

Human Resource Management
and HIV/AIDS
- a study among Share-Net
members -

*' OUR GUT FEELING SAYS YES,
BUT WE NEVER DECIDED ON THIS'*

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FOREWORD

In November 2002 Share-Net organised an expert meeting on ‘AIDS and Business’. As a relative outsider I was asked to chair the meeting. To my astonishment it became obvious during the discussions that Share-Net members had to acknowledge that they did not have an internal HIV/AIDS policy. As organisations well aware of the HIV/AIDS pandemic and employing staff in high HIV prevalence settings, they seemed to lack HIV/AIDS preparedness for their own employees.

As a result Share-Net decided to embark on a research project to map out the experiences, good practices and problems of the members regarding the development of an HRM-based policy. The objective was to raise awareness of the issue and to make NGOs recognise their responsibility as employers.

The outcomes of the research project are described in this report. The researchers have included a very helpful literature review on ‘AIDS and Employment’, from which important lessons can be drawn – one of them being that stand-alone policies that are separated from the core business and the principal body of policies and procedures are seen as add-ons and will not last very long. HIV/AIDS has to be a strategic priority at all levels of the organisation and warrants an integrated response.

It is an understatement to say that the results of the research project are not encouraging. Compared with initiatives taken in the private sector the Dutch development NGOs are lagging a long way behind. There is an urgent need for these NGOs to put their internal ‘HIV/AIDS house’ in order. For the benefit of their employees and partners overseas, but also to be able to legitimately participate in the debate with the private sector on these issues of corporate social responsibility.

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The Steering Committee members, Gemma Crijns (Nijenrode University), Meini Nicolai and Rachel Ploem (Share-Net), Annette Noten (consultant) en Dolar Vasani (Novib) provided an essential sounding board for the overall research approach, tool development and numerous suggestions along the way.

We acknowledge the generous financial support received from Hivos, Cordaid and Novib for this research.

In this final version we are pleased to include a forthright description by Els Klinkert (Ministry of Foreign Affairs) of their internal HIV/AIDS policy process. In addition we wish to thank SNV for their generous use of 'benchmarking information' collected during their HIV/AIDS policy process.

As often happens, this research took more time than expected. We wish to thank our respective employers, ETC Crystal, PSO and SPAN Consultants, who allowed us to spend considerably more time on this research than originally anticipated.

Even though many individuals from a range of organisations participated in this study, the responsibility for the research and this report lies exclusively with the authors.

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EXECUTIVE SUMMARY

In an effort to foster the dialogue between civil society and business organisations in the Netherlands, Share-Net organised an initial meeting in November 2002, which showed that the NGOs needed to scrutinise their internal policy development on HIV/AIDS before progressing further with such a dialogue. The assumption being that putting their house in order is considered to be an essential step in developing a mature and robust response to the employment dimensions of the HIV/AIDS pandemic.

A brief literature review on 'AIDS and Employment' shows that updated information is available on the spread of HIV/AIDS and there is a growing collection of manuals on 'how to develop an HIV/AIDS policy'. In addition, the outcome of organisational responses to HIV/AIDS is generally presented in the form of company statements, principles, road maps and checklists. However, the individual experience of attempting to develop or foster an organisational response to HIV/AIDS is still poorly documented. Too often, the responsibility for an HIV/AIDS response is dumped on human resource departments that do not have the appropriate capacity and means.

Available literature on organisational responses to HIV/AIDS highlights several guiding principals and these appear sufficiently detailed for every organisation that wishes to pursue the formulation of a policy-based HIV/AIDS response. Benchmarking or comparison with organisations that have sought to develop an internal HIV/AIDS response, show that general lessons and practices are similar, especially when articulated as employment questions. Possibly the most important lesson is that formulation of an organisational HIV/AIDS response is a process that requires determination and active senior management support.

Guided sampling was used to select a cross-section of civil society organisations active in the deployment of Dutch staff abroad. The methodology used for this study is a combination of literature analysis, individual and focus group interviews. Individual interviews were conducted using an open questionnaire. Focus group interviews used a tested combination of methods that allowed for active interaction. In addition, this study draws on the professional experience of the principal researchers in the HIV/AIDS and management domain.

The main conclusions of this study show that Dutch civil society organisations have so far barely started to address the employment dimensions of HIV/AIDS. During the time of the study very few organisations appeared to be familiar with the international literature on organisational responses to HIV/AIDS. This finding, in combination with the interview results, indicates that the internal dynamics of a sound HIV/AIDS response are generally underestimated. Analysis of the findings suggests that, on the whole, civil society organisations appear to struggle with the internal employment or human resource development dimensions in relationship to HIV/AIDS, especially in the high HIV/AIDS prevalence regions.

Documented experience by civil society organisations elsewhere in Africa and Europe shows that developing an employment-related or internal HIV/AIDS policy takes a considerable amount of time. Developing such a policy requires a process approach that should involve senior management and sufficient resources, plus a mandate to achieve an effective policy. Inevitably it seems that engaging in such a process reveals other organisational issues.

Published lessons learned from high HIV prevalence countries suggest that there are several key lessons available for any organisation that wishes to embark on an internal HIV/AIDS policy development process. This report contains first-hand experience by the Dutch Ministry of Foreign Affairs on its HIV/AIDS policy development process, plus comparative examples from various organisations.

Overall, the results and conclusions strongly suggest that Dutch civil society organisations need to come to terms with their employment responsibilities and that effective dialogue with Netherlands-based international companies still requires further 'work at home'. The commitment to HIV/AIDS is obvious, as numerous organisations have formulated an external HIV/AIDS policy.

INTRODUCTION

In November 2002, Share-Net organised a seminar on 'AIDS and Business'. This was intended as a first step towards encouraging a dialogue on HIV/AIDS between civil society organisations and the business world. The discourse during the seminar was illustrative: '*How many organisations have an internal HIV/AIDS policy?*' only one participant (a non-member) was able to respond positively. Other quotes heard: '*We are too small for such an initiative*'. '*As a funding organisation we do not send out experts or employees ...*'. None of the organisations present could confirm that they had decided to recognise their responsibility as an employer and as an organisation that, through funding arrangements, enables partner organisations to employ people. This suggested a possible shared problem of developing and articulating internal or employment-related HIV/AIDS preparedness of Share-Net members and their partners. The outcome of the seminar and subsequent discussions was used as a basis for formulating a descriptive research proposal.

HIV/AIDS and employment background for this study

We are now well into the third decade of the HIV/AIDS pandemic and there is an increasing number of Dutch organisations working in high HIV prevalence settings. Most of these organisations and individual employees will subscribe to the view that the spread of HIV is a global tragedy of unprecedented scale, as it primarily affects individuals in the prime of their lives and generally always leads to severe disease and death, especially for those who do not live in North America and Western Europe. The devastating impact on the fabric of society is coming about because various pillars of society, such as teachers, doctors, the military, farmers, factory workers, male and female heads of households to name just a few, are increasingly infected and affected.

Analysis of population data from the most affected countries shows that key development indicators, especially adult life expectancy, are showing astonishingly early death rates. In this respect the spread of HIV/AIDS differs from a disease such as malaria and from the respiratory and gastrointestinal infections that kill so many children in developing countries. Furthermore, HIV fuels the tuberculosis (TB) epidemic, with TB being the primary opportunistic infection taking people's lives in sub-Saharan Africa. The full extent of losing large sections of the population in their productive prime will only reveal itself in years to come.

The importance of this emerging situation has already been recognised by several large corporations, which have since gained valuable experience in developing a variety of employee-employer focused interventions. In addition, it is increasingly obvious that the scale of the epidemic is such that all parties need to be mobilised in supporting national governments to respond adequately. The past, in which the private sector and civil society functioned in a dialectic relationship, needs to change. It is no longer business as usual!

What this means for civil society development and the role of civil society organisations is largely unknown. Civil society organisations can learn from the large transnational corporations that the employment dimension of an HIV/AIDS response is recognised, before this larger problem concerning the future role and position of civil society organisations is addressed. Many of these organisations are directly involved in supporting other organisations, employing staff, working in developing interventions, analysing policies and lobbying a variety of stakeholders. Other organisations are involved in providing humanitarian assistance for shorter or longer periods to people and communities facing a host of different disasters.

All this suggests that organisations that are involved in the 'business' of sending people abroad for shorter or longer periods need to recognise the extent to which the risk of HIV

infection or developing AIDS are taken into account as an employment issue. The task ahead was recently captured in the following phrase: *Previous models of responding do not work. The future does not resemble the past! This has implications....*¹.

Why look at the internal responses of Dutch civil society organisations?

Important international corporations such as Shell, Unilever, Heineken and Microsoft are all active in the area of HIV/AIDS prevention and dealing with the impact of the pandemic on their foreign plants and locations. So far, no fruitful interaction or collaboration has developed with development organisations in the Netherlands that deal with this employment dynamic. Many NGOs still regard international business with suspicion; this can be attributed to the lack of mutual understanding. This is unfortunate, as scrutiny of the achievements and lessons learned in both types of organisations show that there is considerable scope for mutual learning. Such an exchange would require an effective dialogue and communication.

The experience of HIV/AIDS and business efforts in the UK, plus similar efforts focusing on the theme of human rights and business has shown that developing working relations between the NGO and business sectors can be achieved. It requires a long-term focus where the private sector is not predominantly seen as a source of funding. By systematically analysing the position and 'experience' of key Dutch civil society organisations, we aim to contribute to their capacity to expand the debate on 'AIDS and Business' in a responsible manner.

Focus of the research

The primary objective of this research was to produce an overview and assessment of these experiences in developing organisational or internal HIV/AIDS preparedness amongst Share-Net members. Such a description and analysis should lead to activities that enhance the capacity of the Working Group AIDS/Share-Net members to strengthen their internal mainstreaming of HIV/AIDS. The follow up to this research will need to take account of recent findings published by the UK NGO AIDS Consortium, in order to avoid reinventing the wheel.

Approach

The overall research proposal was presented to the board of Share-Net, including the appointment of an external steering committee. This research was obviously conducted in phases, which enabled us to fine-tune questions as time progressed. The literature analysis on 'AIDS and Employment' provides background information and depth to the overall study. It directed the development of the questions that were used in the individual interviews. The guide to the Focus Group Discussions was finalised after gaining a first impression of the interview findings. Respondents were assured from the very beginning that the research would be anonymous, and this permitted frank discussions.

¹ Alex De Waal, one of the initiators of the Government and AIDS Network (GAIN) and an experienced analyst of development in (Southern) Africa, speaking at the lunchtime meeting of Stop AIDS Now at Cordaid, the Hague 09/10/2003.

METHODOLOGY

This study relied mainly on data obtained from interviews with representatives of a number of Share-Net member organisations. In addition, relevant documents and policies of the organisations concerned were studied and a literature review was undertaken.

Selection of organisations

Ten of the 31 Share-Net member organisations were selected for inclusion in this study (www.share-net.nl). In consultation with the steering committee it was decided to select the member organisations that have a significant number of staff actively involved in (long-term) missions to high HIV prevalence settings. In addition, the Dutch Ministry of Foreign Affairs/ Development Cooperation was consulted during this study with regard to their experiences and the opportunity of sharing information with other organisations, because they already have an HIV/AIDS workplace policy and implementation has already started (see Appendix F). This brings the total number of organisations in this study to 11. The results from the ministry are not included in the study outcomes as such, since it is not a member of the Share-Net network.

Data collection was undertaken among the following organisations: CORDAID, Dokters van de Wereld, PSO, MSFH, VU, Health Net International, KIT, ICCO, VSO and the Dutch Red Cross.

Table 1. Data on employees

Organisation	Number of employees	Average age of employees	Male/ Female ratio		Married / Cohabiting	Single
A	290 at Head Office (HO) 115 (expats)	41.4	35%	65%	95%	5%
B	150 (HO) 600 (expats)	33	50%	50%	50%	50%
C	16 (HO) 29 (expats)	40	23	22	23	22
D	200	40	45%	55%	75%	25%
E	460 (HO) 40 (expats)	46	50%	50%	70%	30%
F	170 (HO) 380 (expats)	38	41%	59%	-	-
G	30 (HO int'l dept) 50 (expats)	40	50%	50%	75%	25%
H	30 (HO) 400 (expats)	41	50%	50%	80%	20%
I	280 (local staff)	-	-	-	-	99%
J	figures not made available	-	-	-	-	-

The table shows that the organisations included in the sample employ more than 1000 staff at head-office level. More than 2000 are 'in the field' (expatriates/local staff). Their average

age is around 40 years, with a minority of them being single. There are slightly more women employed than men.

Data collection instruments

Table 2. Description of the research instruments

Instruments (total number)	Human Resource Managers (HRM)	Programme Officers (PO)
Individual interview for HRM (11)	9	2
Individual interview for PO (11)	-	11
Focus Group Discussion HRM (1)	4	-
Focus Group Discussion PO (1)	-	4

Interviews

It was decided to target the human resource manager and the HIV/AIDS programme officer in each organisation, since they are the ones most likely to be involved in an HIV/AIDS workplace programme (Appendix B). Questionnaires containing open-ended questions were used during the interviews (see Appendix C for the interviews with human resource managers and appendix D for those with programme officers). Two organisations were not able to make their human resource manager available for this interview. In these cases the programme officers responded to the questions applicable to human resource managers.

Focus groups

A guide was developed for the focus group interviews with groups of similar respondents, and consisted of:

- Propositions on HIV/AIDS and human resource policies to which participants could express their agreement or disagreement;
- A limited number of issues meant for more detailed discussion (Appendix E).

Two rounds of focus group discussions were held with human resource managers and programme officers respectively. All respondents participating in the individual interviews were also invited to participate in these discussions. Four human resource managers attended the human resources focus group discussion meeting and four programme officers attended the programme officer's focus group discussion meeting. The eight participants represented six organisations.

Analysis of documents

In addition to the information obtained from interviews, data was also collected from relevant documents and policies of the organisations involved. These were analysed in two steps. The content analysis of collected data consisted of two activities:

1. An (anonymous) inventory was made of existing HIV/AIDS workplace policies/procedures based on the data collected from the 11 participating organisations;
2. An assessment of these policies/procedures was made by comparing these with results from the literature review.

Literature review

Prior to collecting field data, relevant publications were selected and studied in collaboration with the Share-Net's Resource Centre. These publications were subdivided into three general categories:

- Analytical publications: some of these papers synthesise the experience of the business or corporate world in responding to the employment aspects of HIV/AIDS in southern and eastern Africa;
- How-to-do publications: these generally provide practical guidelines and models for responding to HIV/AIDS from an employment perspective, through a series of linked steps that focus on developing HIV/AIDS prevention approaches in the workplace;
- HIV/AIDS policies: examples of HIV/AIDS policies developed by individual organisations have been collected from international corporations and civil society organisations.

Implementation

A research assistant was hired to conduct the interviews. She produced individual reports that were checked and discussed by the researchers. The two researchers were in charge of the focus group discussions. They also studied the documents and made a review of the literature.

Timeframe of the research

The interviews with individual organisations were held in the period May – July 2003. The focus group discussions, initially planned for August, had to be postponed to September/October 2003. Due to such practical constraints experienced during the organisation of the two focus group discussions it was decided not to pursue a further focus group discussion at senior management level. A separate workshop will be organised for senior management (directors) of Share-Net member organisations at some point in the future to discuss the findings of this study.

The research process

This study was carried out within the Share-Net structure. The HIV/AIDS coordinator facilitated the study in a number of ways. A small steering committee was set up to guide the research process. The Terms of Reference for the study were submitted to this committee for discussion. The first results of the study were again shared with the committee members. At a later stage the report was sent to all members of the HIV/AIDS working group. As part of a regular meeting of members of the HIV/AIDS working group held in March 2004, the unedited version of the report was discussed in great detail. At that time interviewees from the various organisations were also invited to respond to the study. Two representatives from DGIS (Directorate General for International Cooperation) were also present. As a last step in the process, the researchers aim to contact everyone involved in the study, to consolidate the reactions and comments received regarding the study before the final document is published.

LITERATURE REVIEW AND EXPERIENCES OF HIV/AIDS AND EMPLOYMENT

The overall spread of HIV and AIDS is traceable through regular HIV/AIDS updates published by UNAIDS (see www.unaids.org). The impact of HIV/AIDS on human development is increasingly being articulated in the annual Human Development Reports published by UNDP (see www.undp.org/hdr2003) and the World Development Reports published by the World Bank. Such general overviews appear to be of limited relevance to NGOs and community-based organisations that are concerned with people at a grassroots level and less with population data and statistics.

When working in most countries in sub-Saharan Africa and an increasing number of other countries in the south, understanding the relevance of this data is a critical step in assuming long-term commitment. Based on these overviews of the epidemic and its increasingly obvious impact, a series of important points for organisations have gradually emerged. These points are: changes in life expectancy and development indicators; changes in household income and expenditure patterns, and depletion of household assets.

The drop in life expectancy at birth and the shift in household expenditure and consumption patterns signify the broad outline of the changing nature of operating an organisation in times of a maturing AIDS epidemic. Remember that prevalence figures are well over 20% in southern Africa. The impact of HIV/AIDS will change the economy, development focus and cooperation scene for years to come. Both the size and shape of needs will be transformed. This will most probably imply that operational orientations that do not factor HIV/AIDS into their policies will become increasingly redundant. Not only will the external operating environment of organisations change in key dimensions, the supply and availability of skilled and semi-skilled labour will most probably be less available or of less quality, while demands on staff will increase². An example: *the loss of a key staff-member who was the 'walking library on community participation' set a newly established community forestry organisation back several years, both in contacts and skills*³.

It is a feature of the response to HIV/AIDS that some of the more advanced thinking is not always directly available in the public domain. We see this when looking at individual organisational responses. Key lessons circulate at the informal level. There are only a limited number of books and scientific peer-reviewed publications available that are based on methodologically collected and analysed observations from within organisations. In developing long-term scenarios for Shell, Heinzen⁴ and Whiteside observe that in 2002 there were still very few empirical studies published on the impact of AIDS on household units, organisations and economies. These publications tend to be biased towards large corporations and organisations with adequate resources and specialised departments. This institutional talk portrays images that are far removed from the operational reality of many civil society organisations and, more importantly, their partners or clients. Nevertheless their macro-analysis is useful as it describes the setting and allows trends to be identified.

The World Bank recently acknowledged the (macro-) economic bias that has allowed it to ignore or downplay the impact of HIV/AIDS on the process in which human knowledge and potential are created and lost. For South Africa they analyse three subsequent shocks when AIDS destroys people's accumulated (working) life experience. The first shock: skills, knowledge and insights accumulated over the years are present in each and every organisation. The second shock: the steady erosion of mechanisms for human capital

² Sustainability and Profitability in the face of HIV/AIDS. Practical guidelines and Strategies in a Changing Market. P. Badcock-Walters, Director Mobile Task Team on Education Impact 24/04/2002 (available through the HEARD website: www.nu.ac.za/heard/).

³ Personal communication by Isla Grundy to Russell Kerkhoven.

⁴ Barbara Heinzen, The Shell HIV/AIDS Market Impact Study, Final Report 2002; supported by HEARD, University of Natal (Alan Whiteside).

formation. The third shock is that the slide in the quality of education and socialisation will increase the chances for learners to contract the disease in adulthood, hence making investment in education and ongoing professionalism less attractive⁵.

In his general review of publications on the impact of HIV/AIDS on human capital development Cohen⁶ observes that '*significant improvements in the quality of the labour force occur through on-the-job training and experience*'. This ongoing process of professional formation is inevitably diminished, as employees will live shorter and most probably their prior formal education has already been affected due to the increasing attrition of educators. This slow downward spiral of decreasing achievements in performance and professionalism is already being observed in Malawi. Here the reduction in staff and the drop in service output and quality is linked to the impact on skills and experience. In 2002 the Malawi Institute of Management concluded that '*whereas the first (shortfall in the number of people) may be relatively easy to deal with, the second (loss of experience) amounts to a substantial organisational loss. Depending on which staff categories are most affected, certain organisational functions and capacities will be eroded, which will inevitably impact on the core business of the organisation*'⁷. At the same time, one could browse the recent human resource management (HRM) literature in Europe or South Africa and realise that many handbooks on HRM do not mention the issue or the management dilemmas associated with HIV/AIDS. This suggests that many of these books might not provide us with the guidance needed in this area.

The AIDS movement has, to a certain extent, contributed to this by insisting on dividing workplace and human resource issues. The former focuses on prevention activities: such as leaflets, posters, drama performances, condoms and STD (sexually transmitted disease) education. These are activity-based responses that have increasingly become creative efforts by a growing number of companies and organisations. Sadly Clive Evian observes that '*very few programmes have achieved any real measure of success. ... Superficial knowledge about the disease and its transmission has been achieved, however this has rarely been translated into meaningful social transformation*'.⁸ Gillian Gresak in her review of 10 years of business response⁹ notes that human resource departments have often been 'awarded' the problem of HIV/AIDS without the means to undertake meaningful action. She concludes her review: '*while HR executives can drive HIV/AIDS resolutions in the workplace, it is not their responsibility alone. HIV/AIDS has to be a strategic priority at governing board level; it has to have accountability by directors, managers, employees and unions alike*'. The conclusion is obvious: unlinking or segregating workplace issues from management responsibilities and employment conditions does not appear to be helpful, as it leads to fragmentation.

In various countries during the 1990s, employers, NGOs and unions collaborated with governments to formulate legislative responses on AIDS and employment. For example, Zimbabwe and Zambia developed specific statutory instruments; South Africa formulated specific legislation. In 1998, the Heads of State adopted the SADC (Southern African Development Community) code on AIDS and employment: a collaborative effort by the formal tripartite partners, with input from NGOs and National AIDS Programmes. During the first years of the new millennium, ILO developed an international code of practice on HIV/AIDS and the World of Work (ILO, 2001). This code provides a further framework and

⁵ World Bank, The Long-run Economic Costs of AIDS: Theory and an Application to South Africa (available at: http://www1.worldbank.org/hiv_aids/docs/BeDeGe_BP_total2.pdf).

⁶ Desmond Cohen, Human Capital and the HIV Epidemic in sub-Saharan Africa, Working Paper, ILO, 2002.

⁷ Malawi Institute of Management/UNDP, The impact of HIV/AIDS on Human Resources in Malawi, 2002.

⁸ Clive Evian, AIDS in the Workplace a review article in Everybody's Business – the enlightening truth about AIDS, Metropolitan Group, 2000.

⁹ Gillian Gresak, HIV/AIDS in your Workplace: From Ostriches to Proteas, a review article in Everybody's Business – the enlightening truth about AIDS, Metropolitan Group, 2000.

presents a list of steps that can be taken (see Appendix A). These codes provide a legal or guiding framework for developing further policies and plans of action at organisational level. The Organization of Africa Trade Union Unity – Health, Safety and Environment Programme published key lessons on responding to AIDS and employment. These nine lessons present a broad range of further steps and are presented towards the end of this report.

HIV/AIDS policies

Policy development (at national and international level) by the tripartite partners¹⁰ with civil society input has been effective in several countries by formulating codes of conduct (SADC and ILO, in addition to national codes; in South Africa legislation provides the framework). Private sector organisations have been instrumental in developing several fora for exchanging experience in response to HIV/AIDS. Some of the more well known are: the Global Business Coalition, the Business Exchange on AIDS and Development, the Thai Business Coalition. In addition to the appreciated discussion and exchange role, some of these fora have assumed more operational responsibilities by producing guides, blueprints and undertaking state-of-the art research among individual members. There is no doubt that the employment dimension is seen as an essential part of a broad multi-sectoral response to HIV/AIDS.

This work on developing an employment-based response to the HIV/AIDS epidemic has increasingly allowed the identification of key lessons that can be seen as guiding principles for (internal) organisational responses to HIV/AIDS:

1. Ensure commitment throughout the organisation;
2. Match the core business of the organisation to the HIV/AIDS-related needs;
3. Engage in a multi-pronged approach that includes the external environment;
4. Relate core business costs and benefits to resource implications;
5. Use a multi-stakeholder approach, including PLWHA (people living with HIV/AIDS);
6. Develop partnerships with useful external agents;
7. Use peer group methods to approach different groups;
8. Be creative and cost-effective;
9. Monitor and review progress.

How can this be achieved?

There are many guidebooks on responding to HIV/AIDS in organisations. Initially these guides took the form of how-to-do manuals that provided prescriptive measures to address HIV/AIDS within organisations. These often resulted in activity-based interventions that focused on instructive forms of communication that appear linked to the operational language of command and control. However, over the years, both HIV/AIDS organisations and managers have realised that following these 'how-to-do' manuals did not lead to the desired response. For example, replacement and recruitment costs are seldom calculated per position or category of positions. The institutional approach developed by Barnett and Whiteside and tested with Debswana (UNAIDS, 2002), the largest mining cooperation in Botswana, made management realise that several positions within the organisation required long-term experience and skills development. Apparently, the critical nature of these positions had not been realised before, suggesting that previous human resource management did not perceive these positions as critical. Nor does the presence of modern high-tech personnel monitoring systems automatically lead to comprehensive HRM. From our consultancy practice we know that several organisations operating across the globe do not have a reliable monitoring system for absenteeism.

¹⁰ The tripartite partners are government, employers and labour unions.

The assumption made in many of these 'responding to HIV/AIDS' guides is that organisations in Africa routinely collect quality data on performance, attendance and resources available through operational and reliable management information systems. This data is further assumed to guide most HRM decisions and that this rational decision-making involves an insight into accounting and staff investment data. It is increasingly obvious that this is not really the case for many small to medium-sized organisations, whether they be commercial enterprises or civil society organisations. From anecdotal evidence in southern African countries, it appears that this lack of human resource data is not unusual, even though the popular management 'discourse' tends to portray a more refined image. Research undertaken by Simon Matzvai in Zimbabwe during the 1990s, and more recently the research undertaken by Community Development Resource Association (CDRA) in the Eastern Cape, South Africa, confirms that civil society organisations lag behind in basic human resource management. These studies show that many civil society organisations struggle to define their employment role in general and even more so in times of HIV/AIDS. Again our work with several of the major co-funding organisations in the Netherlands during recent years has shown that awareness of the employment aspects and identification of responsibility in developing an internal HIV/AIDS response has (so far) not been a real priority. Sustainability does not yet seem to include wider employment responsibilities.

An HIV/AIDS response requires an integrated or institutional approach

Initially, organisational responses focused on prevention. An overview produced by CIMAS in Zimbabwe in 1994 showed that very few of the 60-odd responses went beyond prevention. Care and treatment were assumed to be covered by the general health service response. Loewenson has been a tireless advocate for an integrated HIV/AIDS response that is linked to occupational health and safety and, if necessary, includes a smart review of occupational benefits. As more experience is gained with formulating and implementing HIV/AIDS policies within organisations, it is obvious that stand-alone policies that are separated from the core business and the principal body of policies and procedures are seen as add-ons and appear to eventually run out of steam and motivation. Policies that are integrated, in terms of standing organisational practices (as articulated in general codes of conduct, dealing with chronic and terminal illness and sexual harassment), are probably more effective. Achieving such integration of policies is obviously a noble and rational choice, but it is not automatic, as can be seen from the anecdotal experience of several organisations, including leading NGOs.

Whiteside and Sunter¹¹ explain that when addressing the economic impact on the human resources in an organisation it is important to distinguish between direct costs, indirect costs and systemic costs. Direct costs are: benefit packages, recruitment costs, training and the cost of HIV/AIDS programmes. Indirect costs are all the costs related to absenteeism, on-the-job morbidity and management costs. Systemic costs are the impact of HIV/AIDS on workforce cohesion and the loss of experience/knowledge, plus the slippage that occurs due to loss of key staff and experience. For civil society organisations articulating the HRM dimension appears to be problematic for a variety of reasons. The employment dimension of the funding relationship between northern and southern NGOs is often ignored or downplayed. Barnett, in his work with Oxfam UK, suggests that this is due to the feeling of guilt and solidarity that lies at the core of several organisations. The lack of attention for the employment dimension possibly reveals that even though sustainability is part of the development discourse, civil society has possibly not adjusted to the realisation that organisational sustainability might call for a role beyond that of a project implementation or management agency. Unfortunately, this may suggest that civil society organisations claim a

¹¹ Alan Whiteside and Clem Sunter, AIDS – the challenge for South Africa, 2000.

role next to the corporate and government sector without identifying the deeper organisational dynamics of such a role.

Questioning the employment dimension of civil society organisations should not lead to minimising the potential contribution of this 'sector' towards policies on HIV/AIDS and employment issues. There are a limited number of recently documented experiences with implementing HIV/AIDS policies in the public domain. The impact of HIV/AIDS on the workforce has been documented since the mid-1990s. The apparent reluctance to consider this issue has been very insistent for too long. It is only in recent years, linked to the increasing availability of Anti-Retro Viral (ARV) medication, that there has been a consistent move towards a genuine employment response to HIV/AIDS. To a certain extent this engagement with HIV/AIDS appears to be similar to the conclusions by visionary companies, as both call for top management to lead by example and to avoid top-down instructions. A further similarity is that core business values provide guidance; these values are not only about profit making, but also about socially responsible employership and business ethics. A final similarity is the notion that change is permanent and inevitable and can better be embraced than resisted at all costs. These are other conclusions that might help understand why business and civil society organisations have been slow to respond to the internal dynamics of HIV/AIDS with some form of policy guidance. CDRA's (Community Development Resource Association) recent analysis of civil society organisations struggling with their internal response to HIV/AIDS shows that few organisations are well prepared. Many organisations appear to face related dilemmas of empathy, increasing absenteeism and staff attrition, plus operational and sustainability demands, which are often further accentuated by funding contracts.

The number of large corporations incorporating an HIV/AIDS policy is growing: Daimler-Chrysler, Debswana, Heineken Breweries, Anglo American are but a few. They have realised that waiting for national governments and international agencies involves too long a wait and they have moved ahead with the corporate or private sector response to HIV/AIDS. The most telling example is the Debswana case, published as a global benchmark by UNAIDS¹². This case study was prepared by Tony Barnett and applies the institutional analysis approach as opposed to the earlier accounting or cost-benefit methods (see AIDS in the Twenty-First Century, Barnett and Whiteside pp. 242-270). An important feature of the institutional approach is the flexibility and opportunity for learning by doing, rather than a rigid blueprint approach that is based on instructional methods. This appears to suggest that the policy and response within each organisation has common features, but is a unique process of involving and mobilising stakeholders, identifying the organisational values and a lot of hard work to ensure that effective approaches are put in place. Campbell's recent social evaluation of a failed peer education programme¹³ in a formal workplace setting contains a wealth of lessons, but perhaps one of the more important ones concerns the need to take time, incorporate ongoing reflection and true involvement by all stakeholders. If this is true then this increases the chances of seeing civil society organisations with an HIV/AIDS policy and a documented implementation record.

The International HIV/AIDS Alliance¹⁴ has only recently published its endeavours in developing an internal HIV/AIDS policy within the organisation and following the chain down to its link organisations or partners active in HIV/AIDS response. It is remarkable that this policy development experience has been published several years after this same organisation published a toolkit for establishing partnerships in the HIV/AIDS domain. This earlier publication did not contain any reference to this internal or organisational dimension of responding to HIV/AIDS. The Alliance-documented experience is instructive, though the

¹² UNAIDS, The private sector responds to the epidemic: Debswana – a global benchmark, September 2002.

¹³ Catherine Campbell, 'Letting them die' How HIV/AIDS prevention programmes often fail, 2003

¹⁴ Developing HIV/Workplace and Medical Benefits policies – with partners in Cambodia, Burkina Faso and Senegal, AIDS Alliance, Draft summary 2003.

current publication is of unclear use in this context as the link organisations are all HIV/AIDS focused and are therefore familiar with many of the problems and questions concerning HIV/AIDS. The examples are also developed in countries that are not facing a full-blown AIDS epidemic such as in southern and eastern Africa. The obvious painful question that remains unanswered is: why did these well-resourced and informed organisations take so long?

Nevertheless, we cannot deny that a sense of urgency has further developed during this study, especially as we realised that the writing has been on the wall for a decade now, because as far back as 1993 the Personnel Director of Barclays Bank in Zambia observed: *'...we acknowledge that AIDS is a national problem at every employer's doorstep. The threat of AIDS and the problems arising from it cannot be left to government and non-governmental organisations alone. We are committed to the dire need to control the spread of AIDS and discrimination against people with HIV infection. The way forward is to accept that AIDS is a national problem at every employer's doorstep – it is a management problem'*. Persistent failure to acknowledge this responsibility has been likened to 'ostrich-like' behaviour. Future generations will ask: what were these people doing in organisations working in high HIV prevalence settings?

RESULTS

Outcomes of interviews and focus group discussions with Human Resource Managers of 10 Share-Net member organisations

Prevention of HIV infection: a responsibility of the organisation?

'Our gut feeling says yes, but we never decided on this.'

Even though the need for acknowledging (potential) infection risk in high prevalence settings has been identified as a public health issue and workplace-based interventions are included in most national HIV/AIDS plans in countries with an expanding epidemic, most HR officers do not want to intervene in the private lives of their employees. Most HR managers perceive discussions regarding possible HIV infection due to travel and work abroad as invading the privacy of an employee. The employer needs to inform all staff members of the health risks involved and provide additional medical insurance to ensure good coverage in case of infection. But in the end it is the employee who is responsible for his/her own behaviour. Some organisations (not all) that send international medical staff to high prevalence areas provide them with a PEP (post-exposure prophylaxis) kit and tell them the required procedure. Access to this medication is generally restricted to incidents such as skin cuts at work and to sexual violence; but having unsafe sex is not considered suitable justification for using PEP. A PEP kit was often reserved for international staff only, as national or local staff presumably did not encounter sexual violence or the lure of casual sex. The respondents indicated that financial motives appeared to be the reason behind this attitude.

Others don't know who is responsible or what is actually going on: *'We are far away from the field practice and we don't want to correct the local employer. We want to work with local employers on the basis of equity, therefore we don't want to tell hospital managers what their protocol should be'*. In practice, the implications for equity might unfortunately be the opposite.

One HR officer describes the responsibility of the employer as the obligation to inform employees of the health risks encountered during work. Sexual behaviour, from this perspective, is not part of the work environment: *'We expect people to be informed about these risks. As long as they are well provided with protocols and guidelines then it is their own business, and therefore it is their own responsibility to apply these during work and in their private lives'*.

Some organisations have members or partner organisations belonging to faith based organisations that don't want to discuss HIV infection or see it on the development agenda. Inadvertently this position seems to contribute to the taboo on HIV/AIDS.

Do organisations have experience of HIV-infected employees?

Human resource officers from five organisations informed us that there were no known cases of HIV in their organisations or had so far been brought to their attention. However, when reading the statistics from the high prevalence countries where these organisations are working, they expect that their organisations will be affected in future. Medical information is confidential and is handled by external medical services, therefore these organisations are not aware of the current situation.

Three organisations have provided PEP protocols at the request of staff members. However, after use, these organisations did not monitor whether or not any incidents or actual infection had occurred.

Only one organisation has experience of local staff being infected, but so far no international staff. When available, they supply care to their local staff via a clinic, but in many countries this is not possible. Staff at this organisation are required to report when their skin is cut or they have accidents with syringes. Eight accidents have been reported over the past three years. However, there is no follow-up information available on these eight incidents. All medical staff, both international and national, have access to a PEP kit after exposure at work. But unsafe sex is not a reason to provide PEP. This had been requested in the past by national staff, but such requests were always denied. The number of experts returning with a positive mantoux (TB test) has increased over the past few years.

Another HR officer knew of one international employee who died of AIDS and three HIV-positive cases within his organisation. To encourage open dialogue, and to avoid stigma and discrimination, they had twice called in external facilitators to provide information on prevention and counselling in the workplace, with a special focus on a non-discriminative work environment.

Educational institutes with international students are confronted with a new kind of problem – for which there is still no solution. They discovered that infected international students remain in the Netherlands after completing their studies because they are too sick to return to their home country. These unforeseen costs are not covered by the bursary funding organisation, but are carried by the educational institute. This provision is seen as an act of goodwill rather than an obligation. Yet there is no policy or plan available on how to act in such circumstances.

Reaction so far to HIV cases: ad hoc, or a structural approach?

'We offer a PEP kit and procedure.'

Most organisations follow the Dutch labour legislation and medical insurances give the required coverage for international staff. International medical staff have access to PEP protocol. Some organisations have provided financial support in special cases.

One HR officer mentioned doctors' requests for counselling when they returned after their assignment, as they were in need of emotional guidance to help them cope with (often traumatic) work experiences due to the inequity in the workplace. Another officer mentioned that a director of a partner organisation had approached him for ARV treatment. This request was rejected for two reasons: *'We did not want to be in a position where we would have to make a distinction between a director and a driver; and secondly the scope of such an assistance policy would be totally unpredictable'*. International and national staff work in a very unequal structure, which some of them experience as unethical. Another HR manager said that they don't know how their international staff would react to the issue that only they have access to PEP. There is no structure to ensure that this kind of information returns to head office. The consequence is that there is no information on replacing the PEP kit. Are provision and use of the PEP kit confidential? Are follow-up testing, counselling and therapy provided?

For national staff most organisations initially operate on an ad hoc basis to HIV/AIDS-related issues. Support often depends on the duration of employment with the organisation. One organisation explained that they used to have an ad hoc response, but have now developed a health policy for local staff. In future they expect to be able to respond in a way that is based more on agreed policy.

Another organisation initially had ad hoc arrangements for national staff, but when they found that most local medical insurance companies did not cover HIV/AIDS care and ARV,

additional medical aid insurance was provided to all national staff. The point was raised that in the case of ARV medicines, provision will be a problem when an employee decides to leave the organisation. Will the ARV supply also stop?

Does your organisation need a specific HIV/AIDS policy?

'We had a SARS policy within 10 days: it was organised in no-time. But we do not have an HIV/AIDS policy, despite the fact that SARS had a death toll of 774 in 2003, and AIDS has a daily death toll of 8,000.'

An organisation has to decide whether or not to develop a specific HIV/AIDS policy. In general, international staff are covered through comprehensive medical aid packages. But employers often do not know whether national staff have access to such coverage. Other human resource-related HIV/AIDS issues are generally not discussed with staff members. Many organisations will therefore fade away due to the impact of AIDS.

The participants interviewed expect that the implementation structure and the therapy itself will be a burden on their organisation's budget. Therefore they expect that any policy adopted will focus primarily on awareness-raising activities. Few organisations want to commit themselves to anything else, since it is almost impossible to budget for the expected costs of such policies.

HR managers generally believe that specialist knowledge is required to develop an HIV/AIDS policy. Their organisation does not have the size and expertise required to develop their own tailor-made policy. They are not aware that other organisations might be facing similar dilemmas.

What are the high-risk situations encountered by your staff members, and how can they be reduced?

'High-risk situation: everyone living in a high prevalence area.'

Dealing with occupational hazards: according to all HR officers, medical staff are particularly susceptible. Further occupational risks are more indirect, and are often due to the way the 'work' is organised, i.e. that staff are frequently travelling, and are often away from 'home' for prolonged periods.

PEP protocol is offered to most international staff to reduce vulnerability at work. A first-aid kit and gloves are often included. The organisations have not received any feedback from returning contract employees about such provisions, so information regarding gloves, for example, is not available.

General opinion has it that national staff are more susceptible, due to their limited knowledge of HIV infection, and are more exposed to behaviour involving some risk, due to local taboos and strange ideas about HIV/AIDS. International staff are expected to know about these risks, although it was generally felt that it was probably better to tell them twice rather than be blamed later for not telling them at all.

Dealing with unsafe sexual practices: three organisations offer condoms to their staff as one of the elementary prevention measures they can provide. Others don't supply condoms for a variety of reasons:

- Sexual contact is perceived as a private issue, therefore no information on condom use is provided and no condoms are distributed;
- Sexual behaviour cannot be changed, therefore, as an employer, we ignore it;

- Employees have to supply their own condoms; the organisation cannot specify the number of condoms needed. Staff are advised to take sufficient condom supplies with them.

One HR manager points out that their international staff are trained to make their own decisions. This kind of training is not provided at local level. Therefore national staff members, e.g. drivers, are more susceptible, as are young (single) staff and people who are highly mobile and frequently away from their 'normal' social environment, who may engage in additional sexual contacts. This also applies to highly skilled professionals and to staff involved in emergency relief operations; their status and financial position are inevitably attractive.

Contributing factors: Other risk situations mentioned include: stressful circumstances in which people live and work; staff whose spouse/partner stayed at home; working in a strange environment where almost no information on HIV/AIDS is available, therefore a higher risk envisaged; and finally there is a perceived higher risk for those working in crisis situations in comparison to those working in a more or less regular development setting.

Doubts were expressed about the risk-reduction effect of being married. Some of the married members of staff divorce and some marry abroad in the country where they work. In fact very little is known about the sexual behaviour of single and married persons.

Does the medical aid provided cover ARVs?

'I expect it to be covered by the medical aid package.'

Four HR officers are not sure if the medical aid insurances offered include ARVs. Three officers confirm that the medical aid offered does cover ARVs in the package. The remaining three organisations offer different types of insurances, with some of them covering ARVs. Here the decision lies with staff members themselves. They can decide which medical aid insurance they want. However a discussion is going on to opt for an insurance that will cover all these needs, including ARVs. One of these organisations has an emergency fund for special circumstances.

Are new staff members informed about the health risks, especially HIV/AIDS?

'Before departure, the risks of HIV/AIDS infection are discussed during the physical examination conducted by the health service.'

In general staff members are informed during the selection and preparation period. The effects of HIV/AIDS on the work setting are discussed and further information is provided by external health services. One can question the time available for this during these medical exams.

Studying the available information packages for experts working abroad revealed that seven of these packages contained absolutely no information on HIV/AIDS.

Two organisations brief their staff on arrival in the field through a meeting and in-country training. One organisation is contracting only international staff with more than five years field experience and these people are expected to know the risks. Another organisation provides its staff with public health information (including HIV/AIDS awareness) during a single evening session, where everybody receives a health manual that includes a section on the health risks of HIV infection.

Is HIV/AIDS considered a chronic illness?

'It is not a chronic disease.'

Most organisations look at HIV/AIDS with the perspective that it does not belong to the chronic illness category. A list produced by the ARBO (Dutch agency for health and safety at work) service makes a distinction between short-term and long-term absenteeism. HIV/AIDS and chronic disease are not considered to have a similar prognosis. HIV/AIDS and cancer are seen as belonging to the long-term absenteeism category.

On the question of whether organisations make a distinction between HIV/AIDS and chronic illness, many organisations answer that their reaction will depend on how often the employee is expected to be sick due to the HIV infection. Organisations currently have no specific policy in place to cover this. It depends on how the employee's insurers cover such events. One organisation commented that HIV/AIDS differs from any other chronic disease because this can be transferred to other persons, while in general other chronic diseases cannot. The WHO (World Health Organisation) has added HIV/AIDS to its list of chronic diseases, and perhaps insurers might take this into account. The Dutch labour legislation stipulates that employees with a negative medical prognosis can be dismissed after two years.

Can an employee adjust her/his work conditions as a result of HIV/AIDS?

Only a few organisations mention that changing working conditions can be discussed. Examples given of such accommodating changes include: negotiating a new division of working hours between the office and home, adjusting the workload and travelling less. Most organisations are not aware whether or not such adaptations could be realised. The issue is that they expect employees to be absent more due to illness; the HR officers assume that their organisation makes decisions about changing working conditions on an individual basis.

Did you notice a change in the type of contracts offered over the past five years? Was there an increase in contract workers (outsourcing)?

The contract type depends mainly on the source of financing for a programme. When a donor finances a specific programme, then the duration of the labour contract will depend on the duration of the donor contract. Permanent contracts are financed from regular organisational budgets. Due to fluctuations and uncertainties in the 'market', organisations depending on external funding see an increase in short-term contracts. So far an HIV/AIDS policy for employees has never been a point of discussion when signing a contract with a donor.

Does your organisation have a management information system that provides general information on sick leave and absenteeism?

'You have to know the situation, otherwise you don't know how to act if you want to change things.'

All organisations have a good overview of attendance rates at their head offices. But field offices often have their own registration system, and such information rarely reaches the head office. The medical insurance organisations receive this information in the case of sickness, but the employer at head office is not necessarily informed.

Is special attention given to creating and keeping an open dialogue and confidentiality in your organisation?

From the personnel management side there is no regular contact with employees at field offices. Open dialogue usually takes place in the form of personal contacts between staff members. Medical information is confidential. Confidentiality, as such, is not organised. Some organisations have appointed counsellors that can always be called upon if someone needs to speak confidentially about personal issues that relate to the workplace. These counsellors' tasks within the organisation are generally promoted through various channels. It is recognised that secrecy is a prerequisite for VCT (voluntary counselling and testing). The HR officers could not provide an indication on how often the counsellors are consulted with questions related to HIV/AIDS.

Does your organisation have a protocol for sexual harassment in the workplace?

Most organisations have appointed counsellors for their employees at the head offices. These counsellors have to follow a certain protocol when a complaint is brought to their attention. It is unclear whether similar structures are functioning at the field offices. One organisation has a code of conduct with a special focus on the relationship between relief/development worker and receiver, since such relationships tend to be unequal in terms of power and could easily be abused.

Is there attention given to 'good governance' in your partner organisations?

Partners often ask for capacity building assistance to their organisation. However, it is not always clear if 'being a responsible employer' is also included in such capacity building programmes. Typically such programmes would deal with issues concerning: organisational structures, transparency, and corruption. 'Being a responsible employer' is apparently a sensitive issue, since all these partner organisations are independent and function within their own cultural context. There is also a difference between development organisations and emergency relief organisations. In emergency situations organisations are often forced to work only with the organisational structures that are already in place.

During discussions with partner organisations, some of the organisations interviewed discuss the application of the national labour act during contract negotiations. One organisation mentioned that they only want to work with locally registered organisations. A project coordinator at the head office or regional office is usually in charge of monitoring whether partner organisations stick to negotiated agreements.

Other organisations do not have partner organisations or do not know if these matters are discussed with their partner organisations in the south. It is not always clear who is responsible for what.

What would you do if a colleague informs you (s)he is positive?

The answers showed considerable variety.

'I would advise them to seek the help of a doctor.'

'Apart from the medical assistance, I would try to find out what I can do.'

'We are not prepared for such questions. I expect the organisation will take care of such employees and will find out what is possible.'

'I would be shocked at first, but would ask the person if she/he was already receiving any medical assistance and make sure that normal procedures are being followed in case of sickness. I would also ask the person what she/he expects from the organisation as such because there are currently no provisions or policies for such cases.'

Outcomes of interviews and focus group discussions with Programme Officers of 10 Share-Net member organisations

Of your staff members, who has the highest risk of becoming HIV infected, and why?

All colleagues who are going to, or are working in, high prevalence areas are at risk. Local staff run a higher risk because it is expected that they do not always protect themselves. Maybe they do not know how to do this. International staff are assumed to be knowledgeable about how to protect themselves against HIV infection at work and in their sexual relationships. Long-term assignments abroad, travelling in high prevalence areas and working in post-conflict countries are considered high-risk assignments.

Two specific groups were mentioned in the discussions:

- staff working in clinics/hospitals are more prone to cuts and syringe accidents; and
- young expatriates.

The latter group includes single people who go abroad and, to them, having (sexual) relationships with local partners is often part of what is described as 'going native'; an identification with local culture.

Is there a budget line for HIV/AIDS activities within your own organisation?

Two organisations have a budget line for education and in-service training, which can also be used for HIV/AIDS activities. One of these organisations is also working on developing a solidarity fund for their personnel. The other programme officers did not have access to a specific budget line in their organisation or they did not know of any such provision.

What best practices and dilemmas have so far been encountered during the internal mainstreaming process?

Discussions and, in some cases, action on internal mainstreaming has only just started. The internal mainstreaming policies and action plans in these organisations are still being developed. The main focus during these preparations is on the impact of HIV/AIDS on their activities and the access to treatment for the entire staff. There are no best practice experiences as yet. The lesson learned so far is that it has become clear that doing nothing is no longer an option.

Dilemmas met during this process include:

- Partners see HIV/AIDS as something detached from their normal work, while it should become integrated into all their activities. The main problems are: how can it become an integral part of their partner's daily activities and are there enough competent staff to implement such policies?
- Some of the partners with religious convictions have problems with the package of a total prevention approach; it is not possible to develop a blueprint for all partner organisations;
- Every country is different, with its own culture of conscience and typical problems;
- Confidentiality must be assured because stigma is hard to fight. When confidentiality is compromised it is extremely difficult to come out and fight stigma and discrimination;
- Colleagues in decision-making positions (management level) are often not aware of what is going on. They don't know how HIV/AIDS will affect the organisation and its work;

- High burn-out levels in staff working in HIV/AIDS projects; but also in other staff who feel that development problems, such as poverty and child mortality, are being ignored;
- Access to treatment: how is access to treatment defined? Organisations expect a burden on their budget; where should the money for internal mainstreaming come from?
- Internal experience and expertise in designing and implementing internal and external mainstreaming plans for HIV/AIDS is not always available.

How would you describe the strong and weak points for improving the HIV/AIDS internal mainstreaming process?

'The distinction between medical and non-medical and between international and local staff is bizarre, when you look at the behaviour of risk.'

Commitment by management is a prerequisite. Cohesion among and between all levels of an organisation is important for the internal mainstreaming process.

There is no clarity as to which budget lines should fund the internal mainstreaming activities. Is there any money available at all for this process? Are donors willing to pay for this in a programme?

A weak point is that knowledge is generally overestimated. The gap between knowledge and behaviour needs more attention. More focus on HIV/AIDS often results in a shift of funding away from other public health and other issues. Striking a balance between an organisation's core activities and its HIV/AIDS commitments proves to be a real challenge for most of these organisations.

Many organisations started too late with this process of internal mainstreaming. Now the discussion about access to therapy can no longer be ignored, so external support is requested for this internal mainstreaming process. Specific knowledge is required for the formulation of a human resources/organisational policy.

Many considered the impact of HIV/AIDS to be a technical issue and these are normally handled within the organisation at the level of technical programme officers. The result of this was that the management, personnel and financial officers were not, or not sufficiently, involved in the whole mainstreaming process. Now most organisations don't have an internal mainstreaming policy or an implementation plan. The internal and external mainstreaming requires a specific policy and a similar approach such as 'gender', which cuts across the entire organisation.

In 2001, two organisations prepared a policy on mainstreaming for their international staff, and these are currently being implemented. These policies do not apply to national staff. Four organisations started discussions on developing internal interventions, which yielded two views: Just offering PEP is a mechanical approach. It is discussed during the 'in-take' procedure. No follow up. *'We are not used to many procedures so we never thought of offering anything else.'* PEP should be supplied in response to a high-risk event and a follow-up procedure, with more instruments, should be in place.

Most organisations provide PEP to their individual international medical staff members. This is a problematic concept because local colleagues with whom they work don't have access to PEP. Cases are known in which such positions have led to emotional dilemmas.

It became very clear during the discussions that it is not only large organisations that can do something about HIV/AIDS. People in all types of organisations and at all levels in an

organisation can pull their weight in direct HIV/AIDS prevention and developing appropriate human resource policies. It is not only a personal and/or a personnel matter, all departments in an organisation have to play their part. The fact that many development and relief organisations are active in many different countries provides an extra challenge.

Management should be aware of the impact of HIV/AIDS on the work and activities of the organisation and its employees. It is the management who can prioritise, not the workforce. Interest has to come from both the top and the bottom of the organisation, even though it will be difficult to get all involved to agree.

Is there attention for 'good governance' of your partner organisations?

The organisations that work with partner organisations pay attention to institutional capacity development: the structure, independent board, role of management, gender, financial management, participation of all stakeholders and human resource management. In general it can be said that the focus towards HRM is limited. Once this relationship is established, not all institutional matters, such as HRM, are discussed during every recurring field visit. Development organisations are in a better position to discuss HRM issues than emergency relief organisations. In emergency situations, HRM is rarely a priority on the agenda and these organisations operate in countries where labour legislation is often non-existent. Five organisations provide financial assistance on 'being a responsible employer' to their partner organisations in the south; but the other five do not.

What would you do if a colleague informs you that (s)he is HIV positive?

The answers varied from:

'I don't know.'

To personal comments such as:

'Advise them to seek medical and spiritual care.'

'Ask the person to come home.'

'Inform the personnel department, they should be prepared for these kinds of situations.'

One officer commented that if a colleague consults you regarding whether he/she should reveal their HIV status, the potential reactions of other colleagues should also be taken into account. The organisation should support the person in their decision. They had a situation in which one of their employees spoke about the fact that she was HIV positive. The result of this was that the work situation became even more difficult. Her colleagues accused her of misbehaviour.

Table 3. Attitudes of the organisations towards HIV/AIDS

Organisation	Internal HIV/AIDS mainstreaming policy	Training on HIV/AIDS risks and epidemic	Prevention information and material	Quality of care provided	Financing/ supporting HIV/AIDS-related projects
A	Policy being prepared by external consultants. Point of discussion: are staff members with local contract included or not?	Not really, sometimes there are internal discussion meetings on HIV/AIDS	During physical examination by an external medical service	-	-
B	PEP protocol available since 1999; Internal mainstreaming policy being prepared by head office; Negotiations are ongoing with pharmaceutical industry on reduced prices for ARV medicines	Pre-departure internal training where PEP protocol and sexual relationships are discussed	Supply of condoms for the field offices; Worldwide HIV prevention programmes	Access to care is a priority	Some of our staff members work in HIV/AIDS programmes
C	-	-	Briefing takes place at the field offices, no idea if HIV/AIDS is discussed.	-	-
D	Policy is being prepared by an internal working group on AIDS	Capacity building at HO through seminars, often implemented by external facilitators	During physical examination by an external medical service before departure and every two years. Expatriates are informed during their preparation period	-	-
E	Not necessary for staff members, social insurances provide all care needed	Workforce sessions conducted by external facilitators	During physical examination by an external medical service before departure	Not specific. In general employees are covered by a good medical aid insurance	-
F	Being developed, as a response to field experiences. A National Staff Policy has been developed (April 2003)	Courses offered to experts who will work in HIV/AIDS care programmes. This is carried out by internal and external facilitators and through internships	PEP, condom use, and other relevant issues are discussed during the preparation period. Condoms are available at the field offices. HIV/AIDS is discussed during in-country briefing	-	Implementing agency

G	-	Health aspects are covered during the preparation training. Sexual relationships, e.g. relocating without partner, are discussed during interview	Condoms available at field offices, only in countries where they cannot be bought easily	-	Implementing agency
H	-	-	During physical examination by an external medical service before departure. It is not specifically discussed during the general intake interview	Medical staff have access to PEP, and repatriation if necessary	-
I	Head office abroad has developed one for staff who became infected	During preparation courses and during the in-country training. During physical examination by an external medical service before departure	Condoms are available at the field offices in the relevant countries	Per person a ceiling of GBP 2500 covered by medical aid insurance	Budget for southern Africa: GBP 75,000 per year
J	Never thought about it	-	Staff and students can receive information on HIV/AIDS during a consultation at the institute's travel clinic. Information is also provided, on request, via the ARBO service on the risks of HIV/AIDS	As a tertiary education institute, some of our student doctors do their internship in high prevalence countries. They all request the PEP protocol, but we only provide PEP when they go to a hospital (Tanzania and Surinam) that also has a PEP protocol. We feel that student doctors cannot decide for themselves when PEP should be used On return no standard exit medical examination available. Any physical complaints should be discussed with their general practitioner	-

CONCLUSIONS

This research focused on those NGOs that are actively involved in providing technical assistance as part of their development strategy of capacity building. At this point it is important to recall that the initial survey among the Share-Net members at the start of this research revealed that none of the members had formulated an employment-based HIV/AIDS strategy. This means that neither the organisations that actively use technical assistance nor those that opt for other capacity development methods appear to have actively considered the HIV/AIDS employment dimension of civil society organisations in high HIV prevalence settings.

The research team used several methods to assess the Share-Net members that generally cover capacity development of civil society organisations in eastern and southern Africa. The inclusion of technical assistance or personnel would imply that those staff members would be at risk. There are two further reasons, based on experience, that suggest that we cannot stop there. Firstly, frequent travel to high-prevalence regions exposes employees (experts, advisors, consultants etc.) to higher risk settings. It is also well known that prolonged absence from the 'normal' home environment is linked to the possible development of sexual relations beyond the 'regular' partner. Secondly, during this research we were not able to conduct representative field visits to 'partners' in the south. Over the past 10 years our professional experience has involved working extensively with NGOs in Kenya, Malawi, Namibia, South Africa, Zambia and Zimbabwe. Discussions took place in most of these countries with umbrella organisations and with an extensive range of national NGOs. The employment dimension was obviously a difficult, if not neglected, issue. The research by Matswai in Zimbabwe and CDRA in South Africa confirm this. For a long time this was considered acceptable, even though the legal instruments in various countries were developed with the active involvement of civil society.

Today, rapid improvements in accessibility to ARV treatment, and the lesson that ARV treatment alone is seldom a sensible strategy, exposes a real need for planned action in addressing the employment dimension within civil society in southern and eastern Africa.

The organisational response of Dutch civil society organisations

From the data gathered it is obvious that so far the Dutch civil society organisations tend to focus on their external dimensions of responding to HIV/AIDS. The internal focus has so far not received a lot of attention. There appears to be the start of a policy response on paper, but there is seldom an operational plan to ensure implementation of measures that, in combination, could be described as a response to HIV/AIDS. Although responding to HIV/AIDS is considered an issue for their contractual partners, this should be addressed in their operational environment. Some organisations perceive that there is no need for their own employment-related response.

To illustrate the need for reaction at an organisational level, consider the following case: 'A tertiary education institution that knowingly allows 'on-the-job' training of medical students in clinical settings in developing countries, does not have a policy for the post-graduate students who seek to gain this experience outside the two countries, Tanzania and Surinam, with whom a government-to-government protocol has been signed'. Respected and experienced medically trained contacts initially refused to believe this representation, indicating their disbelief of such a position.

Knowledge on HIV/AIDS policy development

From the research results it is obvious that all organisations interviewed claimed to be unaware of useful resources available on organisational approaches to HIV/AIDS. It is useful to realise that, although the 'AIDS and Employment' codes developed by the SADC member states and by ILO/UNAIDS are not legally binding, they do provide a guiding framework for

action in the domain of AIDS and Employment. Other useful guides have also been published by the Global Business Coalition on HIV/AIDS and by Family Health International and Horizons. Legal statements are increasingly being formulated as part of the formal sector response to HIV/AIDS. All these frameworks require updating in the light of the increasing availability of anti-retroviral drugs, but the basic principles can be used in all formal organisation employment settings.

Distance and lack of knowledge and awareness of what HIV/AIDS means in a formal employment setting, and what can reasonably be achieved regarding HIV/AIDS through protocol and procedure development, suggests that there is a genuine gap in understanding of employment conditions and issues to be faced in high HIV prevalence settings. From research work in the formal sector it is obvious that many employers think that recruiting replacement staff will not be an issue, until they discover that the skills and experience required are not readily available. It's not common for civil society organisations to have a well-developed perception of their internal critical skills and experience. Many civil society organisations take it for granted that they will be able to dip into the pool of unemployed or (ex)-government officials and appoint a replacement as and when required without any major disturbance of their organisational performance.

Internal action on HIV/AIDS takes time ...

It is relatively easy to hold a 'soap-box' talk on why HIV/AIDS should be an issue for any organisation. Stumbling blocks appear to be related to internal decision-making, allocating responsibilities and maintaining a proactive response. Some organisations take time to realise that outsourcing and contracting staff for limited periods only appears to be an effective risk-reduction strategy, but is not necessarily a sustainable option. If service provision is the main business of civil society organisations, then international practice and experience shows that the quality of human resources are the main assets of an organisation. The logical consequence is that investment in an effective HIV/AIDS policy is essential in high HIV-prevalence settings, as it shows understanding for the operational and living environment and confirms civil society discourse on responsible employership.

The following falls outside the direct scope of this research, but is possibly indicative of what we are up against. At the 2003 Dutch World AIDS Day Conference, the authors assisted in planning and organising a breakaway session on developing workplace responses to HIV/AIDS. During this session, one of the participants suggested that the predominant project funding mode and accountability towards the ultimate donor, the Dutch government, thwarted all efforts to articulate an organisational response to HIV/AIDS. There are no records received, or available, to suggest that during the annual or funding allocation discussions this dimension of responding to HIV/AIDS has been tabled.

A suitable approach might be the AIDS competence approach taken by UNAIDS, which means that we – as people in families, communities, in organisations and in policy making – acknowledge the reality of HIV and AIDS. This approach starts with learning from action, self-assessment, knowledge sharing and building knowledge assets, networking and talking to people who know. It brings together people, processes and supporting technology to share and create knowledge to improve AIDS competence¹⁵ (see website: www.unitar.org/acp).

Are faith-based organisations exempt from HIV/AIDS policy development?

Responding to HIV/AIDS can be useful, even within the framework established by a religion, as can be demonstrated by the following. One of the larger American faith-based organisations, with a long track record in development and emergency relief, reviewed their internal health policy from an HIV/AIDS perspective and, to their amazement, discovered that in the distant past they had excluded all diagnosis and treatment for STDs, as these were

¹⁵ AIDS Competence Programme, UNAIDS.

considered to be sinful and the outcome of personal irresponsibility. It is obvious that excluding STD treatment (in these times of HIV infection) leads to increased risk. This glaring policy error from the past was only discovered when the organisation started to develop an HIV/AIDS policy. The rationale put forward by faith-based organisations (that they would perceive an internal HIV/AIDS focus as conflicting with their individual identity) appears to ignore the employment dimension of operating and supporting organisations in high HIV prevalence countries.

The internal dynamics of organisations

The data concerning the internal response to HIV/AIDS and the literature documenting the experience of organisations that have formulated an HIV/AIDS response (see Heineken, Save-the-Children, Anglo-American, Oxfam) confirm that formulating and deciding on an internal HIV/AIDS policy within an organisation is a process that requires a considerable amount of time.

An illustration: Heineken first encountered the issue of HIV/AIDS in the mid-1980s, but their organisational policy was only finalised in 2000. The company began working on a policy in 1997, when large-scale use of AIDS-retarding medication first became possible. Oxfam also took more than two years to complete the formulation of their HIV/AIDS policy. Informally we were told that the main stumbling block was the distinction between different types of staff that had been internalised in all human resource practices within the organisation. Our own involvement with developing HIV/AIDS policies within organisations also confirms that the decision to address HIV/AIDS as an employment issue and the development of a feasible set of coherent interventions at various organisational levels takes a considerable amount of time.

Is PEP a sufficient HIV/AIDS response?

The research data shows that organisations perceive that having a PEP treatment protocol, including making the drugs available, is already a significant measure in responding to the possible threat of HIV/AIDS to their organisation. However, the organisations tend to formulate clear restrictions on potential access to this organisational PEP, such as making it available for international staff only and not for cases of unsafe sex. The provision of PEP is presented as an HIV/AIDS measure, although the regulations that surround its use clearly suggest that it is a welcome component of understanding the potential dangers of sexual harassment and violation, generally of female members of staff, in their place of work and their operational presence in a high HIV/AIDS setting. This is significant recognition, especially if we take into account the data on sexual violence in South Africa and in conflict-prone areas. But from an HIV/AIDS perspective this measure does not seem to recognise that the sexual behaviour of men and women in various liaisons has been clearly identified as the main reason for HIV/AIDS infection. The PEP-response seems to be based on the increasingly defunct argument that employers should have no involvement of any kind in the private sexual behaviour of their employees and partners.

Responding to HIV/AIDS as a cause of stress

Recent research undertaken by CDRA among an opportunistic sample of national NGOs in South Africa, showed that many organisations were facing internal stress caused by the operating environment of still increasing HIV prevalence. This internal stress expressed itself as perceived ill-will of managers to assist infected staff members, and as perceived failure by managers to deal with the dilemmas of organisational continuity and individual problems and suffering. This same publication also showed that the majority of the South African organisations had not prepared themselves for the dynamics of having HIV-positive employees. This data confirms earlier conclusions that many NGOs did not follow legal employment standards and appeared to be unconcerned about many aspects of HRM and administration (see Simon Matsvai 1997). In the Netherlands, Berenschot Consultants recently published a report that showed that many national and international NGOs do not

appear to include human resource development in their annual reports. A leading international health organisation even stated that they had never realised that the annual report could include a focus on human resource development.

This position goes against the experience of increasing numbers of private sector organisations that have realised that responding to the potential threat of HIV/AIDS requires a creative, rather than a strictly reactive, HRM attitude. Even before the private sector included HIV/AIDS in their current generation of programmes, there was growing experience in the south that showed an active attitude towards HIV/AIDS, as is obvious from the formulation and adoption of the SADC AIDS and Employment code that applies to all employers active in the members states. This includes international governmental and non-governmental organisations. The international literature increasingly shows that responding to HIV/AIDS is different to responding to other forms of infection and illness. A narrow and hence purely reactive response in the sense of defining HIV/AIDS as an event that occurs 'out there in the private lives of employees' and that this 'has no bearing on our organisational performance' is simply not true.

Are NGOs aware of the problems being faced?

The evidence presented seems to suggest that NGOs are somewhat unaware of their HRM responsibilities. PSO (the Dutch umbrella association for international NGOs) has, to date, not included human resource development in their annual reports. Could it be that the NGOs still behave as project management agencies or is it a more obvious disregard of management responsibilities? Or is it that NGOs tend to focus on their performance in civil society development and fight the battles for recognition in the governance and human development arenas that are also being affected by the spread and impact of HIV/AIDS? Consequently the senior managers lead organisations that tend to 'forget themselves' and (for noble reasons) are not too concerned about their own HIV/AIDS risk.

The sum total of this is that human resource development in the international development NGO sector does not seem to have the priority that it has in other employment settings. The fact that few NGOs pay attention to internal HRM is confirmed by their annual reports. If this perception is representative of the choices made within the international NGO arena, it confirms that NGOs can learn from organisations that, for historic reasons, have taken a more active interest in human resource management.

Management Information Systems do not allow this data to be captured

The Management Information Systems that are in place record data on current and future overseas personnel. The organisations operating with these systems admit that the reliability of their data on absence, ill health, possible early retirement, including costs and benefits is not high. Similarly, organisations that recruit expatriate personnel admit that they do not include a briefing on the HRM dimensions of working in a high HIV prevalence setting. HIV/AIDS preparation in all cases encountered consisted of a briefing on the risks of direct HIV transmission. The dilemmas associated with assuming a role, and responsibility in an organisational setting in which there will inevitably be staff or colleagues who are HIV positive, is not considered part of the preparatory cycle.

As the management data and the preparation activities, such as training and briefing, do not provide data on HIV-related situations or histories, it is possible to continue to treat any examples as rare or exceptional incidents that do not require any systematic response. Similarly, debriefing meetings with personnel who have been exposed to working in a high HIV-prevalence setting do not dwell on the stress or personal risk of working in this environment. The countless reports and media articles that illustrate the size and dimensions of the HIV epidemic and its impact on households and human development have not yet led to routine enquiry on how a professional has coped with this situation. The cynical analysis would be that the expatriate circle permitted the myth to continue that this only happens to

'the locals'. A far more realistic analysis would probably be that there has inevitably been a series of encounters at personal, household and professional level.

Involving senior management

Current literature on HIV/AIDS responses within the private sector published by UNAIDS and various employers' groups all emphasise the need for active and serious involvement by senior management in addressing HIV/AIDS. This involvement is considered to be important as:

- It legitimises the importance of an HIV/AIDS response;
- Leadership by management is a prerequisite for an effective organisational response;
- Working on HIV/AIDS inevitably has financial and human resource implications that become clearer over time;
- Addressing these resource-related issues is only possible if the people responsible for these domains are aware of and involved in their 'own' response to HIV/AIDS.

Participating staff members frequently referred to the apparent impossibility of getting senior management interested in the internal HIV/AIDS response as they appeared to be reluctant to become involved in the development of an HIV/AIDS policy. It is only when the 'lower' echelons seek clarification on these human resource or organisational issues from the top that answers are delayed, or never forthcoming. Although all organisations contacted articulate external goals and services in the international HIV/AIDS response, this repeated lack of interest within senior management suggests a disregard for the internal HIV/AIDS domain.

State of denial, or hiding in the corner?

In the global arena, civil society organisations (including churches and trade unions) continue to make a significant contribution to the HIV/AIDS response. From an HIV/AIDS perspective we all know that significantly more will need to be done to curb the impact of the pandemic. This obviously calls for the 'long haul', which means making sure that civil society organisations will still be able to play that role the 'day after tomorrow'. Given the history of the international HIV/AIDS response, their continued presence is a prerequisite for ongoing action. This is the rationale behind asking NGOs to discuss their own employment response to HIV/AIDS.

Stanley Cohen in his book 'States of Denial' explores the dynamics of denial¹⁶ and analyses that there are several different categories of reactions to unwelcome knowledge. His sociology of denial presents a useful frame of reference when analysing the role of NGOs, i.e. organisations that lay claim to be change agents and represent civil society. This role of agent fits well within Cohen's 'triangle of roles: victims, perpetrators and bystanders, those who see and know what is happening'. Cohen's bystanders display typical behaviour that is based on 'it can't happen to us'.

Counter statements were expressed during this research and have also been encountered on other occasions. This message generally means: NGOs consider themselves too small and too insignificant to assume a responsibility for the internal organisational aspects due to working in a high HIV prevalence setting. The following anecdote from an established international NGO shows that this is a thin argument. *'We have been working on HIV/AIDS in different settings for over two decades, but have never developed an internal HIV/AIDS policy. In 2003 when SARS scared the world, including our 'own staff', we managed to develop a policy and protocol within two weeks!'*¹⁷

¹⁶ Stanley Cohen (2001) States of Denial – knowing about atrocities and suffering, Polity Press.

¹⁷ This NGO has since started policy development on HIV/AIDS.

If phrased in this manner, most NGOs would be indignant about the portrayal of their response to date. They point to their track record in supporting HIV/AIDS organisations and developing funding policies and collection interventions. As employers their numbers are minute when compared with international corporations. Nevertheless their responsibility to face the daunting task of ensuring that the NGO sector faces its responsibilities as employers, and that as funding agencies they support many other civil society employers, cannot be underestimated. It is perhaps the final confirmation of the bystander role that NGOs know that their partners face dilemmas as employers, but choose not to discuss this role, the responsibilities and dilemma's that exist due to operating in a high HIV-prevalence setting.

Developing a new 'model' to deal with HIV/AIDS

Alex de Waal recently pointed out that responding to the governance dimensions of the HIV/AIDS pandemic increasingly suggests the need to develop new models. In our opinion there is little doubt that this statement may be applied to civil society in their capacity as employers. It is obvious that, compared to the growing private-sector response to HIV/AIDS, the civil society organisations are lagging behind. Responding to HIV/AIDS requires the development of 'new' or 'different' models of management than we have seen so far. If NGOs feel uncomfortable about this they could recall Jonathan Mann's observation: *'HIV/AIDS will relentlessly expose the fault-line signs in our society'*. A proactive stand here, which is based on joint action and solidarity between northern organisations and further solidarity with the 'partners' in the south, is clearly called for.

LESSONS LEARNED AND RECOMMENDATIONS

The following are a selection of the lessons learned that seem to be appropriate for the Share-Net member organisations. As researchers we do not claim to hold defining wisdom in this regard. It is our recommendation that organisations involved in the business of recruiting and deploying people abroad to high HIV prevalence areas should accept that this involves additional responsibilities and assess how to deal with the resource issue involved. These responsibilities, and the options that are available, will vary from organisation to organisation. The collective experience suggests that each organisation needs to follow its own route in this regard. The most important decision is to start!

Involvement at all levels

1. The persons interviewed often knew what they would do personally, but could not always reply to a question because their organisation had no answer ready. Senior management of Share-Net members should assume their responsibility in developing an adequate HIV/AIDS response.
2. Starting on an internal HIV/AIDS response obviously requires developing a plan and ensuring that senior management actively supports this plan.
3. All levels of an organisation should be involved in the development: top management should take the initiative, but representatives from all departments (programme, personnel management and finance) should be involved.
4. As a start, Share-Net should organise a workshop for senior management of the Share-Net member organisations, as a follow-up to this study.

Process

5. A set of basic organisational principles and commitments related to HIV/AIDS is required. Heineken has set out its principles on one A4 page!
6. Developing an HIV/AIDS response is a trajectory that can generally be incorporated into the normal planning format used in an organisation. At the beginning the development of a road map identifying issues, steps, responsibilities and ambitions can be useful to convince senior management and the workers' council.
7. Developing an internal HIV/AIDS response will take time. If a true 'learning' attitude is adopted and the internal lessons are learned as the response evolves, then there is more chance of success, especially if all staff involved have not yet assumed their natural responsibility.
8. Any HIV/AIDS policy that does not seek to make the workplace a safe environment is doomed to failure. Creating and investing in an open dialogue between the staff members through the use of interactive methods is an essential element of the response.
9. It seems impossible to work on an internal HIV/AIDS policy without realising that this inevitably brings you face to face with the state of the internal dynamics, such as gender bias, a safe and conducive environment, as the 'true' hierarchy in the organisation. How you respond to this unfolding knowledge is just as critical for the success of the HIV/AIDS policy as the actual policy itself. If there are too many initial bridges to be built then this will cause the process to lose momentum. Be less ambitious and use a narrower set of actions that can lead to further momentum.
10. The influence of the HIV/AIDS epidemic on the workplace and personal life should be given a clear place in the preparation period of (international) experts. This should not be simply left to the medical check up before departure.
11. Some organisations already have a structure (with counsellors) for sexual harassment in the workplace; this could also be developed for HIV/AIDS.
12. Knowledge on HIV infection is generally overestimated. Internalising the significance of this knowledge can be a strategy for closing the common gap between behaviour and knowledge.

13. Developing an institutional analysis of the HIV/AIDS impact is essential in order to be in the position to take accurate and appropriate action (see Barnett and Whiteside).
14. Human resource development, including HIV/AIDS, should be included in the annual reports of civil society organisations, if they are to be taken seriously by major private sector companies.
15. At this point in time, none of the Share-Net members have a human resource policy focused on HIV/AIDS. This is an opportunity to take joint action towards:
 - The shared development of an HRM HIV/AIDS policy within the Dutch civil society; inevitably this will lead to a debate on the position of their 'partners' in the south that have to face the music at countless funerals. In both settings, there is the possibility for organisations to share and exchange experience gained, lessons learned and external expertise. There are obvious reasons (both in the north and south) for developing an active dialogue with business organisations that have embarked on their own HIV/AIDS response. There are interesting possibilities (e.g. economies of scale) and for establishing smart 'piggy-back' arrangements with individual corporations.
 - All organisations should be explicit on the influences of HIV/AIDS on the budget and expected increase in overhead costs. Donors should allow a budget line for this in proposals.
 - The Share-Net members should collectively explore the possibilities of HIV/AIDS organisational responses with their major donor, the Dutch Ministry of Foreign Affairs. These same organisations should establish contact with the UK NGO AIDS Consortium and other European-based umbrella organisations, and approach the European Union in a coherent and strategic manner.

Resources

16. The HIV/AIDS task force within organisations needs to access some of the essential documentation available on HIV/AIDS and human resource development.
17. The Best Practice collection is growing, and is useful, but organisations seem to interpret these practices as the industrial norm that they should meet. The Debswana case, the UNAIDS global benchmark, stems from a production environment and its 'added value' is linked to the primary mining process. Most civil society organisations are service organisations, and only a small minority are membership organisations. These are all different settings that will require different HIV/AIDS responses. The Best Practice sets a framework for action, but not necessarily a norm that needs to be met.
18. Through this research, the Share-Net Resource Centre (Royal Tropical Institute) has acquired a growing collection of relevant literature. Organisations wishing to embark on HIV/AIDS policy development should access this collection.
19. There is a growing body of knowledge and experience on HIV/AIDS and human resource development in the Netherlands, apart from Share-Net (SNV) and in neighbouring countries, especially the United Kingdom (BEAD, UK NGO Consortium, International HIV/AIDS Alliance), Germany (GTZ) and Belgium (MSF-Belgium). It appears useful to access this knowledge in a systematic manner that benefits the response of the Dutch civil society organisations.
20. This report contains the UNAIDS AIDS Self-assessment Tool; organisations can use this tool in the early stages of their follow-up response to this report (see website: www.unitar.org/acp).

APPENDICES

Appendix A: The ILO Code of Practice on HIV/AIDS and the World of Work

Key principles of the Code of Practice

4.1 Recognition of HIV/AIDS as a workplace issue

HIV/AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.

4.2 Non-discrimination

There should be no discrimination or stigmatisation of workers on the basis of real or perceived HIV status.

4.3 Gender equality

More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV/AIDS.

4.4 Healthy work environment

The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

4.5 Social dialogue

A successful HIV/AIDS policy and programme requires cooperation and trust between employers, workers, and governments.

4.6 Screening for purposes of employment

HIV/AIDS screening should not be required for job applicants or persons in employment, and testing for HIV should not be carried out at the workplace except as specified in this code.

4.7 Confidentiality

Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with existing ILO codes of practice.

4.8 Continuing the employment relationship

HIV infection is not a reason for terminating a person's employment. People with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

4.9 Prevention

The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behaviour.

4.10 Care and support

Solidarity, care and support should guide the response to AIDS in the workplace. All workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

Appendix B: Participants

Human resource officers:

Individuals interviewed:

Cor Bezemer and Ewout de Jong - CORDAID
Meralda Slager - DOKTERS van de WERELD
Martsje van der Schaaf - PSO
Annemiek Komen - DGIS
Riekje Elema and Michiel Lekkerkerker- MSFH
Piet Gallee (company doctor)- VU – Arbo dienst
Sarah Wisnoucks - HEALTH NET INTERNATIONAL
Rene Mentink - KIT
Dineke ten Klooster and Hester Koppen - ICCO
Arjen Mulder- VSO
Hans van Steen - Nederlands Rode Kruis

The following human resource officers participated in the focus group discussion:

Hans van Steen - Nederlands Rode Kruis
Sarah Wisnoucks - HEALTH NET INTERNATIONAL
Martsje van der Schaaf - PSO
Annemiek Komen - DGIS

Programme officers:

Individuals interviewed:

Christine Fenenga - CORDAID
Meralda Slager - DOKTERS van de WERELD
Geert Custers (replacing Roel Klarhamer) - PSO
Anita Veldkamp - DGIS
Riekje Elema and Michiel Lekkerkerker - MSFH
Anke van der Kwaak- VU
Jos Dusseljee - HEALTH NET INTERNATIONAL
Madeleen Wegelin (plus George Tiendrebeogo) - KIT
Willeke Kempkes - ICCO
Arjen Mulder – VSO NL
Karina Balyan - Nederlands Rode Kruis

The following programme officers participated in the focus group discussion:

Meralda Slager - DOKTERS van de WERELD
Madeleen Wegelin - KIT
Karina Balyan - Nederlands Rode Kruis
Akke Schuurmans - PSO

Appendix C: Questionnaire Human Resource Officers

Questionnaire

Personnel manager

Name:

Organisation:

1) What is the total number of staff within your organisation?

Total number	
Average age	
Men/women ratio	
Married/long-term relationship	
Single/divorced	

2) How long is the average stay (days per year and duration of mission) overseas?

Length of average stay	
Men/women ratio	
Married/long-term relationship	
Single/divorced	

3) What is the ratio (in numbers) between permanently and temporarily deployed staff?

Permanent contracts	
Temporary contracts	

4) Are staff members classified in any way? (deployed or international staff and local staff). What are the most important differences between the categories? Are there any differences, for example, in working conditions?

5a) Is preventing HIV infection a matter for you and your organisation?

5b) Can you describe the experience with HIV/AIDS, up to now, within your organisation? (Experiences with HIV-infected employees, or those with a chronic disease.)

5c) Can you describe the reaction by the organisation in these cases? Was this reaction structural or did it depend on the individual situation? Who decided in these cases?

5d) How has the organisation focused on HIV/AIDS up to now?

Developed an internal HIV/AIDS policy	
Training (workshops/seminars)	
Who are the facilitators? External? Internal?	
Prevention	
Provide examples or materials	
Quality of the care	
Sponsoring local AIDS projects	Total amount:

6a) Has the organisation developed an HIV/AIDS policy?

Yes	No
-----	----

If yes, what does this HIV/AIDS policy specifically focus on? Internal or external?

If no, what is the reason for this?

6b) Does the internal policy include the following rights of the employee:

Absence by the employee (due to sickness, medical treatment, caring for others, attending funerals and other family commitments)	
Medical assistance (content, quality, confidentiality)	
Opportunity for an HIV test	
Access to medicines, or providing facilities leading to this access	
Unpaid leave and/or carer's leave	
Possibility for modified work	
Compensation for absence from work in the form of overtime by others/hiring in temporary external staff	
Presence of a mutual solidarity fund	
Attention to modifying secondary labour schemes, such as phased payment of any accrued rights	

7) In your opinion, which members of the organisation run the greatest risk of becoming infected with HIV? And Why? Is this given any form of attention? (General staff: first-aid kit with condoms; free access to condoms via automats or large box on the coffee table. Drivers: first-aid training, and first-aid box with rubber gloves. Medical personnel: wear gloves; access to PEP.)

8a) How are new staff members informed of the various medical insurance packages? Do these packages cover anti-retroviral medication?

8b) How are new staff members informed of the health risks and specifically about HIV/AIDS? Are they given a briefing pack?

9a) Is HIV/AIDS included in the list of chronic diseases?

Yes	No
-----	----

9b) Do you and your organisation differentiate between HIV/AIDS and other chronic diseases? Motivation?

9c) Does your organisation allow employees to change their secondary working conditions in the event of HIV/AIDS or other chronic disease?

10a) Over the past five years, has there been a movement away from permanent contracts and more towards temporary staff (outsourcing)? What is the effect on personnel management from this increase in the number of temporary employees?

10b) Does your organisation have a reliable/objective picture of staff presence/absence, or this 'arranged' per department?

11) How does your organisation focus on achieving and maintaining a confidential working environment?

12) How does your organisation respond to sexual harassment in the workplace?

13a) To what extent does your organisation encourage 'good employership' of partner organisation overseas? Who takes the initiative in this?

13b) Do you expect these partner organisations to follow their national labour legislation? To what extent is this discussed in meetings with the partner organisations? Who implements these discussions (personnel manager, the controller, or the programme officer)?

13c) If yes, who monitors this implementation process and how is this achieved?

14) May we receive the following documents as part of our research project?

Briefing pack	
Annual plan/Budget	
Other relevant documents, e.g. information material, workshop programmes etc.	

15) Observations by the interviewer

Time taken	
Impressions	

Appendix D: Questionnaire Programme Manager and/or Director of the Organisation

Name:

Organisation:

1) To what extent do you encourage 'good employership' by your overseas partner organisations? Do they follow the national labour legislation (give further details). Who takes the initiative here?

1b) Is implementation of 'good employership' included in the financial support given to your partner organisations?

Yes	No
-----	----

2) Do staff of these partner organisations have a work contract that follows national legislation, and that offers access to medical care and a pension scheme?

Yes	No
-----	----

3) In your opinion, which members of the organisation run the greatest risk of becoming infected with HIV? And why?

4) Is there a separate budget for HIV/AIDS activities within your own organisation? If so, what is the amount? What percentage is this of the total budget for your organisation?

5) Up to now, what would you say are the 'best practice(s)' in the internal HIV/AIDS mainstream process within your organisation? And Why?

6) What were the pitfalls within this process?

7) How would you describe the weakest and potential-improvement points of the internal HIV/AIDS mainstream process within your organisation?

8) Can you describe the timeframe between the planning phase of the HIV/AIDS mainstream process and the implementation thereof? Who took the decisions?

9) May we receive the following documents as part of our research project?

Internal AIDS Policy	
Other relevant documents	

10) Observations by the interviewer

Time taken	
Impressions	

Appendix E: Focus Group Discussion Statements

Focus group discussion with human resource managers

Propositions:

In the future, from a personnel management perspective, HIV/AIDS will become a chronic and treatable disease, that does not require a specific policy.

I have enough HIV/AIDS knowledge to develop a short and practical HIV/AIDS policy for my organisation.

In this HIV/AIDS era, condom distribution and basic health extension are absolute minimum efforts.

Offering PEP treatment without further support, such as anti-retroviral drugs, is possibly not the best option, but is an acceptable intervention.

For people who live in the Netherlands and occasionally travel abroad, you would expect them to be sensible enough not to take any (HIV-related) risks.

Only large organisations such as the Ministry of Foreign Affairs and large private corporations are capable of really doing something about HIV/AIDS.

Statements that require in-depth discussion by the focus group:

Is a specific HIV/AIDS policy necessary?

HIV/AIDS prevention is a personal matter. This is not an issue that requires the involvement of a board, employer or personnel manager.

Formulating a sound HIV/AIDS policy is a management responsibility. Such a policy can be devised in a relatively short period of time and then be implemented in the organisation.

What would you do if a colleague informs you that they have tested HIV positive?

Focus group discussion with programme officers

Propositions:

In the future, from a personnel management perspective, HIV/AIDS will become a chronic and treatable disease, that does not require a specific policy.

I have enough HIV/AIDS knowledge to develop a short and practical HIV/AIDS policy for my organisation.

In this HIV/AIDS era, condom distribution and basic health extension are absolute minimum efforts.

Offering PEP treatment without further support, such as anti-retroviral drugs, is possibly not the best option, but is an acceptable intervention.

For people who live in the Netherlands and occasionally travel abroad, you would expect them to be sensible enough not to take any (HIV-related) risks.

Only large organisations such as the Ministry of Foreign Affairs and large private corporations are capable of really doing something about HIV/AIDS.

Statements that require in-depth discussion by the focus group:

An HIV/AIDS policy is unnecessary. You don't need a policy to distribute condoms and rubber gloves, and ARV medication is covered through standard insurance policies.

HIV/AIDS prevention is a personal matter. This is not an issue that requires the involvement of a board, employer or personnel manager.

Formulating a sound HIV/AIDS policy is a management responsibility. Such a policy can be devised in a relatively short period of time and then be implemented in the organisation.

What would you do if a colleague informs you that they have tested HIV positive?

Appendix F: HIV/AIDS as part of the Personnel Policy at the Dutch Ministry of Foreign Affairs

Els Klinkert, HIV/AIDS Coordinator, Ministry of Foreign Affairs

Signals from the field and a parliamentary resolution

Over the past five years it has become increasingly clear that a growing number of Ministry and mission employees, both local staff and staff posted from The Hague, were being confronted with HIV and AIDS. 'HIV/AIDS and personnel policy' was an item on the agendas of both the Mission Councils Conference (2001) and the Regional Ambassadors' Conference for Southern Africa (October 2001). Following the outcomes of these meetings the Secretary-General of the Ministry of Foreign Affairs confirmed the importance of developing an HIV/AIDS policy for personnel and designated the existing HIV/AIDS focus group to work out recommendations on integrating HIV/aids into the existing personnel policy. In response to a parliamentary resolution, the Minister for Development Cooperation promised a personnel policy enabling (local) embassy staff access to prevention, care and treatment.

Starting points: International Labour Code and existing practices

The 'ILO Code of Practice on HIV/AIDS and the World of Work', as well as the current personnel policy at the ministry, served as starting points for developing the HIV/AIDS component. An inventory was made of existing HIV/AIDS personnel policies of other donor agencies, international organisations and private sector companies. The policy at DFID and Heineken proved to be interesting and both organisations were very willing to share their experiences.

Internal working group

The HIV/AIDS focus group responsible for developing this policy consisted of representatives from the personnel department, medical services, the employees' council, the Africa office and the Social Policy Division. Soon the group realised the need for specific expertise on 'HIV/AIDS and Employment'. The Dutch Aids Fund – STOP AIDS NOW! – had the expertise required and a cooperative agreement was signed between the Ministry and the Dutch Aids Fund. The Dutch HIV Society scrutinised the policy with regard to the (labour) rights of People Living with HIV/AIDS (PLWHA). Monthly meetings were set up to develop a work plan, to discuss the feedback from the embassies and to identify the most crucial issues and questions in defining a realistic and feasible workplace policy.

Questionnaire sent to the embassies

Several questions needed to be answered before a policy could be drafted. What types of employee groups exist? How large are these groups? How many partners and children do these employees have? What kinds of health services already exist in these countries? What are the current costs and what kind of insurance systems are already in place? How is the privacy of staff secured? In order to obtain this information, questionnaires were sent to 20 embassies. A small group of Ambassadors, most of them based in hard-hit countries, formed an advisory group to the HIV/AIDS focus group at the ministry.

An overview was made of the number of people involved. Costs were calculated based on national prevalence rates and local medical costs. In response to questions by the management of the ministry, several scenarios were developed, cost projections were calculated and the various responsibilities of the ministry, embassy, employees and local employees of civil servants posted abroad were determined.

HIV/AIDS personnel policy

In June 2003 the ministry's management team endorsed the policy, stating that it would begin a five-year pilot phase and would cover 19 countries in Africa. An evaluation will be

conducted in 2005/6. Pharmaccess International has been contracted to support the implementation of the programme.

Aims

- To prevent HIV infection and eradicate prejudice and misunderstandings about HIV and AIDS;
- To provide information about, and better access to, voluntary counselling and testing;
- To promote proper care, including treatment, support and counselling in the event of infection with the AIDS virus.

Eligible groups

Officials¹⁸, employees¹⁹ and domestic staff²⁰ and their family members are eligible for the programme. Family members consist of one spouse and children, stepchildren and adopted children up to 23 years for whom the individual in question is responsible.

Scope

The following countries are included: Angola, Mozambique, Benin, Namibia, Burkina Faso, Nigeria, Côte d'Ivoire, Rwanda, the Democratic Republic of Congo, South Africa, Eritrea, Tanzania, Ethiopia, Uganda, Ghana, Zambia, Kenya, Zimbabwe and Mali.

Prevention and information programme

- Information meetings will be held. The aim is to bring HIV/AIDS into the open, to combat prejudice and misunderstandings and to show how the problem can be dealt with.
- It will be possible to undergo voluntary HIV testing under the professional guidance of a doctor or clinic.
- Condoms will be supplied at the missions. Recipients will remain anonymous.
- MTCT: Treatment is available before, during or after birth to reduce the risk of mothers transmitting the virus to their children.
- Post exposure prophylactic (PEP) will be available.

Care and treatment programme

Each field office will contract a clinic or doctor to provide the necessary preventive care and treatment of HIV-infected employees. Laboratory facilities will also be available. If HIV/AIDS is diagnosed, then treatment with ARVs will be provided if needed by the clinic contracted for this purpose. Those eligible for the care and treatment programme will be required to pay a contribution amounting to 0.5% of their gross salary.

Experience shows that privacy and confidentiality are crucial for successful implementation of an HIV/AIDS staff policy. In order to ensure maximum privacy, the number of people involved in the implementation and monitoring of the programme is limited. Numbers instead of names are used in the administration of the embassy and ministry. The location of care and treatment is well outside the embassy premises and people undertaking voluntary counselling and testing can be assured that the outcomes remain confidential.

¹⁸ As referred to in article 1c of the Foreign Service Regulations.

¹⁹ As referred to in article 114 of the Foreign Service Regulations.

²⁰ Individuals appointed under civil law contracts of employment to perform work in and around the house of an official for at least 20 hours a week and who have been registered as domestic staff with the designated official within three months of the entry into force of personnel policy on HIV/AIDS or within three months of recruitment.

Appendix G: Benchmarking Information; Responses from four Organisations

In order to highlight the process involved in developing an internal response to HIV/AIDS, the following comparative information provides an insight into the experience of four organisations operating in the international arena.

Organisation 1 is a leading development organisation employing over 3,000 people worldwide. There are several sister organisations and they jointly implement a wide variety of poverty-focused development interventions. Their publications on development issues are considered to be influential and are often used as a reference point.

1) Could you describe the timeframe between the first discussions within the organisation up to the point where the policy (or draft) was actually written?

- HIV/AIDS in the workplace was made a priority in February 2002.
- A needs analysis and programme design was carried out in June-July 2002 by an external consultant.
- Awareness-raising of staff was implemented in October 2002.
- A policy document was drafted in November 2002.
- An Intranet site on HIV/AIDS was set up in January 2003.
- The policy was communicated to staff in March 2003.
- A human resources forum to discuss HIV/AIDS in the workplace was held in March 2003.

2) What were the most difficult issues in this process?

- Commitment from management and staff.
- Ownership of the programme – as you will realise one important step was missed out, i.e. that of setting up an HIV/AIDS committee to oversee the policy process.
- Relying too much on risk/impact analysis as a basis for setting up a workplace programme. These analyses create a lot of expectations and limit the workplace programme to that of minimising impact on operational costs and productivity, which in reality is not easy to document. There are plenty of good reasons for having an HIV/AIDS workplace programme, and if set up in this context, there is better ownership by the staff.
- The actual understanding of a workplace programme in terms of scope.

3) What resources do you have available to implement the HIV/AIDS policy? (If possible, please give us an indication of the costs involved)

- Human resources: implementation manager solely for the role of implementing the policy.
- Commitment from management: a vital resource.
- The staff themselves, through involvement in the activities of the HIV/AIDS committee and volunteering as peer educators.
- Human resource managers.
- Financial: initially GBP 47,000 in the first year but this was later upgraded to GBP 170,000.
- Alliance and partnerships: to share experiences with several organisations that have been going through the same process.
- Literature: review of available case studies from GHI (Global Health Initiative).

4) What advice would you give to an organisation that is busy developing its HIV/AIDS policy?

- Do not proceed with the policy process without setting up an HIV/AIDS committee, which should consist of members from all levels of the organisation. This should be the first step. Discussion and consultation should occur via the committee. Once established, the committee can begin to address elements of the programme - policy, legal issues, impact on the organisation and staff, prevention programmes, wellness management and monitoring and evaluation of the programme.
- The policy should address the concerns of both employees and the employer; establish roles and responsibilities of employees, employer, union representatives and middle management.
- Do not rely too much on impact analysis or needs analysis; the HIV/AIDS committee should be guided to handle these issues. This increases ownership of the programme.
- As the champion of the policy process, you should apprise yourself of the hard facts and latest information.
- Train management and leaders first, before training the staff.
- Review the policy regularly.

Organisation 2 is a worldwide transnational company, with close to 100,000 employees located around the globe. Many of their facilities still operate under their initial brand name. As a worldwide top-class brand they have a high profile and a long-standing commitment to active human resource development.

1) Could you describe the timeframe between the first discussions within the organisation up to the point where the policy (or draft) was actually written?

- August 2000: first contact with leading pharmaceutical expert (J. Lange) and setting up a steering group.
- February 2001: first report by the steering group, and request for outside consultancy.
- August 2001: approval by the board, plus 1 September 2001 official start of the programme in two pilot African countries, Rwanda and Burundi.
- On 1 September 2002 the Democratic Republic of Congo and Congo (Brazzaville) followed.
- Nigeria followed at the end of 2002.

2) What were the most difficult issues in this process?

Most difficult: how to reconcile the medical need for continuity of the programme with personnel management principles. Continuity of treatment was considered the most important principle; no link to HR issues was to be made. Also: what to do with children and infected adolescents?

3) What resources do you have available to implement the HIV/AIDS policy? (If possible, please give us an indication of the costs involved)

We have a yearly budget at corporate level; this is for training. The operating company in the country covers most of the investment and running costs.

Estimation of costs: drugs USD 1100 per person/per year; monitoring USD 500 per person/per year, then there are the costs of building infrastructure, training staff and overhead costs (Pharmaccess, HIMS (Health Information Management System)).

4) What advice would you want to give to an organisation that is busy developing its HIV/AIDS policy?

Cooperate as much as possible with other partners and pool investment costs. Go ahead and start the programme, solve some of the problems as they present themselves, but follow the principles that were laid out from the start.

Organisation 3 is a recognised child and youth-focused organisation with operations and teams in many regions. Their track record in HIV/AIDS-focused interventions is recognised as that of a leading organisation. As with Organisation 1, they are also involved in humanitarian assistance and long-term development assistance that is often implemented with and through local partners.

1) Could you describe the timeframe between the first discussions within the organisation up to the point where the policy (or draft) was actually written?

The first discussions took place before I started working for this organisation. We did a survey in late 2001 across all country programmes in Africa. Delays at head office meant that we then progressed with our own individual policies in southern Africa – all countries have undertaken TOT (training of trainers) in participatory HIV awareness (a full two-day workshop to take people through their personal experiences of the issues), plus ongoing awareness. Individual countries are now refining their chronic health guidelines (after training on workplace policies in February 2003) with all country programmes coming up with individual guidelines by December this year. We can't share their outcomes with you as they will vary from one country to the next. In South Africa we changed our health policy to an increased flat-rate contribution (previously it was a percentage of staff salary, which is inherently inequitable) to give a minimum policy that covers ARV treatment for all staff and named dependents on the policy. Global 'guidance' was delivered in May this year, but in Africa we plan to take this further and then share the programme globally once we have things finalised.

2) What were the most difficult issues in this process?

Headquarters buy-in (not seen as a priority), plus concerns about rising costs. We tried to resolve this by pushing for HQ staff to become involved in HIV awareness raising, feedback from countries on decreasing ARV costs, etc. Country programmes face the challenge of resolving the issue of staff losing access to care if they are made redundant but are receiving ARVs or other chronic health treatment on employer-paid medical insurance; this is a big issue in countries such as Zimbabwe, where we have a large number of staff on relatively short-term contracts for emergency relief operations.

3) What resources do you have available to implement the HIV/AIDS policy? (If possible, please give us an indication of the costs involved)

Have not yet done a country-by-country costing. We have paid for staff TOT training in all countries and will probably update each year, as ongoing sensitisation is cheap. Health costs are currently being calculated. In our South Africa office, with a staff of approx 15-20, additional cover for all staff plus dependents (current practice) to meet a minimum ARV coverage is calculated at an additional USD 5000 per year (approx). However, this does not include cost savings over the longer term due to improved health.

4) What advice would you want to give to an organisation that is busy developing its HIV/AIDS policy?

The main priority is management ownership and buy-in from the top, so that all staff can see that the organisation takes it extremely seriously. Clear consultation with staff so that they feel that the range of issues that are of most concern (e.g. time off for caring for sick relatives etc.) are taken on board.

Organisation 4 is a government ministry (see more in elaborated box further in this report).

- 1) *Could you describe the timeframe between the first discussions within the organisation up to the point where the policy (or draft) was actually written?*

From 2000/2001 onwards, we started to receive signals from the field (embassies) that they were confronted with HIV/AIDS and did not know how to handle this, especially because the medical costs were starting to rise astronomically. In April 2002, we approached the national PWLHA organisation and the principal fund raising and AIDS knowledge organisations to assist them in formulating an HIV/AIDS policy. A policy was finally formulated in June 2003; meaning a pilot for a couple of years. After two years this will be evaluated and adjusted where necessary. Pharmaccess International will guide the implementation and carry out some parts of the implementation.

- 2) *What were the most difficult issues in this process?*

It took a very long time to convince the heads of the various departments to see the need for an HIV/AIDS staff policy.

- 3) *What resources do you have available to implement the HIV/AIDS policy? (If possible, please give us an indication of the costs involved)*

Once the programme is up and running, it will cover 20 field-based operations in Africa. The estimated costs will be up to one million euro per year. Experience has shown that these costs usually turn out to be less than expected (according to experiences within DFID, the UK Department for International Development).

- 4) *What advice would you want to give to an organisation that is busy developing its HIV/AIDS policy?*

Look at what others do, make use of the ILO Code of Conduct on Aids in the workplace, involve the company doctor in the discussions and pay a lot of attention (and time) to the top of the organisation. Without their support you will eventually get nowhere. To convince them, we found it very useful to invite people from the private sector to share their motivation, planning and implementation of their HIV/AIDS policy. It is currently very important to see what is happening worldwide, which countries have been selected and how to link up (cost-sharing).

Ask advice from an expert organisation that already has practical experience; they know what they are talking about and can assist you. They were very helpful to us. Development of an HIV/AIDS staff policy cannot, in my opinion, be achieved without the contribution and insights of people living with HIV/AIDS.

Short analysis of crucial points -

Developing an HIV/AIDS policy is a time-consuming process, and there does not appear to be a 'most appropriate' moment to do so. It is a question of getting started, initiating activities and identifying policy guidelines as issues emerge. This requires an open and flexible approach with a clear goal that is comprehensive and non-discriminatory.

Embedding the process and its product, the policy, into the organisation is of great importance.

An internal HIV/AIDS committee (or steering committee) should be set up, with a mandate to take the lead in this process.

The role of senior management is essential in mandating those working on the HIV/AIDS policy and also showing leadership in action.

Learning by doing is essential for working on attitudes towards HIV/AIDS and has consequences for monitoring.