any funds. But what we had gone ahead internally to do sensitization amongst ourselves about the document at least to know that it exists and we wish it to have it implemented.

We went ahead and nominated, besides the Finance Manager, we nominated a real focal person to do the policy implementation of HIV and AIDS issues who is the Logistics Assistant. He has attended the twelve model training [12-box training for organisation self assessment] and then we insured everybody, corporate comprehensive. That means HIV and AIDS now is a component within our medical insurance. So at least we are safe, everybody can get treatment regarding HIV and AIDS. And we have encouraged the focal person to collect information from everywhere. He has promised to put – like a shelf at the reception to display information so that everybody can access it. So we hope that is going to be implemented within this – two months.

In the non-discrimination elements, just because you are infected it doesn't mean that you leave work. You can – you get your salary, your full salary. We are also integrating our human resource document that talks about what happens to staff members who fall sick and the time when they are supposed to leave the organisation. So, because of this policy we have improved our human resource – if a staff is completely unable to work and his workload is too heavy, they get a lighter workload on the recommendation by a doctor and then the human resource committee. (FGD)

3.1 Sensitization of staff

Awareness raising and sensitization of staff concerning HIV prevention and other issues related to HIV and AIDS was done in several ways: through regular discussion among staff, through seminars and training, peer education, and sharing of information and IEC materials, or hanging posters to the notice boards depicting preventive and non-discrimination messages. In all organisations which started implementing their WPP, sensitization of staff took place. Some details on awareness raising and sensitization activities are the following

IEC within the organisation

Most organisations had started in-house awareness training programmes by availing IEC materials and holding of talks and discussions on HIV and AIDS amongst staff members.

> *We have peer talks at lunch time where we discuss HIV issues. (IDI, FIDA)*
>
> *Sensitization of the staff members on the spread and prevention of HIV and AIDS is one of the activities going on. We even have the brochures addressing HIV issues. (IDI, CEFORD)*

There is creation of awareness within the workplace and community through the foundation course each morning. We have dedicated Friday afternoons to group discussions for issues to do with AIDS. If we are few we show a film and watch that (FURA)

We need to repeat the messages and refresh people's mind on HIV and AIDS. We do this through bi-monthly meetings (IDI, Africa 2000)

Seminars

Training seminars were conducted in 11 organisations. Some three were conducted by peers, whereas others were by involvement from outside trainers or facilitators In HOSPICE Uganda, peer education activities took place where technical staff members trained the support staff in HIV and AIDS related issues such as prevention efforts.

We had a training facilitated by an outsider, initiated by NOVIB and have monthly staff meetings to discuss (LABE)

AIDS corner

Seven organisations, including KALI, TTP, LABE, WOUGHNET, NOGAMU, NUWODU and HOSPICE Uganda, had put in place a special AIDS corner. The AIDS corner refers to a place where management and staff of an organisation agree to place all relevant materials related to HIV and AIDS. Ideally an AIDS Corner contains but is not limited to:

- A notice board to display information on HIV and AIDS (including newspaper cuttings, fliers etc);
- A box file or any other file containing HIV and AIDS information which may not be pinned up on the board;
- Books and other IEC materials on HIV and AIDS;
- A first aid kit with various items for emergency use.

3.2 Condom promotion and provision

There was routine condom promotion and provision reported in 19 organisations. Condoms are put in places of convenience such as washrooms where staff members feel comfortable to pick at their own will. In NOGAMU it was said that they put them in strategic places, meaning those places with privacy, where people can pick condoms without others seeing. KALI had a first aid box already and with the WPP added condoms to the first aid box. Others like ACORD Gulu put them in open space.

We have routine condom distribution. We don't give that staff get and take. We put it in many places. Even in the hall – the centre there, we put. So that if the support staff is shy to come and pick from here, the support staff can pick from where – from the hall. Originally we used to put in the toilets because some people could fear to pick openly. But now we have decided, okay everybody agreed that we should put it in what – in different places (IDI, ACORD Gulu)

For those organisations providing condoms, it was reported that the uptake is high which implies they are being utilised as illustrated by quotes from FURA and TTP.

Yeah, they are being used because we have staff in the field in different sub-counties and whenever they come at the health office here, they take some condoms. When they come they take which means consumption is at a very good rate (FGD, FURA)

We have condoms in place. They are usually in our toilets and boxes get finished. We do not even know who takes what ... Condoms used to be expensive for us. It is not expensive monetarily, but for example, imagine K.

going to a shop saying that ''pass me that blue packet". It is difficult. But when it is here, it might be easier for him to say ''Aha, nobody is seeing me, let me take some. (FGD, TTP)

For Health Need it is not whether condoms should be provided, but rather discussion on the brand of condoms:

The challenge is that there are people who do not want the brand we have in plenty here [Ngabo]. *Recently we went to attend the last workshop we bought a few boxes of Life Guard. I think they are already finished. (IDI, Focal person Health Need)*

Two FBOs, KARUDEC and Vision TERUDO also provide condoms – although they are supposed to be only used for Family Planning. In the FGD in KARUDEC (in a hospital setting) a participant said:

It does not distort our prayer mission of spreading the gospel of Christ. We normally put the condom behind and the bible in front. That is our mission (FGD KARUDEC)

3.3 Access to treatment

Nineteen organisations ensured access to treatment in their WPP. They did this either through comprehensive insurance, paying for expenses, linking with (free) treatment institutions, or a combination of these.

Insurance
In five of the organisations (ACORD HASAP, Africa2000Network, CDRN, Hospice Uganda, and EASSI), staff members were comprehensively insured to cover HIV and AIDS treatment. Some other organisations, like FURA, were in discussions with insurance companies for inclusion of ART in the existing health insurance. Some organisations have staff pay a certain percentage of their salary towards their insurance, like 1% in CDRN.

Pay for treatment
Some organisations provided their staff members with free treatment regardless of whether one was suffering from HIV or AIDS or not. In ACORD-Gulu, 80% of treatment is paid for by the organisation:

It is the policy that we pay 80%, but now there are a lot of free ARVs in the district. There are also places where you can get for free, them especially for those who work with TASO. (FGD, ACORD Gulu)

Provide treatment
In some health providing organisations, there were anti-retroviral therapy (ART) services available for staff with HIV. TAP provides HIV treatment including ARVs. Fort Portal Diocesan Health Office gives treatment in their clinics, also to HIV-positive staff and some dependants.

Link with services
Other organisations, including Concern, FAPAD, Raising Voices, give support to their HIV-positive staff members by linking them to the Uganda Joint Clinic Research Centre (UJCRC) or other centres, which provide free ARVs, CD4 counts and other AIDS specialised care. Concern specified they have drawn a memorandum of understanding (MOU) with UJCRC to treat their staff. ACORD-Gulu specified how they facilitate access to free services and give time off for their staff to get their treatment

Any time one can write that: "I am not attending today's office. I will be out following my treatment." So we can take it for granted that that is the right information. And the doctor presents us with a voucher. ..... if he has counselled somebody, he has maybe prescribed somebody drugs. ..... And even he can get that type of drug, but

the rest is almost free. (IDI, ACORD-Gulu)

3.4 Establish networks

Several organisations reported that the WPP made them establish contacts with other organisations, within and outside the SAN! network, and with Ministry departments for assistance for instance in counselling, IEC materials and treatment. Specific networks and linkages created included:

- Africa 2000 (Kampala) link their staff to TASO for counselling and guidance
- BUSO (Kampala) gets condoms from ACORD and MOH.
- CONCERN (Kampala) has linked HIV positive staff to JCRC.
- FIDA (Kampala) linked with UAC for IEC materials
- SOMED (Masindi) refers to Masindi Hospital and Uganda Anti-Aids commission
- NOGAMU (Kabalagala) gets free condoms from Epopa and NACWOLA
- TAP (Soroti) networks with Uganda Cares, Concern and MOH
- Health Need (Soroti) links with Uganda Cares and District Health Services for counselling and gets condoms (brand Life Guard) from the Ministry of Health in Entebbe (also for other SAN! Organisations in their region)
- UMFL (Kampala) links for services with Mildmay, AIC, and JCRC
- LABE (Yumbe) has contacts with TASO and AIC who share information and assist in training
- VISION TERUDO (Ngora-Kumi) is in partnership with AIC on provision of VCT and CD4 count
- FURA (Kasese), a lead organisation gets free condoms from the district and other sources and also distributes these to other partner organisations.

3.5 Other activities

Participants in IDIs and FGDs identified some other activities that they related to their WPP, which included:

- Moral support: Psychosocial support through visiting the home of the affected/infected staff was reported being done by ACORD Gulu and by CEFORD.
- Non discrimination of HIV+ with recruitment: In CEREDO and FORT PORTAL, it was reported that there was no discrimination of HIV+ persons when applying for a job, all having equal opportunities.

  For us when we are recruiting our employees, we do not discriminate against whether someone is HIV-positive or whether s/he has signs, or whether she has shown that she is sick. We employ whoever qualifies to be employed in our health unit.[they plan to draw guidelines which can rule out discrimination of the recruitment panel]. *(IDI, FORT PORTAL)*

3.6 Effects of WPP implementation

Although implementation has just started, already there are some visible results of the whole process of developing a WPP and the few activities, as reported in IDIs and FGDS. If resources are made available by donors, it is expected that implementation will take off in a bigger way, as is illustrated by a quote from one of the participants in the FGD in CEFORD:

> *According to me, the changes have been minimal because the policy has not taken off fully. If we get more resources to implement this policy, then we can be in better position to assess the change (FGD, CEFORD).*

Increased awareness and confidence of staff
Organisations such as EASSI, CDRN and FURA reported that the policy was very helpful in creating HIV and

AIDS awareness which has given their staff members confidence and support. This has made the employees to be more committed to the organisation and in the long run, it is hoped that there will be an increase in output from the employees. Staff members are now more knowledgeable about HIV prevention as well as care and support to HIV-positive people as a result of the information they got from workshops and involvement in HIV and AIDS workplace policy development. Further it was noticed to that staff members pay more attention to AIDS information than before (TTP). A spill-over is the increased openness and discussions on HIV and AIDS with their family members that staff reported.

Availability and use of IEC and prevention materials
Organisations provide IEC materials to their staff through leaflets, or posters. Some organisations have gone ahead to put in place First Aid Boxes, which was not the case before implementing the policy. AIDS Corners with information on HIV and AIDS are now in place in some organisations. Organisations promoting and distributing condoms reported an increase in condom use, meaning that many people are benefiting from them. In these organisations staff members were also reported to be not shy anymore to talk about condoms (FURA).

Increased Voluntary Counselling and Testing
The existence of the WPP is reported to have increased staff members' openness as many have now opted to voluntarily go for HIV testing, for instance in NORRACOL, CEFORD, LOFP, IRDI. Also special sensitization sessions on the importance of VCT increased VCT uptake.

> *In November we did some sensitization and VCT where some staff tested. (IDI, KARUDEC)*

Reduced stigma and discrimination
It was reported that there are fewer instances of stigma and discrimination against HIV-positive people. Previously, HIV-positive staff could not openly talk about their HIV-status because it meant automatically losing one's job. Concern reported that retaining infected staff has helped to reduce stigma and discrimination. A sign of reduced stigma and not considering AIDS as shameful was reported in the FGD in LABE: *'We no longer hide talking to colleagues that I have lost a relative to AIDS.'* FGD participants in SOMED shared how they have lost one staff, but showed solidarity with him till he died. In BUSO they had a HIV-positive staff member before who left because of stigmatisation. They have someone now as well, but they discuss freely with the person to manage the situation.

Trust in confidentiality and job security
Confidentiality ensures that staff is confident to disclose to the superior, to be able to access treatment, without others in the organisation knowing. FGD participants in TPO said that they knew someone of their staff is 'benefiting from the treatment activities', but that they did not know who this person was. Staff members now know that their organisations value their health and are assured of job security. In addition, this brings psychological satisfaction knowing that one's employer is there to support them, as was reported in TTP, TEDDO, and DETREC among others

HIV-positive staff on treatment staying productive
In those organisations where staff has disclosed their HIV-positive status (to the management or HIV focal person) and accessed treatment through the organisations, this was reported to have contributed to these staff staying productive.

> *We are able to maintain our staff. We have good staff members who are infected but still contribute positively. (IDI, Concern)*

> *We are helping our support staff member who is in the field but infected, to access ARVs to keep him in good health so that he is able to work. Actually if I personally had not intervened, probably now he would have died because he was once on ARVs but he decided to discontinue the treatment.*

He used to complain of unending sickness week-in week-out. I decided to talk to him at length and he opened up to tell me he is HIV-positive and that is how I got him back to using the required medication and he is now strong and doing his work properly. (IDI, TPO)

Visibility of lead organisations

The regional lead organisations such as FURA in the Southwest and Health Need in the North East were reported to be more visible and their work as lead organisations better understood.

3.7 Sustainability of WPP

Most IDI respondents with final WPP and activity plan reported that they had put sustainability measures in place or planned for in case the SAN! donor funding would stop; they did this in various ways, either through the regular budget, or as a specially funded project for which a(nother) donor had to be found, or a combination of the two.

Most organisations that had thought of sustainability indicated that because the policy implementation activities will already be in their work plans, they would devise means of funding the activities just like their other programs. ACORD Gulu reported that they have developed a proposal for 2008-2011 to cater for the policy, while ACORD HASAP, CONCERN, HEALTH NEED and CDRN indicated that they would write proposals to seek for more funds as well as mainstream the policy activities in all their projects. Other organisations such as EASSI reported that since they were still piloting the policy, they would include it in their Human Resource policy and continue to fund it from their regular funds if it turned out as a success. On the other hand, NOWODU reported that they would fundraise for the policy if SAN! donor funding were to stop. TTP, TEDDO, ORUDE, LABE planned to mainstream HIV and AIDS in all their project activities. FIDA planned to create a social fund to cater for the sick while JIDDECOU and AMFI planned to form linkages and partnerships with other organisations to provide free medical HIV and AIDS services and capacity building to reduce funding requirements. In CDRN staff contributes 1% of their salary for comprehensive insurance as a sustainability measure. FURA has put in a proposal to the Global Fund and to the District to fund WPP related activities.

4 Promising practices and perceived challenges

4.1 Promising practices

From the ways organisation developed their WPP and the activities that some organisations have started implementing, as explained earlier in this report, some promising practices can be identified that may be replicated by other organisations. Maybe we can assume that in this stage *all implemented activities are promising practices*, and especially the fact that organisations started implementing without special funding of their work plan, because it means the project is progressing,

4.1.1 Participatory development

Development of the WPP with full participation of all levels of staff greatly enhanced staff's commitment to and involvement in implementation of the policy. Nearly all organisations allowed some participation of staff at this stage (it being a recommendation in the SAN! project and from the first phase of the AR), and did this in different ways. Some promising practices:

- NOGAMU solved the problem of field staff always often being unavailable for participation, by having them fill out questionnaires with what they would like to see in the policy.
- KALI organised single sex group discussions first where issues dealing with WPP were discussed and agreed upon.
- LABE gathered views from staff through several meetings. A draft was developed, reviewed and all staff came together to cross-check whether WPP content is all staff agreed on. Finally they came up with the final draft.

4.1.2 Commitment of senior management and support from board of directors

A good practice is to getting the support of the senior management of the organisations from the start. From the FGDs and IDIs it appeared that if they are committed, this ensures that HIV and AIDS issues are seen as a priority and more likely to be funded from internal sources, even if outside funding has not been received yet. In WOUGNET support of the management was crucial. The kind of involvement by management and the board in some organisations is highlighted in box 2 below.

Box 2: Involvement of board and management

TPO

We had a kind of board and staff meeting to share out the issues to do with HIV and AIDS. To ensure that both management which is the board or what I would say the top leadership and also the secretariat have equal understanding of what we are going to do. So we have made sure that we have that kind of exchange – general exchange so that everybody is at par with what is going on. Now, whether it's a board member or a staff member, he knows what we are supposed to do regarding HIV and AIDS. When it comes to the programming bit of it, as I said we have already mainstreamed HIV and AIDS within our operations. So we have actually, I think over 20 organizations which have already received support from us. As we go to support them with things to do with organizational development- this and that, we also add the package to do with HIV and AIDS mainstreaming. *(IDI, TPO)*

Health Need

After the workshop we had with SAN! in Soroti here, we were advised to share with management and all staff. That is exactly what we did. So there was a board meeting between staff and management and I introduced that issue. So management allocated some board members to liaise with staff. Then we sat together and brought in our ideas. *(IDI, Health Need)*

COU-TEDDO
And then when we look at a supportive board, the board is supportive including the patron who is the Bishop of Kumi and the Bishop of Soroti is also very supportive in this process, and they would wish us success. So given that competent board and given the leadership of Bishops, the two Bishops, because of the work of COU-TEDDO cutting across the two lines, I would also say, that counts as one of the factors *(IDI, COU-TEDDO)*

4.1.3 Creating awareness in the organisation

A good practice is to start with creating awareness about HIV and AIDS, either by routine discussion, seminars, or meetings. In fact the process of WPP development itself is a way to create awareness. A specific promising way was how Hospice Uganda had technical staff training their support staff.

4.1.4 Giving feedback to all staff

Good practice was reported by FURA, where the focal person always gives feedback on what she has learned during workshops.

> *When that policy was developed, because now we have a focal person, we have a staff member who is responsible for attending meetings. Then she comes and tells us about the program then we present our views, then after they record them and integrate it in the policy. (FGD, FURA)*

4.1.5 Supply of condoms

Supply of condoms to staff, if not in opposition to moral values, is a good practice for prevention of HIV. A promising practice is the way ACORD Gulu makes the condoms accessible in various places in the organisation for people to pick wherever it is convenient to them – not that they have to go to one place, either the bathroom, AIDS corner etc. The way condoms were discussed, accepted and being provided in two FBOs (KARUDEC and VISION TERUDO), that they do not necessarily go against Christian morals, may be an example for other FBOs who are divided over the issue of condoms.

4.1.6 Proposals for sustainability

It is a good practice to think of sustainability now after the SAN! project money has ended. The proposal to mainstream HIV and AIDS issues in all organisation's programs and plans (and thus funding for it) as well as starting fundraising for the WPP activities were seen as important ways of sustaining the program in future. Some of the organisations that reported this kind of promising practise were:

- ORUDE: To integrate the policy in all organization activities and then set up an emergency fund.
- Health Need: Write proposals to other donors to fund the policy
- WOUGNET: The policy is to be integrated in other operations.
- LABE: Integrating the policy in all their proposals

4.1.7 Giving the good example

Good practice is when senior staff members give the example of good practices. The HIV focal point person of Africa 2000 Network openly took an HIV test and so encouraged other staff to take the test as well.

4.1.8 Networking

Good practice was that many organisations were found to be networking and collaborating with training institutions, service providers, information organisations etc, to be able to implement their policy and with minimal cost. Also the linking and learning with other organisations in the SAN! project is enhancing. Specific networks and linkages were specified in 3.4 of this report. They show which specific services providers in certain areas SAN! organisations networked with. A good practice is to draw a MOU with services providers to make the relation more formal.

4.1.9 Continuing capacity building by SAN! and associates

The capacity building efforts provided by SAN!, CDRN and other lead organisations are good practice, because this ensures that skills are built for different organisations to tackle HIV and AIDS issues.

4.1.10 Being gender sensitive

Recognising that it is difficult to disclose one's HIV status, which is necessary to be able to access ART through the organisation, EASSI selected a male and female focal person whom staff can approach. In KALI initial discussions on development of a WPP were divided by sex to get gender specific needs and wishes for the WPP.

4.1.11 Anti-discrimination measures

Have a committee where complaints about discrimination can be put to (as in TPO). Have guidelines for the recruitment committee to prevent discrimination of HIV-positive persons applying for the job.

4.2 Facilitating factors in the implementation of activities

Respondents in IDIs and FGDs were asked about what factors had made them achieve something as far as implementation of WPP was concerned. The factors outlined included the presence and commitment of a focal point person, participatory approaches, open discussion, technical guidance from SAN! and CDRN, networking and information sharing as well as the support from board and management.

4.2.1 Participatory approach during the drafting of the policy

Respondents were of the opinion that having all staff members involved in the drafting of the policy made it easier to implement many of the activities. For instance, teamwork and enthusiasm of staff as reported by COU-TEDDO made it possible to realize the activities. Also, the high level of solidarity within some of the organisations such as Raising Voices made it possible to be open because they were like one family unit which made it easy to share views that formed the policy.

> *I think it is because we all participated in drafting workplace policy. Even those who were reluctant before we had to convince them to participate because – especially the junior staff they thought it was not something to do with them. Because they could say, you people do it – you will inform us later. But they had to be brought on board (IDI, Health Need).*

4.2.2 Staff commitment

Participatory development of the policy led to staff commitment and dedication, which was said to have helped to give a driving force to having the policy in place. This was coupled with a volunteering spirit as the staff members spearheading the development of the policy were not paid but still endeavoured to put in time despite their busy schedules. Also of importance was the availability of personnel, especially those capable of drafting and implementing the policy. Other reasons that led to the success of the HIV and AIDS workplace policy included cooperation and solidarity between management and staff, which enabled many organisations to mobilize themselves. This meant that staff members considered HIV and AIDS more of a workplace issue than anything else.

> *Our commitment, willingness and partnership as an organisation helped to give a driving force because it was participatory. (IDI, JIDDECO)*

4.2.3 Support from board and management

Most organisations reported that the support provided by the board and management made them succeed in executing the policy activities. Where these were actively involved and had commitment for the policy, it became easy to implement the activities.

The goodwill from management, our values of care and the nature of our work i.e. we provide psycho-socio support to people out there that need it. We can not preach to be compassionate to our clients in the field when we are not to staffs. So our values have been a factor to a greater extent."(IDI, TPO)

The LPG also recognised this important contribution of the management.

Management has to own the whole process, I mean the top management. If top management looks at HIV as something that can be mainstreamed and give it its full support, then the other things can fall in place. (FGD, LPG)

4.2.4 HIV focal point person

The appointment and level of commitment of the HIV focal persons were reported to have played an important role in facilitating the implementation of WPP. Often the focal persons attended seminars and then shared information with the rest of the staff members. In SOMED it was decided to install a committee of four to coordinate the activities, which works very well. SAN!'s contact with the focal persons has contributed to success in terms of information sharing and exchange. SAN! provides IEC materials through them to facilitate exposure among the staff to HIV and AIDS issues at the workplace which made it easy for them to embrace the policy.

The LPG members commented on the importance of choosing a qualified focal person.

There has to be a focal point person at an office to coordinate activities. Sometimes they pick somebody that should be in charge of HIV and AIDS yet sometimes this person isn't qualified in mainstreaming. But if they bring on board someone who is competent, then in most cases activities run.

4.2.5 Networking

Organisations that had established networks and shared information with other organisations, such as Uganda Cares, GOAL, CONCERN, Mildmay and the Ministry of Health, felt that this helped them develop and implement the policy more easily. In addition, networking with referral services was considered very important (see 3.4 for specifics). Furthermore, the networking between SAN! partner organisations facilitated the process: Commitment of DETREC in dealing with other organisations (NGOS and CBOs) working on HIV and AIDS issues enabled them to facilitate the development of the policy. There was also technical guidance from CDRN to ORUDE and EASSI. The LPG recognises and advocates networking:

...... Then there is coordinating and networking with other people because you may not be having a few things. But if you are having networks and coordinating well then you might be able to outsource a few things from your partners (FGD, LPG)

4.2.6 Technical guidance by SAN!, PC and lead organisations

Respondents reported that SAN! support especially in capacity building in form of training and workshops enabled the organisations to develop policies and carry out the different activities regarding WPP. The SAN! workshops in most cases helped staffs to concretize the idea of the workplace HIV and AIDS policy.

Also I think the coming of the SAN! Project, I think it has also helped us here. Because they are the ones who gave us guidance on how to come up with the HIV and AIDS policy. And the interactions we had with them in meetings and what have you that we had organized, it has helped us to get this far. (IDI, FHRI)

Similarly participation of CDRN, NOVIB and others in workshops for capacity building of various organisations in terms of information sharing and exchange helped staff members of different organisations to know the importance and viability of the policy. Likewise, KARUDEC also explained that the lead organisation (FURA) played a very important role towards the development of their HIV and AIDS workplace policy.

4.2.7 HIV/health focus

Organisations such as TAP and Health Need which are operating within the area of HIV and AIDS and health said they were better placed in drafting and implementing the policy. TPO said the WPP is in line with their general organisation's goal of showing compassion for people.

4.2.8 Financial support

Organisations which got funding were in a better position to start implementing activities. Organisations such as ACORD, HOSPICE, VISION TERUDDO and Fort Portal Diocese who had direct donor support indicated that it enabled them to draft and implement some of their policy activities. However, some organisations started with their own resources generated internally to run their WPP activities as they waited for support from outside, which meant that their management was supportive of workplace policy activities.

> *The funds are always available to enable the focal point person fulfil her duties." (FURA)*

> *The board was supportive and resources were availed." (COU-TEDDO)*

With time, these organisations started getting some funding from other organisations such as the SAN! project itself, Cordaid, CDRN, TEAR, Icco and Uganda Cares, which facilitated the implementation.

4.2.9 Donor requirement

Some of the donors had already made it a requirement to externally mainstream HIV and AIDS in other areas, which ensured its integration in core programs. The deliberate approach from donors to fund the WPP was seen as a motivating factor in helping organisations meet their requirement. Organisations where HIV and AIDS was already mainstreamed in all the day-to-day activities include Concern, EASSI, NOGAMU and DETREC.

> *HIV and AIDS is one of the core issues for Concern. We make sure we mainstream HIV in all we do. So when workplace policy came it was given priority, with strong commitment by management towards workplace policy. (IDI, Concern)*

4.2.10 Problem analysis and work plan

In addition to the facilitating factors mentioned in IDIs and FGDs, the Local Project Group expressed some other factors that enable organisations to implement WPP activities, including conducting a problem analysis and making a work plan.

> *Doing an internal problem analysis makes staff realise that HIV and AIDS are issues for them, for their clients and for other people and therefore they begin to build their values around what they could do about it and that brings in that passion of them beginning to work on it. So in some organisations they have not actually sat down to analyse what HIV and AIDS mean for them as an organisation, for their work and then for other people. So when that isn't inbuilt, they felt people take long to begin to understand that HIV and AIDS are actually critical issues and therefore the effort to work around it becomes weak. ...... Having a clear work plan such as an annual work plan, or a quarterly work plan, backed by an M&E framework, facilitates activities to be easily carried out. (FGD, LPG)*

4.3 Perceived challenges in the implementation of WPP

Several challenges concerning the development and implementation of WPP were raised in IDIs and FGDs. Most notably among them were limited skills, financial and time constraints, acceptability, and having the policy as a stand alone program.

4.3.1 Lack of funding

Unreliable funding was identified as a challenge for the policy activities to be fully functional. The shortfalls in the budgets have meant that organisations implement only some or none at all of the policy activities. One organisation for example, noted that if the donors would not fund their budget, then the policy would remain dormant because they could not hire experts to conduct the trainings they had planned for, without paying them. Other organisations observed that their health scheme budgets could not cover provision of ARVs, or ARVs for all the dependants, they would like to include. In Africa 2000 Network, only staff is party to the health insurance due to lack of money, meaning that their dependants are not insured. TPO reported that due to the limited financial budget, they have been unable to implement most of the items in the policy. Also FURA, despite being a lead organisation, mentioned the late release of funds as being a major constraint to the implementation of their WPP.

> *The late release of funds e.g. funds for this quarter are not yet in place yet we are the lead organisation. So this affects the budgetary allocations. (IDI, FURA)*

Funding from different donors is a problem for IRDI:

> *For us at IDRI we are paid as per project we are attached on. So, it was difficult for especially those staff attached to project activities of non-Dutch donors. For the Dutch donors the 4% is fine, but with other donors it is not okay. So, we are having problems with those staffs to make it universal in the organisation. (IDI, IRDI)*

4.3.2 Stigma and hesitance to disclose HIV-positive status

Confidentiality remains a big challenge especially if staff members have to disclose their HIV status within the organisation in order to access treatment (for instance in Health Need). The HIV focal person for JIDECCO said: *'It is easier to talk to other people but not among ourselves. Here we need much help. It is still a challenge.'* Some of the respondents felt that planning for the sick was likely to create stigma instead of reducing it.

> *Not yet so far, maybe because nobody has come up to say he is positive. But staffs have relatives and friends who are infected and affected and this is a challenge to us. (IDI, Environmental Alert)*

> *People's attitudes are not easy to change. Much as we have had good communication channels, some people don't want to come out because they don't want to be known. (IDI, Concern)*

The LPG thought stigma was especially a challenge for FBOs because religious people are not supposed to be infected by HIV, if they follow the religious and moral teachings of the church.

4.3.3 High staff turnover

It was also noted that staff turnover, especially of the HIV focal point person, affected the speed at which activities related to the policy progressed, because know-how on the processes of motivation and sensitization of staff is lost.

4.3.4 Difficulty to include condoms in WPP

Some organisations, especially those religious based, found it difficult to consolidate the policy because of their stand on condom use. It was felt in some religious organisations that "*Christian staff is not susceptible to HIV, because they do not have unsafe sex*". Therefore, condom distribution was omitted in the development stage of the WPP.

> *The nature of the organisation; it is church based (Catholic) we cannot preach about condom use say in workshops, we cannot freely hang information concerning condom use in our offices. (IDI, JIDDECO)*

> *We cannot freely hang information concerning condoms in our offices. (FGD, COU-TEDDO)*

This is more of a Christian organisation and some members think staff are not promiscuous so why the policy? This at times puts us down. (FGD, IRDI)

However, also in secular organisations condom provision may be not acceptable, such as in Africa 2000 Network and WOUGNET, where there are arguments that condom use is associated with immoral behaviour (of extra-marital and pre-marital sex). In Africa 2000 Network condoms were provided first, but then decided against for these moral reasons.

4.3.5 Lack of (skilled) staff and time

Organisations such as ORUDE reported lack of skills to implement the activities while Soroti Diocese of Church of Uganda lacked time and personnel. Other organisations argued that because they had to run various projects under different offices, it was difficult to find staff with time to implement the policy activities.

A related problem is that in some organisations, including NOGAMU and LABE, staff members are usually away in the field, due to the nature of their work, and thus not always available when activities are being implemented.

Some staff members spend a lot of time upcountry, therefore it becomes difficult to engage them in key sessions and get the message across. HIV and AIDS being a sensitive topic, so the resistance sometimes may rise. (FGD, LABE)

4.3.6 Language / understanding barrier

Some of the organisations complained about the failure of the WPP documents to be translated from English to their operational local language since many of their support staff did not understand English. Furthermore, some of the uneducated staff members, although they showed a lot of interest, did not understand the WPP. It was further noted that unless the HIV focal point person was committed to make staff understand the policy, implementing the policy would be difficult.

Mobilization of staff is not easy as most of them think it is a waste of time. (IDI, LOFP)

5 Conclusions, programme implications and recommendations

The findings of this study have shown that the SAN! project has progressed since the previous phase 1 and has shed light on the areas of success and those which still need attention. Learning from promising practices of organisations, and recognising challenges and suggestions on how to overcome them, can help organisation that lag behind or meet challenges, and those that want to progress, to proceed.

5.1 Summary and progress in Phase Two

The number of organisations with final and draft policies have increased as have organisations that have started implementation of activities, even if limited. Comparing information of 51 organisations that were included in Phase One and Phase Two shows that 26 organisations have progressed in the 6 months from data collection in the first phase to the second phase data collection; 8 from having no policy to a draft, 5 from no policy to a final policy and 13 from a draft to a final. Fifteen organisations still have no policy, whereas 10 have not progressed from a draft to a final WPP.

Of the 72 organisations visited, 24 had a final WPP, 23 had a draft WPP while 25 had no policy in place yet. Out of the 25 without a policy, 4 had started the process and 14 were definitely interested to start. Of the 47 who either had final or draft policy, 27 reported having activity plans in place.

The Good Donorship guidelines (GDG) proved to be useful tool for developing of WPP in a majority of organisations (who were asked so). In 23 of the 27 organisations in which the GDG were known, the GDG were considered to be very useful to developing their WPP. In 11 of the organisations to whom the question was asked, the GDG were *not* known.

It was a promising finding that many organisations seemed to have taken the recommendations of the first phase report to start implementing activities, even with no or limited fund: they have discussed feasibly ways to provide access to ART, have routine discussions on HIV and AIDS within their organisation, linked up with information, counselling, training and service provision organisations.

In 36 organisations WPP related activities have started, including sensitization and awareness raising, provision of IEC materials, prevention through condom provision, facilitating access to treatment, anti-discrimination measures. Effects are already noticeable, as it was reported that the policy has created HIV and AIDS awareness and has given staff confidence and support. Also VCT uptake has increased and decreased stigma and discrimination are noticeable.

All activities of implementation were considered promising practises, especially in the light of minimal funding with the majority of organisations having not yet received any donor funding. Several exemplary strategies by organization were identified as promising practices concerning implementation of WPP including: a) Making the process of development and implementation of the WPP participatory with all staff b) Commitment of senior management and support from board of directors, c) Creating awareness in the organisation, d) Networking with other agencies for IEC, counselling, and (free) service provision, e) Making proposals for sustainability, f) Supply of IEC and prevention materials, g) Senior staff living by example, i) Feedback to other staff if someone has gone for relevant training or meeting, j) Always being gender sensitive.

Perceived challenges related to the implementation of the WPP reported were mainly lack of financial support, continuing feared stigma which causes not wanting to disclose status, high labour turnover, and unavailability of staff and lack of time for implementation of activities. Similar challenges were mentioned in the first phase, when developing the policies. The additional challenges in Phase One were lack of skills to finalize formulating WPP, activity plans and budgets and uncertainty in the provision of ART to staff. These last two challenges

seem to play a minor role in this Phase Two, with more know-how among the organizations having started (but not for those having not started yet) and finding other ways to access ART. It is increasingly easy for organisations to establish referral systems with free service providers, since (free) ART scale-up in Uganda is progressing very fast.

In Phase One enhancing factors in the development of WPP were: technical support by the SAN! project coordinator, the SAN! capacity building workshops, having a supportive senior management. Similar enhancing factors were mentioned in Phase Two for implementation with as addition: the presence of a focal person, financial support and the Good Donorship Guidelines.

5.2 Recommendations

From studying the promising practices, acknowledgement of the challenges and from suggestions by study participants, the following recommendations are made to the partner organisations, the PC, LPG and regional lead organisations and the Dutch SAN! donors respectively.

To partner organisations:

- Start implementing some of those components/activities within the WPP regardless of whether the policy is in draft or final stage. They could phase the implementation with activities with less implementation costs like advocacy and awareness raising activities.
- Continue to write proposals for funding to other donors to broaden the implementation instead of waiting for SAN! donor funds to begin implementation.
- Disseminate WPP documents to all staff to internalise – and translate the WPP in the local language if appropriate, i.e. if some staff members are not able to read English.
- Establish links with free HIV and AIDS services, including Mildmay, TASO, MoH, and Uganda Cares (see the list with links with services providers in specific areas in 3.4).
- Develop a policy in a participatory process. This approach makes staff members to open up and helps to raise their level of satisfaction early enough to obtain a better method of policy implementation.
- Start with internal awareness raising for staff needs to popularize the policies.
- The HIV focal point person and management to look at the promising practices of other organisation and discuss with all staff whether these can be replicated.

To LPG, PC and Lead organisations

- Make a deliberate effort to assist those organisations who have communicated willingness to have a WPP but do not have it yet in place because of lack of technical competence or information on the project. Provide organisations with the GDG and budget tool and promote them.
- Recognise and acknowledge different ways in which organisations can address HIV and AIDS at the place of work such as in HR policy, health scheme etc., and support them accordingly. Learn from organisations where this is already done.
- Send invitations for workshops in time, so organisation's staff can plan for/reschedule their other activities
- Facilitate linking and learning between partner organisations by sharing promising practices. Organisations that have shown exemplary practices could be invited as resource persons in some of the SAN! workshop to share their experiences or/and organisations that need to learn from those promising practices could be advised to visit and learn from them.
- Continue with capacity building workshops and invite more staff members per organisation to participate, so as to accommodate turn-over of staff.

To donors

- Timely funding of the organisation activities to be implemented not to lose the momentum and enthusiasm.

- Since partners are at different levels of development, donors need to think of possible extensions of funding.
- Identify aspects were progressive partners need support, and provide this support.

5.3 Phase Three of the applied research

Phase Three of the applied research is intended to describe and analyze effects of HIV and AIDS workplace policies at the level of the workers and the organisation, and document best practices. It will examine the progress in development and implementation WPP, with special attention to budgets. Data will be elicited using in depth case studies of organisations and a survey of staff of the partner organisation. Special themes will among others include gender equality, stigma and discrimination, disclosure and confidentiality, access and utilizations of prevention, care and support and treatment services, and use of good donorship guidelines and budget tool. It is hoped that issues related to why some organisations have succeeded and other lagged behind in the development and implementation of HIV and AIDS work place policy will be investigated and documented. Data collection for Phase Three is planned for February to April 2008.

ANNEX 1: Organisations visited and WPP status

Organisation acronym	Full Name	Draft WPP	Final WP P	No WP P	Activity plan	Activi-ties	FGD	IDI
ACFODE	Action for Development			X				1
ACODE	Advocate Coalition for Development and Environment			X				1
ACORD HASAP	ACORD HASAP		X		X	X		1
AFR2000N	Africa 2000 Network – Uganda		X		X	X		1
	Akika Embuga			X				1
AMAKULA				X				1
AMFIU	Association for Micro Finance Institutions in Uganda	X			-	X		2
AMWAFRI	Akina Mama Wa Afrika			X				1
BUSO FOU	BUSO Foundation		X		X	X		1
CDRN	Community Development Resource Network		X		X	X		1
CEEWA-UG	Council for Economic Empowerment for Women of Africa – Uganda			X	-	-		1
CEFORD	Community Empowerment for Rural Development		X		-	X	1	2
CEREDO	Catholic Education Research Development Organization	X			X	X	1	1
CERUDEB	Centenary Rural Development Bank		X NOT SAN!					1
CMB	Catholic Medical Bureau			X				1
COMBRA	Community Based Rehabilitation Alliance			X				1
Concern	Concern Worldwide		X		X	X		1
COU-SDED	Church of Uganda – Soroti Diocese	X			-	X	1	2
COU-TEDDO	Church of Uganda – Teso Diocese Planning and Development Office	X			-	X	1	2
CPAU	Concerned Parents Association – Uganda			X				1
DA	Development Alternatives			X				1
DENIVA	Development Network of Indigenous Voluntary Association			X				1
DETREC	Development Training and Research Centre	X			-	X	1	1
EA	Environment Alert		X		X	X		1
EASSI	East African Sub-Regional Support Initiative		X		X	X	1	2

FAPAD	Facilitation for Peace Development	X			X	-		2
FEMRITE	Uganda Women Writers Association			X				1
FHRI	Foundation for Human Rights Initiatives	X			-	-		1
FIDA UG.	The Uganda Women Association – Uganda		X		-	X		1
FOCCAS				X				1
	Fort Portal Diocese – Health Department	X			-	X		1
FOWODE	Forum for Women in Development			X				1
FURA	Foundation for Rural Advancement		X		X	X	1	2
HA UG	Hospice Uganda	X			X	X		1
	Health Development Kabale Diocese			X				1
HN UG	Health Need Uganda		X		X	X	1	2
IRDI	Integrated Rural Development Initiatives	X			X	X	1	2
JIDDECO		X			-	-		1
KALI	Karambi Action for Life Improvement – Kasese	X			-	X	1	2
KARUDEC	Kagando Rural Development Centre	X			X	X	1	2
LABE	Literacy and Adult Basic Education		X		X	X	1	2
LOFP	Lango Organic Farming Production	X			X	-	1	1
NOGAMU	National Agricultural Movement of Uganda		X		X	X	1	1
NORRACOL	Northern Rwenzori Rural Community Agriculture and Conservation Link		X		X	X	1	2
NORTH-ACORD	ACORD Northern Uganda		X		-	X	1	2
NUDIPU	National Union of People with Disabilities			X				1
NUWODU	National Union of Women with Disabilities in Uganda		X		X	X	1	2
ORUDE	Organisation for Rural Development	X			-	-		2
RUCREF	Rural Credit Finance Company			X				1
RV	Raising Voices		X IN HR		X	X		1
SOMED	Support Organization for Micro-Enterprises Development		X		X	X		1
TAP	TESO AIDS Programme		X		X	X	1	2

TOCINET	Tororo Civil Society Network			X				1
TPO UG	Trans-Cultural Psycho-Social Organization		X		X	X	1	1
TTP	Tripartite Training Program		X		X	X	1	2
UCAA	Uganda Change Agent Association			X				1
UCRNN NET	Uganda Child Rights NGO Network			X				1
UCS	Uganda Catholic Secretariat			X				1
UFFCA	Uganda Fisheries and Fish Conservation Association	X			-	X	1	2
UFTL	Uganda Finance Trust Limited			X				1
UJCC	Uganda Joint Christian Council	X			-	X	1	
ULA	Uganda Land Alliance			X				1
UMFL	Uganda Micro Finance Limited	X			X	X		1
UMU	Uganda Martyrs University (Nkozi)	X			-	-		1
UMWA	Uganda Media Women's Association			X				1
URAA	Uganda Reach the Aged Association	X			-	-		1
USDC	Uganda Society for Disabled Children			X				1
UWFT	Uganda Women Finance Trust			X				1
UWONET	Uganda Women's Network	X			?	?		1
VECO UG	VECO-Uganda	X			-	-		1
VEDCO	Volunteer Efforts for Development Concerns	X			-	-		1
VISION-TERUDO	Vision Teso Rural Development Organization		X		X	X	1	2
WOUGNET	Women of Uganda Network		X		X	X	1	2
	Total	**23**	**24**	**25**	**26**	**36**	**24**	**92**

ANNEX 2: Tools for Phase Two Applied Research 2007

Interview Guide
Project coordinators, heads of NGOs, Managers, HIV focal persons

Start with asking whether they have a (draft) policy. If not, then we have to find out why they have no draft policy:

a) If there is any problems (ask for inhibiting factors e.g. lack of technical know how, little support, not considered as priority etc – any other reason)
b) Have they attended SAN workshops?
c) Suggestions?

If they have one:
Basic components and activities of the WPP

1. Your organisation has developed an HIV and AIDS WPP. Is it draft or final?

2. What are the MAJOR? elements contained in the policy in this organization?
   - Probe: sensitization, education, stigma reduction, gender, support for PLWH, treatment, VCT, ETC

3. Have you developed an activity plan? If yes: What is the workplan / activity schedule in regard to policy implementation (*if implementing)? Ask for a copy If not, any plans?*

4. What activities have been accomplished so far in regard to policy implementation?

5. What factors contributed to the success of the accomplished activities? (available resources i.e. human & financial, donor support, project organisation, coordination, capacity building)

6. How are you implementing the policy? Were you involved in making the activity plans?

7. What activities have met challenges in implementation and what are the underlying impediments?

8. How has SAN! good donor ship guidelines facilitated implementation of the activities contained in your policy?

9. How is the aspect of stigma and discrimination being handled in the planned activities?

10. What is the level of staff satisfaction / attitude in regard to activities contained in the policy?

11. Has anything changed concerning level of staff openness/stigma compared to the when the policy was not yet in place – explain

12. What support for implementation was received from / provided by:
    a) The local project group
    b) The project coordinator
    c) the regional lead organization

d) Dutch donor

13. What arrangements are in place regarding treatment of staff living with HIV and AIDS?

14. What monitoring framework is in place to measurer the success of the activities contained in place? (obtain a copy if necessary).

15. What future plans are in place in regard to policy implementation?

16. What institutional arrangements / structures are put in place to enable implementation of the policy (coordination , HIV AND AIDS Focal point persons, health insurance provider, health services i.e. clinics – private / public)

17 What budget has been allocated to the implementation of the WPP activities included in the policy (amount of money per activity, emphasis on treatment, establish staff contribution) in the first year (this year)

18 What sustainability measures have you put in place / planned after the end of the project for WPP programme?

19. What benefits have been realized from the WPP Programme (both to the organization and to the staff)

Promising Practices

20. Which exemplary strategies and practices by your organisation would you want to share with other organisations (can be repeated elsewhere in other organisations when developing and implementing HIV and AIDS WPP)

21. What would make it possible to replicate in relation to the structures, approaches/methodologies, resources?

22. Was there anything that could have been done better – as you realize now – that other organisations could learn from/ i.e. LEARNING FROM MISTAKES)

Recommendations

23. What do you recommend for better development and implementation of HIV and AIDS WPP to

a) other organizations
b) donors,
c) LPG,
d) Project coordinator
e) Regional lead organization

FOCUS GROUP DISCUSSION GUIDE
STAFF OF ORGANISATIONS THAT HAVE A DRAFT OR ARE ALREADY IMPLEMENTING THE WPP

1. Your organisation is involved in the development and implementation of the work place policy.
Are you aware?
What made you think about having an HIV and AIDS work place policy for your organisation?
How were staff involved?

2. What are the basic elements contained in the policy in this organization?
What issues does the policy address?
What were points of discussion

3. What activities does the policy intend to carry out (for those still developing it)

4. What activities is your organisation implementing so far concerning the HIV and AIDS work place policy? (For those who have started implementing)

5. What processes are guiding activities' implementation? (how did you develop the policy?)

6. What have been successes?
What factors if any have contributed to the success of the accomplished activities? Probe for - (available resources i.e. human & financial, donor support, project organisation, coordination, capacity building)
Probe Has anything changed concerning knowledge, stigma, discrimination gender relations, support, treatment etc.

7. Have there been difficulties in the implementation of the WPP?
What would you say has been the challenges? And why?

8. How best do you think the above challenges can be tackled?

9. What lessons have you learnt so far?
probe: what are some of the innovative ideas or strategies that have helped you in the development and implement the policy)
.
10. Has the WPP caused any impact (visible results) , good or bad? Ask how and why for any responses given.

11 Any suggestion for better development and implementation of HIV and AIDS WPP? (What would you like)

Any other thing you would like us to know?

FOCUS GROUP DISCUSSION GUIDE
Local Project Group (LPG)

1 When and how has each of you become a member of the LPG (ask everyone individually)

2 How do you see the role of the LPG in the SAN Project (probe e.g. a) giving support in development WPPs, b) in the implementation of WPP programme)

3 Is there a difference between your role on paper and what you have been able to do in practice (probe for reasons difference – if any)

4 What are the elements in a WPP and the process of developing a WPP that you think are vital?

5 How do you as an LPG, who have an overview of the project, explain why some organizations moved fast, while other lack behind? (Probe accordingly – for successes and failures) Other probes: (motivation of senior management, available resources i.e. human & financial, donor support, project organisation, coordination, capacity building, having experience with HIV positive staff)

.

6 Any visible results in some organizations as a result of development/implementation of WPP activities?

7 What have been the challenges met by organisations in the a) development of WPP and b) implementation WPP programme

8 How best do you think the above challenges can be tackled?

9 How can you as LPG help in tackling some of these problems faced by organisation?

10 What lessons have you learnt as a committee (LPG) in guiding the process?

11 What are your suggestions for improvement in the development and implementation WPP and programmes?

12 How do you see the support/guidance/involvement to/with the LPG of the Dutch SAN! coordinator and Dutch SAN! partners (ICCO, OXFAM/NOVIB, CORDAID and HIVOS?). What would you like to change / improve?

13 How do you evaluate your own functioning – what was good, what could have been better, what are you plans for the LPG – what do you need for this to happen?

Any other thing you would like us to know?

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