

# **Taking Responsibility**

## **Why, for Whom, for What and How?**

**Report of a study of HIV & AIDS workplace policies  
among and for Share-Net member organisations**

**June 2005**  
**Winy Koster**

## CONTENTS

<b>Acknowledgements</b>	3
<b>Abbreviations</b>	4
<b>Summary</b>	5
<b>1 Introduction</b>	<b>7</b>
Study objectives and questions	7
Definitions	7
Report contents	8
<b>2 Study methodology</b>	<b>8</b>
<b>3 Status of HIV &amp; AIDS workplace policies of Share-Net members</b>	<b>9</b>
Why having an HIV & AIDS WPP is thought to be important	10
Why some Share-Net members feel no need to have an HIV & AIDS WPP	11
<b>4 Development of a policy document</b>	<b>11</b>
Initiative – ‘you need a spark’	11
Getting management support	11
Process of policy development	13
Lessons: Mandate, anchorage and ownership	14
<b>5 Content of HIV &amp; AIDS workplace policies</b>	<b>14</b>
Blueprints or guidelines?	14
Length and detail	15
One policy for all types of staff and organisations?	15
Separate policy or inclusion in chronic illness policy	16
Corporate policy in different countries	16
Components of a WPP	17
Policy on treatment	18
Policy on care and support	19
Operational plan	19
<b>6 Implementation of an HIV &amp; AIDS workplace policy</b>	<b>20</b>
Communication	20
Awareness raising, motivation and prevention programme	21
Treatment and care programme	22
Monitoring of implementation	23
<b>7 Taking responsibility: Conclusions and recommendations</b>	<b>24</b>
Why employers should take responsibility	24
Responsible for whom and for what	24
How to develop an HIV & AIDS workplace policy	25
Implementation	26
Guidelines	27
Follow-up by Share-Net	27
Annex 1 References	28
Annex 2 Respondents	30
Annex 3 Data collection instruments	31
Annex 4 Oxfam GB risk assessment model	35
Annex 5 VSO mainstreaming model	36
Annex 6 Checklist for drafting an HIV & AIDS policy	37
Annex 7 Example one-page treatment regulations form	39
Annex 8 Fact sheet PAI for WFP HIV & AIDS programme Angola	40
Annex 9 Share-Net members and other organisations in the study	42

## **Acknowledgements**

This report is mainly based on interviews and self-administered questionnaires with persons working in development NGOs and consultants working in the field of HIV & AIDS and workplace policies. I want to thank them all for taking time off their busy work schedules to share their experiences and opinions. Some of them took even more time and later sent documents and answered questions by email that I forgot to ask during the interview.

I am especially appreciative of Russell Kerkhoven and Jos Dusseljee who read and commented on the first draft; the inputs by these consultants so experienced in this field were very valuable. I also much appreciate the comments by the Share-Net AIDS workgroup and by Arjen Mulder of VSO Netherlands and Tobias Rinke de Wit of PharmAccess International on the final draft.

Rachel Ploem of the Share-Net secretariat, senior policy advisor HIV & AIDS, supported me throughout the assignment. She assisted in making the assignment clear, offered literature and resources, guided my choice of whom to interview, discussed the findings and recommendations and facilitated the presentation of the report.

With input from all these persons, I hope to have delivered a useful report that can motivate and guide organisations and individuals to address HIV & AIDS in their place of work. Through working on this assignment I personally became convinced that all organisations that have staff working in high HIV prevalence countries should take at least some responsibility for these staff and not leave all of the responsibility to insurance companies and the individuals' themselves. In this report I explain why I think so.

Winy Koster  
June 2005

## Abbreviations

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
ART	Antiretroviral therapy
ATC	Affiliated treatment centre
BZ	Buitenlandse Zaken (Ministry of Foreign Affairs)
CCVT	Compulsory counselling, voluntary testing
CHHP	Countries with high HIV prevalence
DRC	Democratic Republic of Congo
GB	Great Britain
HAART	Highly active antiretroviral treatment
HR(M)	Human resources (management)
HMS	HAART management information system
HQ	Headquarters
IEC	Information, education and communication
ILO	International Labour Organisation
M&E	Monitoring and evaluation
MFO	Medefinancierings organisatie
MSFB	Médecins sans Frontières, Belgium
MSFH	Médecins sans Frontières, Holland
MTCT	Mother to child transmission
NGO	Non-governmental organisation
OI	Opportunistic infections
PAI	PharmAccess International
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother to child transmission
QC	Quality control
SC	Steering committee
STI	Sexually transmitted infection
TB	Tuberculosis
TRIP	Trade-related aspects of intellectual property rights
UNAIDS	Joint United Nations programme on AIDS
VCT	Voluntary counselling and testing
VSO	Voluntary Service Overseas
WFP	World Food Programme
WPF	World Population Foundation
WPP	HIV & AIDS workplace policy or protocol

## Summary

This study is a follow-up to the Share-Net study 'Human resource management and HIV & AIDS – a study among Share-Net members' of 2003 that stated that Share-Net organisations had not or barely initiated internal responses to HIV & AIDS (Kerkhoven & Lówik 2004).

The objectives of the present study are

- 1) To make an inventory and analysis of the existing HIV & AIDS workplace policies and their implementation among Share-Net members and to identify the good practices;
- 2) To give recommendations and guidelines to Share-Net member organisations (and other Dutch development organisations) for developing appropriate internal responses to HIV & AIDS – also including good practices of HIV & AIDS workplace policies and protocols of other (Dutch) development NGOs and organisations.

This report answers the questions why an HIV & AIDS workplace policy (WPP) is important, for whom and for what employers should be responsible considering HIV & AIDS, how a policy document should be developed, what the contents of an HIV & AIDS workplace policy document should be and how it should be implemented.

The study was conducted over a period of five months – from the beginning of January to the end of May 2005. Data collection started with a literature and document review after which short questionnaires were sent by email to nine Share-Net members who had not been involved in the previous study to get HRM information (that was already known from organisations involved in the previous study). The author then conducted in-depth interviews with 22 representatives of development organisations and consultants, 18 face-to-face and 4 by telephone; 12 respondents were from Share-Net member organisations. Additionally, email questionnaires were sent to field offices.

Of the 15 Share-Net member organisations involved in this study (through in-depth interviews and/or email questionnaires), five have an HIV & AIDS workplace policy and ten have no such policy. Of the five, one has just finished a corporate HIV & AIDS workplace policy, one is the Netherlands office of an international NGO that has just revised their corporate HIV & AIDS workplace policy and one member has a draft corporate policy document. The other two organisations (of the five) have a (draft) policy in field-offices only (and did not find a corporate policy necessary). Of the ten that do not have policies, three are members of international organisations that do have a WPP (and think they should do something for the Dutch office), one member was seriously thinking about developing a WPP, two had not thought about it, but were positive, and four did not think a policy was necessary. Because there were not many experiences with HIV & AIDS workplace policies among Share-Net member organisations, the recommendations are also based on the experiences of other organisations.

There are four main reasons why organisations working in high HIV prevalence countries should have an HIV & AIDS WPP. First, to be a socially responsible employer and, second, to provide guidance to managers on how to deal with HIV & AIDS related issues among their staff. The third reason is strategic: it is a way to give staff the experience and skills (not only knowledge) needed to work with partner organisations on internal mainstreaming and to feel confident discussing AIDS with partners. Fourth, HIV & AIDS among staff (and partner organisations) may negatively impact costs, output, efficiency, effectiveness and quality of the projects and programmes and a WPP gives guidelines on how to counter this possible impact.

All organisations that work in high HIV prevalence countries should take responsibility for local national as well as Dutch and other expatriate staff by addressing HIV & AIDS internally. Organisations that employ national staff need to have a comprehensive HIV & AIDS policy or

protocol, stating the employer's responsibility for prevention, treatment, care and support of their employees and a certain number of dependents. Organisations that send Dutch and other expatriate staff to work full or part-time in high prevalence areas may not need comprehensive workplace policies for them, but they should address HIV & AIDS and take some responsibility for their employees, because there are many risks of contracting HIV in high prevalence countries: occupational accident, accident that needs blood transfusion, sexual assault, unprotected sex.

Organisation-wide ownership and the mandate of senior management and board are the critical conditions for successful development of an HIV & AIDS WPP. Senior management and the board have to be convinced of its importance. Policies may be developed by a steering group or task force, possibly with the assistance of consultants. In most Share-Net member organisations there are knowledgeable persons who can take the lead, also because many are supporting partner organisations in developing a WPP.

Organisations should develop a policy tailored to the organisation. There are many guidelines and manuals that can be consulted. Depending on the type of organisation and staff, the organisation may develop a comprehensive policy with all components, including a treatment and care programme, or simply a protocol stating the employer's commitment and responsibilities.

Organisations that offer treatment and care programmes should concentrate on the awareness raising and motivation programmes first, because these are most critical for the success of the treatment programme. Stigma, fear of losing one's job and lack of confidentiality hinder uptake. Qualitative research can explore aspects of the corporate culture in an organisation or office that may hinder the programme and increase the risk of HIV infection.

This report ends by providing brief guidelines for organisations that intend to develop HIV & AIDS responses in the workplace, either a policy or protocol. Share-Net also plans to organise a workshop with member organisations in which the results of this study can be communicated and the implications discussed, possibly identifying training needs.

## 1 INTRODUCTION

This study is a follow-up to the Share-Net study 'Human resource management and HIV & AIDS – a study among Share-Net members' of 2003 that described the experiences of Dutch civil society organisations with internal policy development on HIV & AIDS (Kerkhoven & Lówik 2004). The latter study found that Share-Net member organisations had not or barely initiated internal responses to HIV & AIDS. In a way this was surprising, because all Share-Net member organisations have HIV & AIDS as one of their focus themes and have formulated HIV & AIDS policies and strategies to direct their AIDS work with partner organisations. Many of them are even urging their partner organisations in the South to develop internal HIV & AIDS policies and are supporting them in doing so.

The presentation of the study by Kerkhoven & Lówik in June 2004 to a meeting of directors, senior policy advisors and HR managers of NGOs had as an additional aim to accelerate commitment of senior management for internal HIV & AIDS issues. At that meeting it was recommended that Share-Net embark on an inventory of existing HIV & AIDS policies and protocols of civil society organisations and extract good practices that could be used by other NGOs. In January 2005 an external consultant subsequently undertook this study in consultation with the Share-Net HIV & AIDS coordinator.

### Study objectives and questions

The main study objectives were

- To make an inventory and analysis of the existing HIV & AIDS workplace policies and their implementation among Share-Net member organisations, to identify good practices, and to include HIV & AIDS workplace policies and protocols of other (Dutch) development NGOs and organisations in the analysis.
- To give recommendations and guidelines to Share-Net member organisations (and other Dutch development organisations), for developing appropriate internal responses to HIV & AIDS.

The study focused on four questions: 1) why is an HIV & AIDS workplace policy needed, 2 and 3) for whom and for what should employers be responsible in high HIV prevalence countries and 4) how should an HIV & AIDS workplace response be developed. Because in the end the success of a policy depends on its successful implementation, the study also had to consider good practices of implementation.

### Definitions

HIV & AIDS workplace policies, protocols and programmes concern mainstreaming HIV & AIDS internally. The following definitions are used in this report:

- ***HIV & AIDS workplace policy:*** Outline of an organisation's commitment to addressing HIV & AIDS in the workplace that informs employees of their rights and responsibilities. A policy also provides guidance to managers who may have to deal with HIV & AIDS on a day-to-day basis (Holden 2003, 2004). In this report WPP usually stands for 'HIV & AIDS workplace policy', but can stand for other HIV & AIDS workplace responses as well such as protocols or guidelines, which are less comprehensive than policies but also state the commitment of an employer.
- ***Mainstreaming HIV & AIDS internally:*** Changing an organisation's policy and practice in order to reduce its employees' susceptibility to HIV transmission and the organisation's vulnerability to the impact of AIDS. Internal mainstreaming has two elements:
  1. AIDS-work with staff including prevention and treatment: directly benefits the staff members and indirectly benefits the organisation (*AIDS-work* refers to activities directly focused on AIDS prevention, care, treatment and support for those infected);

2. Modifying the way in which the organisation functions, for instance in terms of workforce planning, budgeting and ways of working (Holden 2003, 2004).<sup>1</sup>

For *best practice* this report uses the UNAIDS definition, which concerns both positive and negative experiences.

- **Best practice:** A continuous process of learning, feedback, reflection and analysis of what works or does not work and why, whether fully or in part. In other words, practices not only have strengths that can be built upon or adapted, but also weaknesses that can be recognised and overcome or avoided (UNAIDS 2002).

## Report contents

Section two of this report describes the methodology used in the study. Section three presents the status of HIV & AIDS workplace policies and protocols among Share-Net member organisations as of early 2005, including their reasons for having or not having policies, as stated by respondents in interviews. Section four presents the study findings on the process of developing policy documents, section five on their contents and section six the findings on implementation of HIV & AIDS workplace policies. In sections four, five and six the experiences of Share-Net members are complemented by those of other Dutch and foreign (development) organisations. Section seven then gives conclusions and recommendations and guidelines for developing HIV & AIDS workplace policies and protocols.

## 2 STUDY METHODOLOGY

The study was conducted over a period of five months – from the beginning of January to the end of May 2005. Data collection started with a literature/document review after which short questionnaires were sent by email to nine Share-Net member organisations that had not been involved in the previous study by Kerkhoven & Lówik. Personal interviews with representatives of development organisations and consultants were conducted starting at the end of January.<sup>2</sup> The following data collection methods and tools were used:<sup>3</sup>

- **Literature review.** Different types of literature and documents were reviewed, including general information on AIDS and impact of AIDS on human development and the world of work, annual reports of the NGOs involved in the study, national and organisations' AIDS policies, HIV & AIDS workplace policies, protocols and activity plans, analytical publications/studies of HIV & AIDS workplace policies and guides for mainstreaming, including for developing workplace HIV & AIDS policies. A list of most used references is provided in annex 1.<sup>4</sup> The researcher had access to the rough interview data of the study by Kerkhoven & Lówik (2004). This was very helpful, because it prevented too much overlap in questions posed to respondents involved in both studies.
- **Structured email questionnaire.** A short structured questionnaire was sent by email to nine Share-Net member organisations that had not been involved in the previous study. The purpose of this questionnaire was to obtain a quick inventory of the number and type of staff employed by each organisation, the number of their field offices, the type of health insurance coverage

---

<sup>1</sup> Compare with 'mainstreaming HIV & AIDS externally': adapting development and humanitarian programme work to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS (Holden 2003, 2004).

<sup>2</sup> As expected, the interviews took a long time, because it was difficult to arrange dates and times for appointments (prospective respondents were often engaged in workshops and meetings or travelling, and the researcher only had three days a week available for appointments).

<sup>3</sup> See annex 3 for the data collection instruments.

<sup>4</sup> Although the literature was reviewed on the impact of HIV/AIDS on the workplace, workforce and general society, this report does not present a literature review on these topics; I refer to the thorough literature review on 'HIV & AIDS and employment' in the Share-Net study report of Kerkhoven & Lówik (2004).

offered, status of their HIV & AIDS policies or protocols, and preparation of their staff for field missions on HIV & AIDS. This information was already known for the organisations that were involved in the previous study. Six organisations returned completed questionnaires, two shortly replied that they had not done anything on HIV & AIDS for their staff and one did not send any reply.

- ***In-depth interviews.*** In-depth interviews were conducted with 22 persons, 18 face-to-face and 4 by telephone. Organisations and individuals were selected in consultation with the Share-Net Secretariat. Most of the respondents work for development organisations (12 for Share-Net members) either as policy advisors, HIV & AIDS programme officers, coordinators, health advisors, or HR advisors/managers; the other respondents are consultants in the field of HIV & AIDS. One respondent is a national staff member working in a field office (Malawi VSO office). More information on the persons interviewed is provided in annex 2. The interviews contained some standard questions, but most questions were tailored to the organisation and the information the researcher already had from the previous Share-Net study and/or the email questionnaires. The interviews lasted between 1 and 2 hours.
- ***Semi-structured email questionnaires.*** Semi-structured questionnaires were sent to field offices of VSO (5) and HIVOS (1) to get first-hand information on implementation of WPP. Only one completed questionnaire and one short summary of experiences were sent back. However, the VSO Netherlands office shared information they had on the WPP of field offices (PowerPoint presentations prepared by the field offices on their WPP), and information on the WPP of HIVOS' field office was abstracted from HIVOS reports and the interview with HQ staff.

### 3 STATUS OF HIV & AIDS WORKPLACE POLICIES OF SHARE-NET MEMBERS

There have been positive developments since the previous Share-Net study, with more organisations having started to address or at least think about HIV & AIDS in the workplace. Of the 15 Share-Net member organisations involved in this study (12 through in-depth interviews, and 3 through email questionnaires only), five had an HIV & AIDS WPP, whereas ten had not developed one. Of the five with a WPP, one had a corporate HIV & AIDS workplace policy at international level, one had just finished a corporate document and one had a draft corporate policy document; two organisations had a (draft) policy in field-offices only (and did not find a corporate policy necessary). The other ten do not have a policy, either at (international) corporate level or at field office level. However three of the ten are members of international organisations that do have a WPP and think they should do something for the Dutch office; one member was seriously thinking about developing a WPP, two had not thought about it, but were positive, and four did not think a policy was necessary (see annex 9).

**Table 1: Status of HIV & AIDS WPP of 15 Share-Net members involved in the study**

<i>status of WPP</i>	<i>type of WPP / intentions for WPP</i>
<i>have a policy (n=5)</i>	International revised corporate WPP – field offices to adapt and develop own. Netherlands office in the process of developing WPP for the office (n=1)
	One corporate policy for all staff, HQ and field offices (n=1)
	Draft corporate policy on hold since 2003 – some field missions have WPP (n=1)
	WPP in field offices only; not necessary for HQ (n=2)
<i>have no policy (n=10)</i>	Intend to develop a WPP; are members of international organisations that do have WPP (n=3)
	Thinking about developing a policy (n=1)
	Have not thought about it, but are positive (n=2)
	A WPP is not necessary (n=4)

Table 2 presents why some respondents feel that having an HIV & AIDS WPP for their organisation is important and why others think there is no need to have such a policy.

**Table 2: Respondents' reasons for having or not having an HIV & AIDS workplace policy**

<i>yes, a WPP is important</i>	<i>no need for a WPP</i>
We need one for local staff, because too many ad hoc decisions are taken and field staff need guidelines and directions for what they can offer.	We do not need to make a big issue out of it – just integrate it in a general health policy; there are also other health risks such as malaria and alcohol abuse.
We need to be HIV prepared. The WPP includes the employer's statement about responsibility, but also information for staff about what to do in case of an accident, information about services in country and PEP treatment.	Expatriate and HQ staff are themselves responsible for their health and are insured.
To be pro-active, make a statement what the responsibility of the employer is and discuss the details. Operationalisation of a policy can be a good start for the process of internal mainstreaming and competency building of staff members who work with partner organisations on the same issue (Cordaid).	No need for HQ staff, because they are insured; it is only important for field office staff.
Organisation is responsible for their workers – if you send out staff to high HIV prevalence countries they are also vulnerable.	Expatriate staff members have PEP (for medical accidents) and SOS insurance [repatriation in case of medical emergency] – that is enough.
When policy is formulated and communicated to staff this is the proof that it is an important issue and they know that HIV is taken seriously. They may then be willing to bring up their status – just being insured is not enough.	Too expensive for small organisations; not comparable to big businesses with thousands of workers. Also bigger organisations have the money to implement the policies.
If partner organisations see we take internal mainstreaming seriously – they will follow. First item in the AIDS strategy is incorporating consideration of AIDS. All existing partner organisations have to do so, partners have to include it in their planning process. So it is pertinent to also have AIDS considerations in our own organisation.	The organisation reasons we do not have local national staff, so there is no need. Dutch staff members are well insured, have a good occupational health service, and our organisation considers sexuality and prevention a private matter in which an employer should not intervene.
Credo: Practise what you preach.	Not necessary, all staff do AIDS work and know all AIDS-related issues.

### **Why having an HIV & AIDS WPP is thought to be important**

Share-Net members that have national staff working at field offices and/or emergency operations in high HIV prevalence areas most often feel the need to have WPP, because they need guidance on how to deal with the problems related to AIDS they are confronted with. Organisations that have many field offices feel the need for a corporate policy. If there are only a few field offices in high prevalence areas, those offices may develop their own policies, with the support and approval of HQ, but no corporate policy is formulated. Another reason for having a corporate policy is when many expats are perceived to be vulnerable because they are sent out under difficult conditions. VSO is such an organisation as it employs many single professionals that are considered to be more at risk – the HR department feels responsible to support them.

Some organisations that do not have field offices in high HIV prevalence countries but do AIDS work with their partner organisations feel they need to have an HIV & AIDS workplace policy themselves because they ask their partners to do so – they believe you have to 'practise what you preach!'

## Why some Share-Net members feel no need to have an HIV & AIDS WPP

The most often-heard reason for not needing an internal response to HIV & AIDS is that all Dutch employees are covered under occupational health and safety laws and have health insurance (collective or individual), covering HIV treatment. Furthermore, the organisation feels that everything to do with sexuality is the responsibility of the employee and not that of the employer.

Another reason given by one respondent for not having a policy, i.e. 'because we do AIDS work ourselves', is interesting, because there is an analogy in internal mainstreaming of partner organisations in the South, as identified by another respondent (ICCO). This person observed that organisations eager to take up external mainstreaming in their programmes or that do AIDS work, for instance organisations that advocate women's rights, are least interested in internal mainstreaming. Probably, for them it is more stigmatising to be HIV positive, because they feel this is an indication that they are weak and 'stupid' since they should have known how to prevent HIV infection!

An important reason for being hesitant is that organisations (especially smaller ones) fear the costs that implementing an HIV & AIDS WPP may bring.

## 4 DEVELOPMENT OF A POLICY DOCUMENT

Because of the dearth of Share-Net experiences, much of the information in this and the following sections is from other organisations. The experiences of SNV are especially useful for Share-Net members.

### Initiative – 'you need a spark'

Initiatives to do something structural about HIV & AIDS in the workplace came up in various ways:

- ***Felt need from field level.*** Usually field directors and P&O staff in high HIV prevalence countries see the impact of AIDS on national staff and have to make ad-hoc decisions. They have to deal with sickness, costs of treatment, absence, due to sickness, care of sick family members and/or funerals. Field directors then express the need for corporate guidelines (SNV, BZ, Cordaid).
- ***Peer pressure or example by other organisation.*** HIV & AIDS programme or policy officers and/or management initiate workplace responses after peers initiate them or after they are questioned as to why they do not have a WPP (SAN!, Cordaid, NOVIB).
- ***Initiative of mother organisations.*** 'Mother' organisations sometimes initiate and develop a WPP and then ask national societies to do the same (VSO, PLAN, Red Cross).<sup>5</sup>
- ***Field offices in high HIV prevalence countries initiate their own workplace response.*** The central level may either take these as an example and develop organisation-wide guidelines (VSO) or support the field-office initiative but not develop a corporate policy (ICCO, HIVOS).

### Getting management support

A requirement for actual development of a policy document is to convince the senior management and board of directors of the need – if they were not convinced already. They have to give their

---

<sup>5</sup> An impediment to following the initiative of the 'mother' organisation may be a high workload of staff and limited capacity. For example, the International Federation of Red Cross can have a global WPP, and ask 181 national societies to follow, but national societies often lack capacity and/or staff strength.

mandate to develop an internal HIV & AIDS policy. If management is not convinced from the start, the advocates/lobbyists need to give good reasons why a workplace response to HIV & AIDS is needed. Advocacy and lobbying are usually done by HIV & AIDS coordinators, programme officers, external motivators and field directors.

One of the powerful ways mentioned in this study to convince senior management and board of the need for a HIV & AIDS workplace response was to remind them that the organisation claims to be a socially responsible employer, so they should also be responsible for (the risk of) HIV & AIDS among their employees. Field directors and programme officers presented cases in their work experiences where they would have needed corporate guidelines to be a socially responsible employer (SNV).

A good way to involve and convince senior management was used by staff of BZ and (recently) Fair Trade. They invited businesses and similar organisations that were already implementing a WPP to share their experiences. (This amounts to peer pressure.)

A valuable tool in securing senior management and board level approval of additional financial commitments (such as for ART) is presentation of a financial risk assessment. They should be told at least the extent of HIV infection in the organisation, how HIV is affecting worker productivity, how much money investments in HIV & AIDS prevention and care will cost the company, what the expected benefits are, and how prevention programmes work. However, this approach can only be adopted by larger, well-funded NGOs, because calculations are difficult to make<sup>6</sup> and impact of HIV & AIDS on the organisation is difficult to prove.<sup>7</sup> It was found that most field offices also do not keep routine data on absenteeism, sickness, costs for medical treatments, etc., which would be a precondition to make the calculations (SNV, case studies by UK Consortium on AIDS and International Development 2003)

Smaller organisations with national staff can present other reasons to their management, such as human rights considerations, ethics, and the need for humanitarian treatment, as mentioned by consultants and noted in the literature. Local governments and individuals in the South do not have the economic resources to treat HIV-infected persons with ARVs. Employers should also take into account that many national staff members are coping with very difficult home lives as a result of the epidemic, and moreover, that their work in communities that are all affected by HIV & AIDS is stressful (O'Grady 2004). Against the argument that it is every person's own responsibility to prevent and deal with HIV & AIDS, WPP advocates say that if individuals do not *take* their responsibility, they may not only harm themselves, but their family and indirectly their work and employer as well.

There is also a very strong strategic reason that can be mentioned in lobbying for a HIV & AIDS workplace policy, also for organisations that do not have (many) national staff: by going through the experience of internal mainstreaming, staff will be skilled to work with partner organisations on the same process. To convince senior management, they could be involved in inter-office workshops. Through these workshops, all staff members come to realise the impact of HIV & AIDS on the whole organisation and how it may affect their fellow-workers and them personally. Participatory sessions can also identify the expectations of staff for support from their employers (NOVIB AIDS project group 2002).

---

<sup>6</sup> Oxfam developed a risk assessment model (see annex 4) – that is only applicable to organisations with many national staff in high HIV prevalence areas. Results of the Oxfam risk assessment showed that costs of providing ART to employees would be more than offset by the savings arising from staff health improvements, including reduced staff turnover, death in service, absenteeism etc. (UK Consortium on AIDS 2003: 8).

<sup>7</sup> There is hardly documentation on the actual extent of the internal impact of AIDS to date. Only some businesses were active in assessing the impact on their profits. Type of costs for development organisations has not been measured, but are similar to those incurred by businesses. Good description of workplace impact of HIV & AIDS in Holden (2003: 97; table 5.2). More challenging for smaller organisations (11-20 staff) because hard to predict how big the impact is or will be and their resources are less (Holden 2003).

## Process of policy development

This study found that policies (or draft policies), at corporate or field office level, can be developed either by one person from the organisation, consultants, a steering committee or task-group, or by all staff members in workshops (small country offices). Below are some examples of how an HIV & AIDS WPP was developed in the organisations consulted for this study.

- ***Consultants and steering committee developed a corporate policy and action plan to cover all field offices.*** Because the staff of the HRM department felt they did not have the required expertise, two consultants were involved to develop the policy. One of the consultants was stationed (part-time) in the HRM department and worked with a steering committee (SC) that was formed around the consultancy. SC members were the organisation's own occupational health officer, an HR manager, an occupational health and safety advisor, a member of the board of directors, and a senior policy officer. The process started with a situation analysis in the countries of operation: through telephone-interviews with field directors and HRM advisors, an inventory was made of how often employees were sick, absenteeism, how staff dealt with AIDS in the office, locally available resources and HIV & AIDS services, costs, networks, and possible experiences with WPP. The SC had the mandate from the board and senior management to make decisions on critical issues (such as eligibility for treatment) brought up by the consultants. The draft policy document was sent for comments to field offices. With these inputs, the consultants wrote the final document including a plan of operation. The process took about two years (SNV).<sup>8</sup>
- ***A HQ task force with consultants developed a corporate policy and guidelines for field missions.*** Based on the input of consultants, a HQ task force developed a corporate policy and guidelines for making operational plans in field missions, with a timetable for rolling out over the 19 field missions. In every field mission a task force together with consultants developed local plans of action – after assessment of the local situation (according to corporate guidelines) (BZ).<sup>9</sup>
- ***A theme group developed a layered corporate policy.*** Senior management gave a mandate to a theme group consisting of representatives of all departments including HRM to develop a WPP. The theme group asked for input from the five field offices/projects on local situations concerning insurance, medicines, treatment facilities, etc. The policy document was written by a smaller group of three who left vital decisions (for instance on eligibility and payment for treatment) open to the full theme group and later to the board and senior management. The head of the theme group commented in the interview that it is good to develop a policy with representatives of all departments, but that you also have to be realistic: everyone is very busy and time is limited. The process goes faster when a small group writes the policy and asks for comments. The process of developing a draft policy lasted five months; it took another two months to finalise the policy document (Cordaid).
- ***Field offices developed their own policy, aided by a reference paper and some directions from central level.*** This organisation started by preparing a reference paper on critical issues and background information on HIV & AIDS (for instance on treatment protocols) and let field offices develop a WPP. Included in the reference paper were recommendations on how to develop the policy, which were intended for the medical co-ordinator/head of mission and for the administrator/financial controller. A national lawyer had to check the legal implications and HQ had to grant its approval before a mission policy could be implemented (MSFB).

---

<sup>8</sup> The process also took longer than 'needed', because during the development of the WPP a major reorganisation took place within the organisation. The development was on-hold for some months.

<sup>9</sup> The same consultants (PharmAccess International) also guide and monitor implementation.

- **HQ and field offices implemented a corporate policy written by a programme manager; a task group then developed a more comprehensive policy after reviewing country experiences.** A corporate policy was written in just nine months by the regional programme manager Southern Africa and it was quickly put into practice in field offices (2001). Field offices were rather autonomous and could adjust to the situation. With input based on the experiences of field offices, a draft was made for a revised version (VSO International, 2005). The draft revised policy was presented and discussed in a (global) meeting with all country directors and AIDS programme and policy officers. The final second corporate policy was written by a small task force from VSO International, together with staff from field offices who had been implementing the WPP. The revised corporate policy is applicable to all VSO staff and VSO development workers. The corporate policy therefore also guides VSO Netherlands in developing its country-specific HIV & AIDS workplace programme.
- **Through a participatory process involving all staff, a small country/field office developed an HIV & AIDS WPP.** Small field offices in high HIV prevalence countries developed their own WPP. Some had corporate guidelines (VSO), others did not, but in both cases HQ supported the initiative (HIVOS, ICCO). In participatory meetings and workshops a needs analysis of staff was made to assess what the impact of AIDS was on staff and their families and how their needs could be addressed in a policy. VSO Namibia staff looked at other policies and gave presentations on local organisations that have experience developing a WPP – a smaller group made a draft policy that was sent around to all the staff members for input. In a staff workshop the input was discussed and the final policy written.

### **Lessons: Mandate, anchorage and ownership**

The WPPs presented in the sections above are now being implemented because they were developed with the mandate and support of each organisation's senior management and board or directors and because the WPPs have an organisation-wide anchorage and ownership. The WPPs were developed either by a task group representing all sections (with or without the assistance of consultants) or by all staff in a participatory process. This broad sense of ownership breeds commitment to put the policy into practice.

There are also examples of initiatives and draft policies that were shelved or put on hold because they did not have the mandate and/or organisation-wide ownership and anchorage. In MSFH one devoted person (operational director) wrote a draft policy, asked for comments from different sections in the organisation and finalised the draft in April 2003. This final draft was sent to country offices. When this one person left the organisation, nobody at HQ proceeded by writing the final policy paper.<sup>10</sup> The first initiative to develop a WPP at Cordaid also became stranded. Two Africa departments of Cordaid organised an internal workshop on internal mainstreaming in 2003. Although people felt that Cordaid actually needed a policy, there was nobody at HQ to take it forward.

## **5 CONTENT OF HIV & AIDS WORKPLACE POLICIES**

### **Blueprints or guidelines?**

'Can we use blueprints – just adopt a WPP from similar organisations?' This question was appropriately answered by the consultants for SNV when they said 'No, each organisation is unique'. It is not just about writing a policy document, but the process each organisation needs to go through while writing such a document. Consultation with different departments and field offices and instigating a dialogue on what HIV & AIDS means in the context of the organisation's work and what

---

<sup>10</sup> Some country missions used the draft to develop a mission WPP (for instance MSFH DRC).

is needed are crucial for developing a tailor-made and hence effective policy. Adopting a document from another organisation will not achieve that same effect.<sup>11</sup> Using a blueprint will not foster organisation-wide anchorage, ownership and commitment.

No organisation in this study just copied another organisation's WPP. Those that have HIV & AIDS policies developed them by using guidelines, manuals, and checklists, of which there are many and an increasing number. The key documents used are 'HIV & AIDS and the world of work: An ILO code of practice' (ILO 2001), 'Working positively. A guide for NGOs managing HIV & AIDS in the workplace' (UK Consortium on AIDS and International Development 2003), and 'Workplace HIV & AIDS programs: An action guide for managers' (Rau 2002).<sup>12</sup>

VSO International recently published the very useful resource document 'HIV & AIDS mainstreaming guide for VSO offices' with background information, references, models, definitions and guidelines for mainstreaming (starting with internal and then moving to external). The centre of the VSO mainstreaming model is sensitisation, which is considered to be a step beyond awareness raising (see annex 5 for the model).<sup>13</sup>

### **Length and detail**

HIV & AIDS workplace policies can consist of many pages or just a few paragraphs. Usually the length depends on whether the document simply outlines the organisation's commitment to address HIV & AIDS in the workplace and gives broad policy guidelines or spells out detailed instructions and procedures on how the policy is to be implemented. Rau recommends that a WPP be detailed and thorough and adapted to local circumstances (Rau 2002:35). The latter is most pertinent for field situations, whereas for HQ a short policy statement and broad guidelines may suffice.

To fill in the details of a WPP it is very valuable to conduct staff surveys during policy development as they help to identify issues of concern among the workforce and provide a baseline from which to measure changes in attitude and knowledge, raise awareness and ensure staff buy-in. Thorough situation analyses can really only be done in bigger organisations, however, internal participatory workshops may achieve the same results in smaller organisations (as is done in the VSO country offices).

### **One policy for all types of staff and organisations?**

Usually organisations have staff members who work only at HQ, some HQ staff who travel to high HIV prevalence countries and possibly engagement of short and long-term consultants; some have field offices with national staff, volunteers, etc. A complicating issue in developing a corporate WPP is how to address these different types of staff who have different working conditions and labour contracts and presumably variable risk of HIV infection. VSO International originally had problems with this; in the draft revised corporate policy, national and international staff members were treated differently with respect to the eligibility of partners and children for ARV treatment and national staff objected to this. However, this problem has been resolved in the final policy. Some organisations only

---

<sup>11</sup> Aantjes 2004. Developing an HIV/AIDS workplace policy for SNV. Reflection and lessons learned.

<sup>12</sup> References on guidelines and manuals for internal mainstreaming and HIV & AIDS WPP are in annex 1. Very useful is Rau (2002:38-40) 'Checklist for drafting an HIV/AIDS policy' including introduction, general considerations, elements relating to employment criteria, elements relating to benefits and treatments for HIV infected and HIV affected employees and elements relating to workplace prevention (in annex 6).

<sup>13</sup> VSO International gives instructions to all staff members and development workers, regardless of the programmes they work in, to address AIDS with partners in their place of work. All VSO staff and development workers get skills training to address AIDS. About 70% actually do something that addresses AIDS – some are involved in only isolated activities, others work more structurally with AIDS. An example is a development worker's initiative to translate HIV/AIDS information into Braille for the project with blind persons he works in.

have a WPP for national staff in field offices and none for (travelling) staff from HQ (MSFH, ICCO, HIVOS).

Cordaid came up with a 'clever' solution to the dilemma by formulating a corporate HIV & AIDS WPP in which there are policy statements and some guiding principles that apply to all staff. In addition there are guiding principles for the different types of staff, including HQ, HQ staff who travel frequently and national staff at offices/projects. Cordaid recognises that these different categories of staff have different levels of risk and vulnerability to HIV infection, and different information and accessibility to services.<sup>14</sup>

### **Separate policy or inclusion in chronic illness policy**

All of the organisations consulted, except for the Eritrea ICCO office, have separate HIV & AIDS workplace policies or guidelines – it is not part of a chronic illness policy. The Eritrea ICCO office has a draft HIV & AIDS policy that is part of the Office Manual, which includes employment terms and conditions, office and administrative procedures, financial procedures and guidelines and security regulations. The document states that the policy does not differ from the existing policies on (chronic) illnesses – also dependants (as declared in the office file of the employee) are covered by medical benefits. However, the HIV & AIDS policy elaborates on education and prevention, confidentiality and stigma and testing, treatment and care, non-discrimination and partner policy (sharing of the internal guidelines with the partner organisations).

### **Corporate policy in different countries**

Field missions and offices have to adapt the content and details of the (corporate) WPP to the local situation. They have to look at the national AIDS policies and possibly specific HIV & AIDS laws.<sup>15</sup> However, various other laws may also support or hinder HIV & AIDS workplace policies, including:

- *Labour legislation.* An increasing number of countries in Africa and the Caribbean have laws against discrimination and mandatory HIV testing for the purpose of employment. However, the VSO office in China reports that there is legal mandatory HIV testing for access to many jobs and insurance companies – securing confidentiality is hardly possible in such situations.
- *Anti-discrimination and human rights legislation.* These ensure the protection of fundamental rights and freedoms.
- *Disability laws.* These aim to protect persons with a disability against discrimination, to ensure equal treatment and to integrate persons with a disability as much as possible into society. The laws may contain provisions on the obligation of employers to make reasonable accommodation to help persons with a disability remain at work as long as possible,
- *Laws against exclusion.* Upcoming national policies will protect HIV-positive persons from being excluded from health and life insurance schemes. VSO South Africa reports that the law is changing so that insurance companies will have to include ART.

Organisations also have to link with the local health infrastructure and need to have a sound idea about the local availability and quality of health and social security services. An organisation has to make decisions about which services they can include in their treatment programme when medicines are not locally available.

---

<sup>14</sup> For all staff the guidelines include basic principles for a supportive environment. For HQ: recruitment, confidentiality, non-discrimination, managing illness, educational activities. For expat staff: guidelines on prevention and supportive measures are added. For national staff at field level: guidelines on local legislation, VCT, STI treatment, gender, insurance, treatment and care are added.

<sup>15</sup> In Cambodia, for instance, all enterprises and institutions are obliged to comply with the comprehensive HIV & AIDS laws. Thailand and the Philippines (and probably other countries) have national HIV & AIDS workplace policies.

## Components of a WPP

The policies, following the ILO code of practice, usually contain the following components

1. General statement
2. Policy framework and general principles
3. Specific provisions (a) protection of the rights of those affected, i.e. anti-stigma and anti-discrimination, b) prevention through information, education and training, c) treatment, care and support for workers and their families)
4. Implementation and monitoring
5. Costs and financing

Another list of components that is commonly used was published in the study of the UK Consortium on AIDS (2002). This list mentions attention to gender issues as a separate component, which the author strongly recommends and which was found to be forgotten or only implicit in some policies. The eight components of a workplace policy on this list are: 1) Clear policies, procedures and objectives, 2) confidentiality, 3) non-discrimination & reasonable accommodation (of working conditions in case of illness), 4) education & information, 5) attention to gender issues, 6) prevention, 7) treatments & care, 8) monitoring and evaluation.

The box below presents an outline of the SNV corporate HIV & AIDS workplace policy.

### *Introduction and background*

Why it is needed: staff are at risk.

### *Guiding principles*

Take responsibility, give information, open dialogue, confidentiality, against discrimination, keep HIV-positive employees, all employees should support the policy, treatment according to WHO guidelines.

### *Policy directives*

1. Legal framework / code of employment – regard corporate policy and legislation in countries of operation.
2. Education, awareness and prevention.
3. Recruitment – based on fitness for the job, not HIV status.
4. Confidentiality – disciplinary action if this is not honoured.
5. Managing illness and job security – HIV is not a reason for dismissal, alternative employment should be offered if employee is not able to continue in his or her current position; regulations of local labour law on employment conditions must be regarded.
6. Benefits – if ARVs are locally available, and there is a sufficient infrastructure, but they are not covered by health insurance, SNV pays; if ARVs are not available, SNV will try to arrange for generic medicines. PEP made available based on local protocols and countries' regulations.
7. Eligibility – pay ARVs for staff and partner with contract >12 months, keep paying as long as SNV is in the country; fixed contract: pay up to 1 year after contract ends.
8. Management and procedures – country director responsible, support by HRM at head office. Practical information provided by field offices on testing, laboratory services, counselling, medical practitioners, and information on PEP protocol.
9. Costs and financing – SNV bears all costs, pursues full medical insurance coverage, field office to budget for prevention and awareness programmes in the workplace and cost of medical treatment not covered by insurance coverage, co-payment by employee of 5% - if not covered by insurance.
10. Monitoring and evaluation – review of policy after 2 years, field offices to give feedback, country directors to report progress in four-monthly reports to board of directors.

The contents of studied WPPs are rather similar for most components, including objectives, confidentiality, non-discrimination and education, counselling and testing. There are small variations in prevention commitments, with some organisations intending to make free condoms available to all staff, some only in contexts where condoms are not available, and others not making them available because they think buying condoms is the responsibility of the employee. The differences in WPP content are most pronounced with respect to the policy on treatment with ARVs, care and support.

## Policy on treatment

HAART (highly active antiretroviral treatment) was only made available at relatively cheap prices about four years ago, and since then more organisations have decided to include HAART in their workplace programmes. Heineken for instance had a workplace HIV & AIDS programme in their African breweries in operation for more than 10 years including prevention, counselling and testing activities, and treatment of STIs and OIs. Only since 2001 have they expanded the WPP to include access to treatment with ARVs – this is being implemented in the company's entire operation in Africa and several sites in the Far East (Cambodia, Vietnam).

Details of HAART provision are difficult to work out. Some critical questions are: who is covered, (how many of an employee's dependents and what types of staff), what services are offered, after how long a term of employment should commitments start, what happens when a staff member leaves or when the organisation leaves the country, how can confidentiality be ensured, what ART provisions should be made if local medical resources are not adequate, how can ARVs be paid for when there are no insurance schemes available?

To answer these questions, organisations did benchmarking with other organisations. They reported that because of financial risks (as most decisions do have financial implications), they wanted to stay on the conservative side of whom to include and what to offer; they could always broaden the eligible group for treatment later. The following benchmarks for ARV treatment eligibility were used among organisations included in the study:

- BZ, Heineken and Cordaid: all local staff, one partner and all children who are part of the household and supported by staff member.
- BZ: also all domestic staff of expats, with partner (unless partner has a higher income) and dependent children – thus children by birth, by legal adoption or stepchildren. Staff members have to supply a list, with 'proof' of the relationship (which may be the paying of school fees).
- SNV: local staff and one partner (no children).<sup>16</sup>
- MSFH (draft): permanent employees with dependents including children and retired parents – have to be registered as dependents in normal health care coverage provided by MSFH.
- VSO: in the international revised policy, national programme staff members get 10% salary allowance for medical costs for dependents. Individual offices can use the money in a slightly different way.

Offering access to AIDS treatment to employees and possibly their dependents asks for more financial commitment of the employer than for other components of a WPP, but assessing the costs of treatment is difficult because prices of ART, tests and other medical costs differ by country and change every year (so far they have been decreasing). Indications of variation in costs of treatment: Heineken uses branded medicines and the total per patient cost of the programme (including lab tests, clinical visits, counsellor visits, etc.) is in the range of US\$ 1,600 per person per year. Heineken has about 200 persons under treatment, which makes a total annual cost of US\$ 320,000. MSFH-DRC has a maximum annual cost of about US\$ 400 per person for treatment, tests and medical services (depending on the stage of HIV infection and length of treatment). Cordaid discussed eligibility, whether those staff should pay a certain percentage of their gross salary for ART and whether there should be a separate fund for the WPP. It was decided to not ask a contribution from national staff for treatment and not have a separate fund, but to let it be part of a bigger fund for unforeseen expenses.<sup>17</sup> The idea that estimating costs may be a critical issue in gaining the approval of senior

---

<sup>16</sup> The reason for not formally including children is that it is often difficult to prove or disprove that a child is a daughter or son. SNV feared there would be too many eligible persons. However, in practice a child is never excluded from treatment.

<sup>17</sup> In budgets for a comprehensive WPP, treatment is of course not the only budget line. Costs for illness, health and life insurance, temporary cover for absent employees, additional recruitment processes, education and prevention programmes, etc., should also be included (Mullins: 2002).

management and the board was shown by the SNV experience: the policy took so long to develop in part because the board wanted to be sure the costs would not get out of hand.<sup>18</sup>

Smaller organisations are especially hesitant to offer treatment for fear of the costs (and they therefore limit the number of dependents eligible for treatment). Some organisations started by asking a minimal contribution from their staff for the treatment or for insurance, but dropped this, because for national staff even this small contribution would often be too high and possibly an impediment to uptake (BZ, MSFB). SNV put in the corporate policy that staff pays 5% of their gross salary on a monthly basis in cases where insurance coverage of treatment is not available.

### **Policy on care and support**

The details of the policy component on care and support provisions are mostly developed through a participatory process, and vary by country. Some examples:

- Positive living promotion – involves people living with AIDS (HIVOS Harare)
- Planning for the future of dependants – life insurance (HIVOS Harare)
- Palliative and terminal care when ARV treatment cannot (or no longer) be provided (MSFB).
- Provisions for care of sick family members; time off for caring responsibilities (VSO) and flexibility of working hours for managing terminal illness of close family members (HIVOS Harare).
- Contribution of money for funeral of staff member in the event of an HIV & AIDS related death and (half) for funeral of a family member (VSO Namibia).
- Provisions for travel, lodging, livelihood support for patient and caretaker, disability arrangements – stipend also after maximum sick leave in normal staff policy (MSFH-DRC).
- Refund of costs for milk-formula for 12 months for HIV-infected mothers to prevent mother to child transmission (ICCO Eritrea, MSFH-DRC).

Thus, when adapting a corporate policy to the local situation, through a participatory policy development process, some issues that were not thought of by HQ may appear to be very important. The HIV & AIDS programme manager from VSO Malawi explained that this was the case for funeral and burial arrangements. The staff discussed the implications of allowances and leave days: for funerals, logistic support from the office, e.g. coffin, transportation of coffin and persons attending from the office, food, how many persons would be eligible. He said that one should look at the local customs regarding funerals, who pays, who participates, how many days the ceremonies last, and the location of the burial. In Malawi one is not only supposed to attend the funeral rites and burial of every member of the extended family (from both the maternal and paternal sides), but also of everyone one knows and everyone who is related to a person one is better acquainted with, be it a colleague or a neighbour. These funerals can take days, especially when the deceased person has to be buried in his or her place of origin; this can be a long way from the place of last residence.

### **Operational plan**

A policy is not complete without an operational plan for implementation. Just adding management and financial procedures is not enough. There has to be a plan for roll out (with specified roles and responsibilities) of resources, communications, prevention, treatment and care programmes, and monitoring and evaluation (M&E). SNV added a two-year activity plan to the corporate WPP. This plan delineates the activities, time frame with deadlines, persons responsible, indicators and M&E system. The activities are ordered under different headings (communicating the corporate policy, training, awareness and prevention, managing HIV & AIDS in the workplace, treatment and care) and for each heading the expected result is stated (for example activities that fall under the heading 'awareness and prevention' should ensure that 'at the workplace, an open and non-threatening environment is

---

<sup>18</sup> SNV contracted consultants (PAI) to estimate the costs of the policy – under different conditions of eligibility for treatment, such as treatment for employees and all dependents or only for the employee and his or her partner.

created, and confidentiality is strictly adhered to'). Under each heading the key activities are spelled out (the details of which have to be worked out in country offices).

Not all the corporate WPP have detailed operational plans attached. The VSO document is a guiding framework. Country offices have to develop locally appropriate policy implementation plans. (The South Africa field office's HIV & AIDS workplace policy 'pack' consists of a workplace policy, an action plan, a resource book and an emergency procedure book). Still, at international VSO level a policy implementation group has been installed, funds have been allocated and dates for implementation of components have been set – for instance in March 2005 all countries should have developed a 'country services paper'. The policy of BZ likewise does not include an activity plan, but gives guidelines to country missions on how to develop their own operational plans and has a time frame for roll out.

A plan for monitoring and evaluation should be part of the operational plan. SNV expects field offices to routinely report on their activities and experiences using a special form in their quarterly and annual reports. The Cordaid draft WPP plans for HRM reports every six months on WPP activities; information for this has to be supplied by heads of offices/projects. The whole programme is expected to be reviewed every two years. VSO also reviews its policy every two years (which it just did for the first time in February 2005).

## **6 IMPLEMENTATION OF AN HIV & AIDS WORKPLACE POLICY**

### **Communication**

The usefulness and success of a WPP can only be measured through its implementation. To start with, a new policy should be communicated widely in the organisation to make sure all staff are aware of and understand their rights and the commitment and support they can expect from their employer. All managers should be made aware of the guidelines stated in the policy that will inform their actions when dealing with HIV & AIDS on the work floor.

It is advisable to have a special formal launch of the policy, as SNV did in an annual meeting with all field directors. VSO International – after evaluation of the implementation of its first policy – realised that it had omitted to do so and that any policy that needs commitment from the organisation and employees needs to be given a high profile roll out with adequate support to ensure that offices implement it effectively.<sup>19</sup> This was subsequently done in May 2005 with the revised policy.

Good practices of organisation-wide communication of the WPP are the following:

- Reproduce the policy as a small booklet (A5 format, 8-page text), translated into various languages, and distribute it to all field offices and within head office (SNV).
- In an annex give an example of an ARV treatment regulations form (1-page A4) that can be easily communicated (MSFB – see annex 7 of this report).
- Have a summary of the workplace policy displayed on the wall of offices, and also distributed to all staff (VSO).
- Directors should always discuss WPP when visiting field offices, because they are the ambassadors of the policy (SNV).

---

<sup>19</sup> Case study of UK Consortium on AIDS and International Development 2003

## Awareness raising, motivation and prevention programmes

Awareness raising, motivation and prevention programmes appear to be the most critical for successful implementation of a WPP. VCT and treatment services are often not taken up by employees because of the persistent stigma attached to sexuality and AIDS, fear of non-confidentiality and discrimination, and fear of losing one's job if found to be HIV positive. Therefore, organisations should take ample time for this phase, before implementing the treatment programme. BZ starts in all countries with awareness raising training by expert local groups before talking about counselling and treatment. VSO field offices use this stage of awareness and knowledge raising for participatory development of a WPP – so all staff members are involved and have input. A reported spin-off of education and awareness raising activities with staff is that there are more open discussions about HIV & AIDS, and frequent consultation of the staff by relatives, neighbours and friends (HIVOS, Harare).

Not all awareness and education activities are successful – convincing persons to change attitudes and behaviour is difficult. Just giving information, or having someone with AIDS tell a personal story, might not be enough to decrease the stigma and false rumours on AIDS (as experienced by VSO Malawi). Participatory training sessions for awareness raising and education should therefore also be used. Good examples of useful activities can be found in Rau (2002), such as one-minute 'incomplete' role-plays<sup>20</sup>, in Peter Busse's awareness raising training (via VSO) and in Oxfam (2004) 'An introduction to mainstreaming HIV & AIDS in projects and programmes'.<sup>21</sup> An organisation or field office should identify and network with local organisations that are good in training – especially in awareness raising training and sensitisation on stigma, behavioural change, etc. These local organisations will know better what are culturally acceptable ways of giving messages and training than international organisations.<sup>22</sup>

Awareness raising and motivation activities should be ongoing and regular, and should take place in a variety of formats: training, pamphlets, newsletters, annual special retreats or workshops (VSO Malawi tries to do this). From Heineken, PAI has figures to prove that education and motivation activities have to be ongoing; after every activity there appears to be an upsurge in uptake of VCT. However, this upsurge is transient – possibly explained by the fact that every activity is 'appealing' to a different group of persons. Good practice is that *everybody* from the office attends the training sessions, thus also expat staff and staff who (think they) know everything already. In this way people who fear they might be HIV positive or are already on treatment do not feel they expose themselves by going to the training (BZ).

Concerning prevention activities: most field offices have free condoms, either in the toilets, in a special corner, or in the reception area. Some have male *and* female condoms (VSO South Africa). Most provide access to PEP treatment for medical accidents, after car accidents and sexual assault, and provide access to PMTCT. Considering the emergency of PEP, the HIVOS Harare office pays straight away for PEP treatment because it would take too long for the insurance company to release the money (the insurance company covers PEP and ART). MSFH missions in rural areas keep a stock of PEP for one week, and get the rest later from the capital.

---

<sup>20</sup> A one-minute 'incomplete' role-play raises an important social issue but leaves it unresolved. The cast asks the audience to discuss the issue. Usually a vigorous discussion starts (Rau 2002: 89 - from the workplace programme of the Kenyan Port Authority).

<sup>21</sup> This manual is not really for internal policy development, but can be used as a first awareness raising participatory workshop with staff – one useful section is on discrimination and stigma (Oxfam 2004).

<sup>22</sup> A consultant interviewed for this study reported on training in Kenya by a non-local organisation that used a straightforward and bold approach regarding sexuality that was offensive to the participants. The result was that the training did not reach the objectives of sensitisation of participants for HIV & AIDS problems.

## Treatment and care programme

Generally the uptake of VCT and treatment is much lower than expected based on the HIV prevalence in the general population.<sup>23</sup> The main reason for this is that staff members fear that by accessing the services, through lack of confidentiality, they will expose themselves as HIV positive and thereby risk discrimination and loss of their job. Thus, ensuring confidentiality in a treatment programme is a precondition for uptake and staying on treatment. Employers should put in place regulations for this, and communicate these to staff.

For their treatment programme, organisations have to set up networks outside the workplace (for VCT, CD4-count, treatment, insurance companies, counselling, etc.) after having assessed the availability and quality of these services and whether these ensure confidentiality of treatment. They have to explore the availability of local insurance policies, whether they accept HIV-positive persons, cover ART, can be upgraded, and whether a special arrangement can be made for organisations that have an HIV & AIDS workplace policy with a strong prevention component.<sup>24</sup> Organisations sign contracts with laboratory and treatment centres including agreements on tariffs.<sup>25</sup>

Ensuring confidentiality is easiest when treatment is covered by a health insurance (as is the case in the HIVOS Harare office and VSO South Africa). It is more difficult to maintain when the office pays for the treatment directly to a health institution. Organisations have made various regulations to ensure confidentiality. A common arrangement is that only one person in the office or only the doctor (who has an oath to respect confidentiality) has a list of eligible persons who are identified with numbers. Others who get the bills only see the numbers, and office reports only reflect total numbers (MSFB, BZ). It is realised that confidentiality is more difficult to keep in smaller offices.

One example of a situation in which confidentiality could not be ensured with a resulting low uptake of VCT and treatment came about because the clinic chosen for treatment was too small and staff were only sent there for AIDS-related issues (VCT, CD4, ART). Even with a confidentiality system in place everyone knew who was HIV positive (MSFB). MSFB suggested that the same clinic should be used for all medical treatments.

To facilitate confidentiality, other organisations have contracts with more than one centre or clinic and staff can choose themselves where to go. Providing written information on facilities for VCT, treatment, counselling, etc., is very important, so staff can know about these places without having to ask someone. UNICEF Angola sends monthly updated emails to all staff on where to go for VCT, treatment, etc. VSO South Africa and ICCO Eritrea have a list of centres attached to their policy documents.

Privacy should not only be guaranteed in the testing, counselling and treatment centres, but also in the office. Care should be taken that information on HIV status is not accessible to others in the office. Following the way files from the VCT and treatment centres enter and travel in the office may reveal that in many places the information is not confidential.<sup>26</sup>

Experiences show that a *good start* of a treatment programme is critical for further success (PAI, MSFB). The start is a challenge, because in the beginning often the most serious TB and AIDS cases report for VCT and treatment – these persons are not so concerned about the stigma. The problem is

---

<sup>23</sup> As an illustration: MSFB reports that of 5500 national staff in high HIV prevalence countries only 28 are on ART.

<sup>24</sup> The American International Insurance Company in Thailand gives 5-10% discount for companies with strong HIV & AIDS workplace policies (ILO 2004).

<sup>25</sup> MSFH DRC collaborates with Goma Hospital and they use a list of tariffs for tests, treatment and consultations for patients that is based on the different phases of HIV infection and the number of months on treatment.

<sup>26</sup> The name may be on an envelope from the VCT or treatment centre and everyone knows that in such envelopes there are files of AIDS patients; the messenger puts the envelope in the in-tray, which is accessible to everyone, or open on desks of financial officers; cabinets may be not locked, etc. (SNV study of paper-trail in field offices).

that these persons are difficult to treat and may even die. If the other staff members are not knowledgeable, they may attribute this to the weakness of the treatment programme and may not volunteer for VCT. Another point of concern is problems with non-adherence to treatment. Therefore adherence counselling should be part of treatment programmes (PAI, MSFH DRC). Heineken has 93% adherence – which is an indication of good counselling services (in company clinics)

A critical and practical question is whether it is possible to give central guidelines to country offices to identify appropriate local insurance companies and treatment services. VSO gives guidelines; MSFH, MSFB and Cordaid want their country missions to identify these services. SNV initially also asked their country directors to identify services. Especially for non-medical NGOs this may be difficult in most countries that generally lack high-quality services. It is possible to hire specialists for this purpose: Oxfam had two consultants working on identifying appropriate high-quality services in East and Southern Africa. PharmAccess International (PAI) conducts country visits for clients (BZ, SNV, Heineken) to assess all relevant local services and to help build up a network of affiliated clinics and laboratories. They also continue to monitor the quality of these services.<sup>27</sup> If needed, PAI trains affiliated doctors in administration of ARVs and adherence to treatment. Based on the assessment visits they also make two-page country fact sheets with all relevant information for prevention and treatment programmes (see annex 8 for Fact Sheet Angola, WFP HIV & AIDS programme).

### **Monitoring of implementation**

Not much information is available yet on actual monitoring of implementation of HIV & AIDS WPPs. There is no feedback on the costs of programmes, although in general organisations have reported that they have spent less than budgeted for.

At the end of March 2005, SNV got its first quarterly reports on implementation of the activity plan in the different countries. There was a big variety in progress, with some countries having done all activities as planned and others near to nothing. It was striking that whether a field office had started implementing the plan or not was not related to the HIV prevalence in the particular country. According to one of the SNV respondents for this study, the fact that some countries started the implementation and others had not depended mostly on the motivation of the director and others in the office. Based on personal experience, this respondent said it requires a change of mind that one should and can do something about the HIV & AIDS problems. The person in SNV HQ responsible for the monitoring reports intends to take action based on the field reports, using some as an example of good practice for others and investigating why others have not been able to progress.

VSO has revised the first policy of 2001 and identified insufficient communication and monitoring of implementation as problematic. Moreover, it identified the need for a more comprehensive policy, greater emphasis on education and training, and a review of ART provision (ART is now more available and reduced in price compared to 2001).

PAI monitors VCT and uptake of treatment in affiliated centres for their clients and has figures on the Heineken treatment programme. Generally uptake in Heineken breweries is quite high among staff – in Rwanda 75% of the workforce and 62% of the spouses have reported for voluntary HIV testing and counselling (VCT). The uptake of HAART by HIV-positive individuals was even higher: 90% of HIV-positive workers and 79% of HIV-positive spouses have been enrolled in the Heineken HAART programme.<sup>28</sup> PAI thinks that the reason for high uptake among employees (usually men) may be

---

<sup>27</sup> PAI installs a patient information database in the affiliated clinics – the HAART management system (HMS) – that monitors the quality of care provided. They make annual visits to affiliated clinics to assess quality and audit the confidentiality system – payment regulations should ensure anonymity even to the employer.

<sup>28</sup> PAI conducted anonymous HIV testing among Rwanda Breweries staff and dependants during a special day (with consent of the workers). In this way PAI knew the HIV prevalence among workers and could compare this to the data collected in the Heineken HAART database.

that in breweries there is a culture of trust and good employership. Additionally, the awareness raising and prevention activities were going on for about ten years before a treatment programme started. A point of concern is that uptake among spouses is lower than among employees. This calls for more focused IEC for these populations.

## **7 TAKING RESPONSIBILITY: CONCLUSIONS AND RECOMMENDATIONS**

### **Why employers should take responsibility**

There are four main reasons why organisations working in high HIV prevalence countries should have an HIV & AIDS WPP. The first is to be a socially responsible employer and the second is to provide guidance for managers on how to deal with HIV & AIDS related issues among their staff. The third reason is strategic: it is a way to give staff the experience of and skills (not only knowledge) needed to work with partner organisations on internal mainstreaming and to feel confident in discussing AIDS with partners. The fourth reason is that AIDS among staff (and partner organisations) may negatively impact costs, output, efficiency, effectiveness and quality of the projects and programmes and a WPP gives instructions on how to counter this possible impact.

These reasons apply to all organisations that have Dutch, other expat and local national staff working (also part-time) in high prevalence countries – all these persons are at risk of contracting HIV. Also for not (yet) high HIV prevalence countries, organisations could start addressing HIV internally as a proactive measure – as some VSO country offices are doing.<sup>29</sup>

Can Netherlands-based development organisations be obliged to take responsibility? Some development organisations that do not have an HIV & AIDS WPP are proposing that their partner organisations *should* have such policies, otherwise they cannot be a partner anymore (HIVOS) – others say you cannot be so patronising. In a similar vein, PSO or BZ could ask Dutch development organisations to address HIV & AIDS internally as an assessment criterion for funding because it belongs to the code of good conduct!<sup>30</sup>

**Conclusion:** *An HIV & AIDS workplace policy is a sign of responsible employership, provides guidance for managers, is of strategic advantage and may be cost-efficient.*

### **Responsible for whom and for what**

All organisations that work in high HIV prevalence countries should take responsibility for both local national and Dutch and other expat staff by addressing HIV & AIDS internally. Most organisations see the need to take responsibility for their national staff in high HIV prevalence countries, but do not find this necessary for their Dutch and other expat staff. The latter are covered by comprehensive health insurance in case they become HIV positive and employers consider them to be responsible for their own HIV risks and risk-taking.

Organisations that employ national staff *need* to have an HIV & AIDS policy or protocol, stating the employer's responsibility for prevention, treatment, care and support of their employees and a certain number of dependents. The employer's responsibility should be determined on the basis of equity; all types of local national employees should be equally treated – from the director and the 'indispensable' trainer in participatory techniques to the 'replaceable' driver.

<sup>29</sup> VSO China, still a low HIV prevalence country, reports how the participatory process of developing a policy (following the corporate guidelines) raises awareness and creates discussions with staff on issues surrounding stigma as well as individual rights and responsibilities.

<sup>30</sup> Suggestions made by Jos Dusseljee and Roel Snelder.

Organisations that send Dutch and other expat staff to work full or part-time in high prevalence areas may not need comprehensive workplace policies for them, but they should address HIV & AIDS and take some responsibility for their employees. Employers and employees should not consider HIV & AIDS to be a problem faced only by the national staff. There are many risks of contracting HIV in high prevalence countries: an occupational accident, an accident that requires a blood transfusion, sexual assault. Unprotected sexual contact may be a result of work hazards because of working in difficult conditions such as emergency aid, frequent travel, being single, working abroad for a longer period, alcohol abuse, etc. Responsible employership would imply taking responsibility for staff who travel from headquarters and consultants by 1) ensuring awareness raising and 2) giving information on availability and quality of local services for PEP, prevention, counselling and HIV treatment – even if these staff are insured against all medical costs.<sup>31</sup>

**Conclusion:** *For all staff working in high HIV prevalence countries, both nationals and expats, employers should take responsibility for awareness raising, prevention, treatment and care of HIV & AIDS.*

### **How to develop an HIV & AIDS workplace policy**

Organisation-wide ownership and the mandate of senior management and the board are the critical conditions for successful development of an HIV & AIDS WPP. Senior management and the board have to be convinced of the importance (see the 'why' above).

Policies may be developed by a steering group or task force, possibly with the assistance of consultants. The two main advantages of involving consultants in developing the policy document are firstly the commitment of senior management and the board, since the organisation *pays* for the consultants, and secondly that consultants have the time to do the job. It is important that the consultant works in the HRM department and acts as a broker and motivator between different departments and that a steering group is formed around the consultancy that has a broad anchorage in the organisation (example SNV). Consultants should never just give the solutions, but facilitate a learning process among the people they work with, so that they become motivated and empowered to continue the process once the consultants leave – this means that consultants should plan for phasing out their involvement.

A task group in the organisation, with the mandate of senior management and the board, could also do the job without the assistance of consultants, provided there is representation of all relevant sections including the board and members of staff on fixed contracts who know the organisation. In most Share-Net member organisations there are knowledgeable persons who can take the lead, also because they are supporting partner organisations to develop a WPP.<sup>32</sup> The usual problems with a task group developing and writing the policy are lack of time and/or the mandate of senior management. The advantage is that there is more ownership and that it is (probably) cheaper for the organisation.<sup>33</sup>

Organisations should not adopt blueprints, but develop a policy tailored to the organisation. There are many guidelines and manuals they can consult, as mentioned in this report. Depending on the type of organisation and staff, the organisation may develop a comprehensive policy with all components, including a treatment and care programme, or just a protocol stating the employer's commitment.

---

<sup>31</sup> Informants cited several examples of situations that caused expatriate staff to be exposed to HIV and that required tests and PEP, including a car accident, rape, and unprotected sex after alcohol abuse. One informant reported that the rape of an expatriate woman in the country made others ask their director and HRM manager how their organisation was prepared to act if such a thing happened to them.

<sup>32</sup> Because SNV was at that time not involved in AIDS work with partner organisations, they felt they did not have the expertise to develop an HIV & AIDS WPP without consultants. AIDS has now become one of the SNV themes (since 2004).

<sup>33</sup> A cost-benefit analysis has not been done – of course an organisation's own staff also cost money.

It is useful to benchmark with policies of similar organisations. The financing of treatment and care programmes are especially issues of concern to management. A calculation of costs under various conditions of eligibility should be provided, before management and board can accept a policy – possibly the involvement of consultants is needed for such a calculation. Organisations can also decide to pool their resources for financing treatment. There were some suggestions by respondents in interviews: 1) All organisations working in high HIV prevalence countries could commit one percent of their budgets to HIV treatment, so that there would be a sustainable central fund for treatment (Jos Dusseljee) and 2) a pooled insurance policy could be adopted with other NGOs who work in a country (MSFH).

To work out the details of awareness raising, prevention and treatment programmes (such as identifying local prevention partners, VCT centres, treatment centres, etc.) organisations could consider involving PAI, as BZ and SNV did. These assessments of local organisations and centres are in some (regions in) countries difficult to make, especially by non-medical HRM managers and field directors. However, the advantages of having the HRM officer and/or field director make the assessments and identify services rather than outsourcing these tasks to a consultancy firm are a higher sense of ownership and a sense of responsibility for ensuring confidentiality and non-discrimination in the workplace. If several development organisations would decide to involve PAI, and link up with the SNV and BZ initiatives, this could reduce the cost of the PAI consultancy services. The PAI tentative proposal to Dutch organisations is to have a subscription system on updated country fact sheets. The first fact sheet would be free, and from the subscription fees, PAI could pay for update visits. It is important to update information, because TRIPS, availability and price of medicines, regulations and laws, etc. change quickly. SNV and BZ, both working with PAI, would welcome more organisations to join.

**Conclusion:** *'The process is as important as the contents' (Quote of Russell Kerkhoven). HIV & AIDS workplace policy should be tailored to the organisation and developed by an organisation-wide task force and possibly consultants, with the mandate of senior management and the board; firm anchorage and broad ownership are key conditions.*

## Implementation

Organisations that offer treatment and care programmes should concentrate on the awareness raising and motivation programmes first, because these are most critical for the success of the treatment programme. Stigma, fear of losing one's job and lack of confidentiality hinder uptake. Especially in organisations where there is a strong hierarchy and there is no culture of trust, staff will not take up treatment. A positive example seems to be the corporate culture in Heineken breweries, where there is a culture of trust. Staff is convinced of good employership and confidentiality – many persons are on HAART.<sup>34</sup>

The author recommends that organisations embark on qualitative country/culture specific action research of conditions that will enhance uptake of offered VCT and treatment services. Qualitative research can explore the corporate culture in an organisation or office; the attitudes, power relations, gender relations, safety, way of talking about sexuality (jokes), denial of problems. If the culture is one of hierarchy and fear of losing one's job – staff cannot be expected to talk openly about their HIV status. The 'culture' may be dominated by male staff who, after getting paid, get drunk together and visit prostitutes or exploit poor women. If the research finds that the corporate culture increases the risk of HIV infection (for any person in or outside the office) – the organisation has to work on changing this culture.

---

<sup>34</sup> It is striking that *none* of them are *openly* HIV positive, which indicates that they trust their employer more than their fellow-workers.

**Conclusion:** *In implementation of a HIV & AIDS workplace policy, the awareness raising and prevention programme is critical for the success of a treatment and care programme; action research may direct an organisation-specific awareness raising and prevention programme.*

## **Guidelines**

The following brief guidelines – which are underpinned in the previous sections – may serve as a checklist for Share-Net organisations, or devoted individuals within these organisations, intending to initiate the development of HIV & AIDS responses in the workplace, either a policy or a protocol.

- Advocacy and lobbying, if needed, by a group or individuals who see the need for an HIV & AIDS internal response, to secure the mandate and support of senior management and the board of directors. Possibly invite peer organisations with a WPP to present their experiences.
- Install an organisation-wide task group or steering committee to start the process of developing HIV & AIDS workplace responses, possibly with input by a consultant (who can serve as broker, moderator, and resource person and to do the jobs that cost a lot of time).
- Make an activity plan for the task group, set dates and responsibilities.
- Appoint a small writing team (if no consultant is involved).
- Use guidelines, manuals and checklists for developing a WPP (see references in this report).
- Make a situation analysis (especially important with field offices and national staff): what impact does HIV & AIDS (possibly) have on employees and their work, what are the local policies related to HIV & AIDS, HIV & AIDS epidemiology, and available prevention, VCT, treatment and care services/organisations.
- In the task force discuss the WPP of similar organisations – (the Cordaid policy with 'layered' commitments and responsibilities and programmes may be particularly useful).
- Continuously keep senior management and the board updated and involved in decisions.
- Present a draft policy to the steering committee (if prepared by a consultant) and to directors and senior management who have to make decisions on details; use benchmarking with similar organisations – for instance on eligibility, treatment, condom distribution, costs.
- Secure funding – make a calculation of costs with and without WPP including treatment (cost of treatment compared to cost of sickness, absenteeism, loss of staff, etc.).
- Get input from field offices on the draft.
- Finalise WPP document.
- Write an operational plan including timetable, persons responsible, output and plan for monitoring.
- Launch the policy organisation-wide with active support of directors, print in attractive and handy format (in different languages if necessary) and communicate and distribute to all staff.

## **Follow-up by Share-Net**

Share-Net facilitated this study in its role as a platform to support and motivate further development of HIV & AIDS WPP among its members. The study results indicate that more Share-Net members than before have started the development of internal HIV & AIDS responses. Some of the organisations are more positive now and do recognise the need to have a policy for HQ staff as well as for expat and national staff. Share-Net, as a platform for exchanging experiences, dialogue and discussion, should further guide and support its members in this process of developing an HIV & AIDS WPP. A first concrete follow-up to this study will be the presentation of the results to its members. The PSO learning Carousel on HIV & AIDS and capacity offers another opportunity to present and discuss the results of the study, which is intended to motivate organisations to take further action and to identify training needs. It is strongly recommended that organisations coordinate and cooperate closely with other parallel processes regarding HIV & AIDS, capacity building and WPP, in which organisations such as PSO and SAN! play a critical role.

## **ANNEX 1 REFERENCES**

### **Share-Net document**

Aantjes, Carolien 2004

Human resource management en HIV & AIDS. Verslag van een Share-Net bijeenkomst op 21 juni 2004.

Download from: <http://www.Share-Net.nl>

### **Studies of workplace policies**

Aantjes, Carolien 2004

Developing an HIV & AIDS workplace policy for SNV. Reflection and lessons learned. ETC  
Crystal

Fleming, Yvette 2004

State of affairs on HIV & AIDS workplace policies. Background Paper. Amsterdam: Stop Aids Now!

Kerkhoven, Russell & Marianne Löwik 2004

Human resource management and HIV & AIDS – a study among Share-Net members. Share-Net: Study report.

Download from: <http://www.Share-Net.nl>

O'Grady, Mary 2004

Managing HIV & AIDS in the workplace: Examples of nine non-governmental organisations in South Africa, Zambia, and Zimbabwe. Oxfam International.

UK Consortium on AIDS and International Development 2003, Case studies:

- Oxfam GB – Central policy with regional implementation
- Experience of people living with HIV & AIDS
- VSO – updating existing policies
- UNICEF – Minimum standard guidelines supported by a step-by-step implementation guide
- Save the Children UK – guidance for developing chronic illness policies at country level
- ACORD – Introducing a strategy while restructuring
- Christian Aid – Central policy with regional implementation
- DIAGEO Africa – Global guidelines for HIV & AIDS policy
- International HIV & AIDS Alliance – Rolling out experiences to partners

Download from: <http://www.aidsconsortium.org.uk>

### **Guidelines and manuals for internal mainstreaming and HIV & AIDS workplace policies**

Holden, Sue 2003

AIDS on the agenda: Adapting development and humanitarian programmes to meet the challenge of HIV. Oxfam GB.

[http://www.oxfam.org.uk/what\\_we\\_do/issues/hiv aids/aidsagenda.htm](http://www.oxfam.org.uk/what_we_do/issues/hiv aids/aidsagenda.htm)

Holden, Sue 2004

Mainstreaming HIV & AIDS in development and humanitarian programmes. Oxfam GB.

Download from: <http://publications.oxfam.org.uk/oxfam/display.asp?isb=0855985305>

ILO 2001

Code of practice on HIV & AIDS and the world of work. + A guide to the manual.

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

ILO 2003

Workplace action on HIV AND AIDS: identifying and sharing best practice. Geneva: ILO.

Download from: <http://www.ilo.org/aids>

International HIV & AIDS Alliance 2004

Developing workplace and medical benefits policies to support staff with HIV. Brighton: International HIV & AIDS Alliance.

Mullins, Dan 2002

Mainstreaming HIV & AIDS into development: What it can look like. Oxfam GB.

NOVIB AIDS project group 2002

Towards HIV & AIDS competent organisations – internal document.

Rau, Bill 2002

Workplace HIV & AIDS programmes. An action guide for managers. Arlington: Family Health International.

[http://www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/Workplace\\_HIV\\_program\\_guide.htm](http://www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/Workplace_HIV_program_guide.htm)

Swiss Agency for Development and Cooperation 2004

Mainstreaming HIV & AIDS in practice. A toolkit. Bern: Swiss Agency for Development and Cooperation, Federal Department of Foreign Affairs.

UK Consortium on AIDS and International Development 2003

Working positively. A guide for NGOs managing HIV & AIDS in the workplace. London: UK Consortium on AIDS and International Development.

Download from: <http://www.aidsconsortium.org.uk>

VSO 2004

HIV & AIDS mainstreaming guide for VSO offices. VSO.

<http://www.aidsconsortium.org.uk/MainstreamingWG/Mainstream%20Downloads/VSOMainstreamGuide2004.pdf>

### **Background on HIV & AIDS**

Barnett, Tony & Alan Whiteside 2002

AIDS in the twenty-first century. Disease and globalization. Hampshire and New York: Palgrave Macmillan.

International Labour Organisation 2004

HIV & AIDS and work: global estimates, impact and response. Geneva: ILO.

Online book of the University of California San Francisco School of Medicine

<http://hivinsite.ucsf.edu/InSite>

### **HIV & AIDS workplace policies and reference papers**

- Cordaid HIV & AIDS internal policy and guidelines (2005)
- Heineken's HIV & AIDS policy. Contribution of a private company. January 2002
- HIVOS Harare regional office (final draft June 2004)
- ICCO Ethiopia field office (draft)
- MSFB 2001 HIV & AIDS care for national personnel – reference paper
- MSFH HIV & AIDS national staff policy (draft 2003)
- MSF-Holland, Democratic Republic of Congo mission (draft 2004)
- Netherlands Ministry of Foreign Affairs: HIV & AIDS workplace policy and guidelines for posts for implementation of HIV & AIDS workplace policy BZ (beleidsnota HIV & AIDS personeelsbeleid BZ. Richtlijnen posten ter uitvoering van HIV & AIDS personeelsbeleid BZ)
- Plan of action. Royal Netherlands Embassy South Africa. June 2004
- PowerPoint presentations on WPP VSO Namibia, China, South Africa, Ethiopia
- SNV Corporate HIV & AIDS policy 2004 and 2-year HIV & AIDS activity plan 2004-2006.
- The international VSO workplace HIV & AIDS policy for staff and volunteers (2005)
- Workplace policy HIV & AIDS VSO Namibia

## ANNEX 2 RESPONDENTS

date 2005	name	organisation	function
31/1	Roel Snelder	PSO**	Senior policy advisor AIDS, knowledge and learning centre
31/1	Irma Hermelink	SNV**	M & E implementation HIV & AIDS policy, HR advisor
2/2 en 23/2*	Geertje van Mensvoort	CORDAID	AIDS policy officer
4/2*	Jos Dusseljee	ETC Crystal	Consultant
4/2	Carolien Aantjes	freelance consultant	Consultant SNV policy
7/2	Michiel Lekkerkerker	MSF Holland	Officer responsible for expat health
9/2	Willeke Kempkes	ICCO	Policy advisor HIV & AIDS and health
16/2	Arjen Mulder	VSO	Programme officer HIV & AIDS (programme development and funding advisor)
17/2	Karina Balyan	Red Cross	Public health officer
17/2	Anny Peters	NOVIB	HIV & AIDS policy advisor
17/2	Annemarie Stolp	HIVOS	Junior policy advisor HIV & AIDS
23/2	Janneke Roos	freelance consultant	Consultant and coordinator of EU National AIDS programmes in Philippines, and Cambodia
25/2	Steve Tahuna	VSO Malawi**	Programme manager HIV & AIDS
11/3*	Madeleen Wegelin	KIT	AIDS section
14/3	Tobias Rinke de Wit	PharmAccess International	Director of advocacy and operations research
14/3	Liz Ostergaard	PLAN Nederland	Programme officer for Africa, senior advisor health and HIV & AIDS (MFO grant)
21/3	Annemiek Koomen and Sandra Brouwer	Ministry of Foreign Affairs**	HRM juridical affairs for national staff and HRM affairs local staff region Africa – both also focal point for HIV & AIDS workplace policy
28/3*	Meinie Nicolai	MSF Belgium**	Director of operations (and 1999-2003 head of mission Ethiopia)
25/2* en 2/3*	Connie Valkhoff***	Fair Trade**	Account manager Fair Trade assistance
13/5	Russell Kerkhoven	PSO**	Director knowledge and learning centre (former consultant for SNV's HIV & AIDS WPP)
19/5*	Paul Allertz	SNV**	Policy advisor planning and monitoring department

\* by telephone

\*\* not Share-Net member organisation

\*\*\* information about Heineken

## **ANNEX 3 DATA COLLECTION INSTRUMENTS**

### **Email questionnaire:**

#### **Inventory of HR and HIV & AIDS policies of Share-Net member organisations**

##### **A. Human resources** (an indication suffices, of figures for 2004)

1. How many staff are working at the head office (HQ)?
2. How many of these staff annually travel to countries with high HIV prevalence (CHHP)?
3. How many expatriates are sent out by your organisation annually?
4. How many of these expatriates are working in CHHP?
5. How many local staff does your organisation employ in CHHP?
6. Does your organisation work in structural development cooperation in CHHP?
7. Does your organisation work in emergency aid in CHHP?
8. How many field offices does your organisation have?
  - 8a If it has field office(s), in which countries?
  - 8b For each field office, how many expatriates and how many local staff are employed?

##### **B. Health insurance**

9. Does your organisation have a collective health insurance policy?
  - 9a for employees at HQ?
  - 9b for expatriates?
10. If it has a collective insurance policy, at which insurance company?
  - 10a Does this insurance cover ARVs?
11. If it does not have a collective insurance policy, how are employees insured against illness?
12. Is the organisation responsible for costs related to illness / health insurance for local staff?

##### **C. Status of internal HIV & AIDS policy (or protocol)**

*Please indicate with an 'X' what applies to your organisation*

13. We have not (yet) thought about an internal HIV & AIDS policy.
14. Not necessary, because HIV & AIDS is covered by a general health/illness policy.
15. In conceptual stage (we are planning to have one).
16. We are in the process of formulating a policy, \_\_\_\_\_ since \_\_\_\_\_
17. Draft policy document ready, \_\_\_\_\_ date \_\_\_\_\_
18. Policy document ready, \_\_\_\_\_ date \_\_\_\_\_
19. Action plan ready, \_\_\_\_\_ date \_\_\_\_\_
20. Policy is being implemented \_\_\_\_\_ since \_\_\_\_\_

##### **D. Preparation and support of staff concerning HIV & AIDS**

21. Do employees before travelling to CHHP get information and get prepared about HIV risks?
  - 21a If so, in what way(s)?

Does the organisation have a confidentiality person for questions about HIV & AIDS?

**E. Remarks and additions:** *All additional information is welcome*

##### **Questions answered by:**

Name:

Function:

Email:

Tel:

##### **Follow-up**

Could I possibly approach you for an interview about your organisation's internal HIV & AIDS policy?

If not yourself – who is/are the person(s) to approach?

Name:

Function:

Email:

Tel:

***Thank you very much for your cooperation***

**Share-Net study: Best practices of HIV & AIDS workplace policies**  
**Email questionnaire to field offices**

**Long questionnaire** (there was also a short version sent)

***Please insert your answers in the text***

**Respondent(s)**

- Names / background / position in the office/ type of involvement with internal HIV & AIDS policy

**Staffing**

- How many national and expat staff are working in the field office?
- How many of them are women / how many are men?
- What are their positions and functions?
- What type of contracts (short – long term)?
- How many volunteers in the country?

**Insurance**

- Is the national staff insured against sickness and if so, how – a collective insurance?
- Name of the insurance company
- Does the insurance cover VCT and ART?
- Is there a special arrangement with this insurance company for VSO staff (e.g. a discount)?
- Who is eligible (spouse(s), children?) for general health care insurance – under same conditions as staff?
- Who pays for the insurance and how much does it cost – per month/year?

**Process of developing the internal HIV & AIDS policy**

- Who (positions) took the initiative, when and why?
- Who was involved in the process of developing the policy, from within and outside the field office? Were all staff members involved from the beginning and in what way?
- Did you have a special AIDS working group? If so, who are the members?
- What were specific points for discussion/argument in the development of the policy (for instance eligibility, leave days, funeral costs – who brought these issues up)?
- What resource materials were used when developing the policy (ILO code of work, VSO international guidelines, policy of other organisation, national workplace policy, national labour laws, etc.)
- Was an implementation plan with activities and a budget included in the policy (how much was the budget)?
- How long did the process take?

**Implementation**

- Did you have a special launch of the policy? If yes, when and how? Do all staff members have a copy?

*Prevention and education activities*

- Did you have any awareness training for staff? If yes, what was the content, how many hours/days, which organisation gave the training, what training methods were used? Was special attention given to sexuality and gender relations? How do you and other staff evaluate the training, did it make a positive change, and if so, how?
- How do you practically try to deal with the stigma related to sexuality and AIDS?
- Did you have any training for family members?
- Are condoms available and, if so, where in the office? Who monitors uptake? How many a week/month? Who supplies/buys? What are the costs?
- What type of information on HIV & AIDS and STIs is available in the office? Where? Is it used?

*Care and treatment*

- How do you ensure confidentiality?

- How did the office select services for VCT and treatment and who did so? Did you make a formal contract with these centres? Are you content with the quality? What system have you set up to ensure confidentiality, payment, etc.?
- Which staff dependents are eligible for VCT and ART and treatment of opportunistic infections?
- How many staff and dependents went for VCT, if any; how many men (or boys) and how many women (or girls)?
- How many are HIV+, if any; how many men (or boys) and how many women (or girls)?
- How many are on ART, if any; how many men (or boys) and how many women (or girls)?
- Do you have staff in the office who are *openly* HIV+? If yes, what is the experience so far? How do other staff members react to this person, how do you manage? Any discrimination?
- Is there a special person in the office to whom staff can go with questions about HIV & AIDS – same for women and men?
- What organisations do you work with / consult with in the implementation of the policy – if any?
- Has anything changed since introduction of the policy (for instance more open atmosphere, talking about AIDS, uptake of VCT, STI treatment)?

#### **Monitoring**

- How is the implementation of the policy monitored and by whom?
- How much has the implementation cost till now? Starting from when?
- What are still issues for discussion, if any; who brought them up?
- Which circumstances hindered implementation of the policy, if any (e.g. weak VCT services, no reliable ART supply, no condoms or PEP, etc.)?
- Do you feel there are culture-specific factors that hinder or facilitate implementation of an internal HIV & AIDS policy? Influence of gender relations?
- What do you consider strong and weak points of the policy?

#### **Advice to others**

- What advice (do's and don'ts) can you give to other aid organisations that want to develop and implement an HIV & AIDS workplace policy?

#### **Is there anything else you would like to share?**

***Thank you very much for your cooperation.  
You will receive a copy of the final report***

## **In-depth interviews: Topic guide about HIV & AIDS workplace policy**

### **Respondent**

How involved is the respondent with internal HIV & AIDS policy?

### **Organisation**

Number of staff – types

Number of staff who travel to countries with high HIV prevalence

Consultants

Field offices, local employees

Collective health insurance? Does it cover ARVs?

### **Status of internal HIV & AIDS policy**

In process, draft ready, final, being implemented

### **Process of development of internal HIV & AIDS policy**

- Who took the initiative / how did it start (who was the 'instigator')?
- When was this?
- Was a situation analysis done – risks and impact of HIV & AIDS? Which methods were used?
- Separate policy, or part of health policy?
- Developing policy document – who was involved, also consultants?
- Problems?
- Involvement of board and senior management?
- How were employees involved – from the start? Were local employees also involved?
- AIDS working group / task force? Steering committee? Who were the members of the group, which departments, how often did they meet?
- Which guidelines did you use / benchmarking with other policies?
- How did you make decisions on eligibility for treatment?
- Who finally wrote the policy?
- Was an action/operation plan made?
- Budget – financing?
- Time frame

### **Implementation**

- Special launch and re-launch?
- Who is responsible for implementation?
- What activities have taken place?
- How were the awareness training and prevention programmes?
- How is uptake of VCT, PEP, ARV treatment, etc.?
- Was PharmAccess International involved? Cost of ARVs?
- Supply of ARVs?
- Who gives treatment (health providers/clinics)?
- How is confidentiality ensured?
- Problems, stigma?

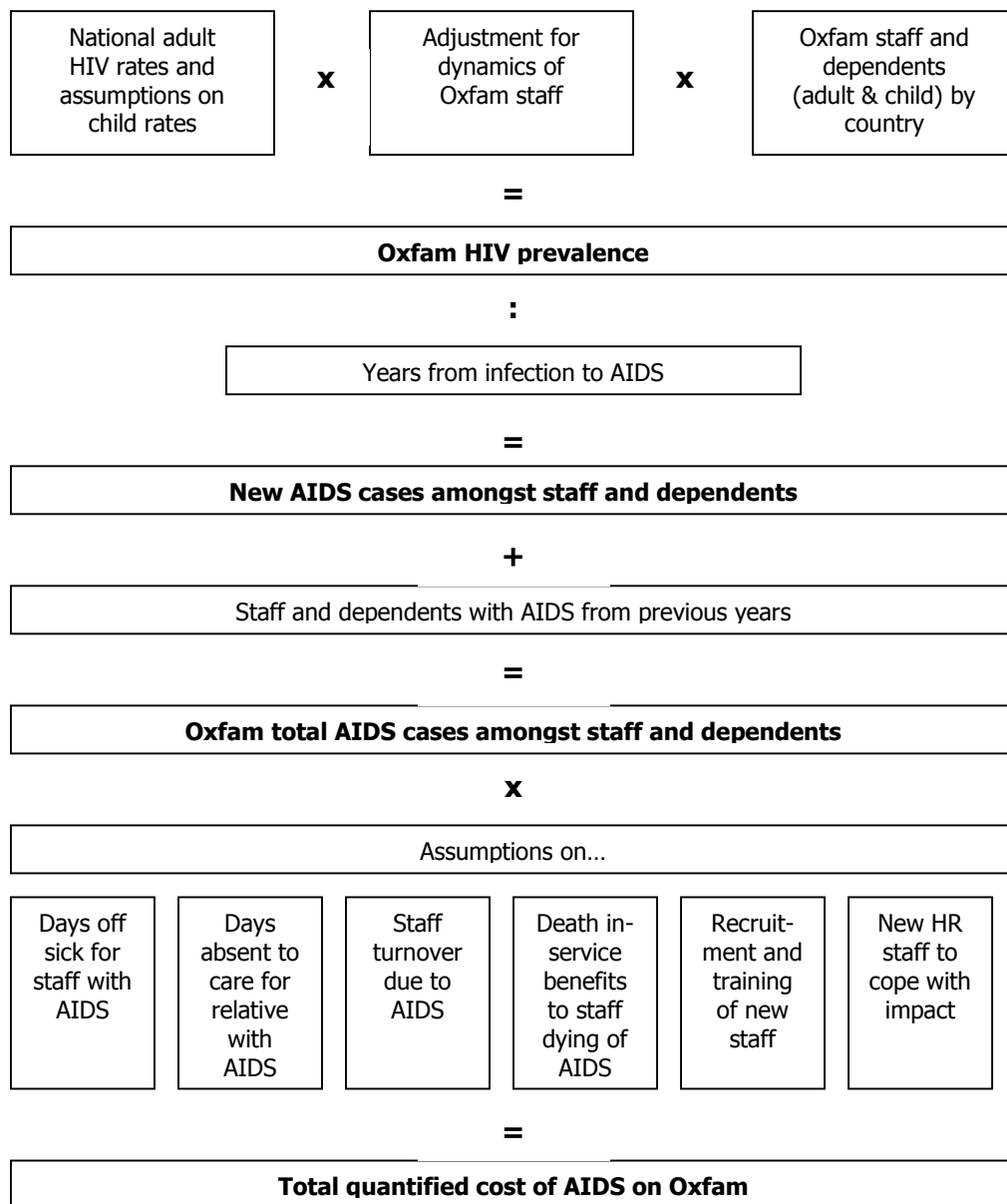
### **Monitoring**

- Who? How?
- Differences per country?
- Has something changed in the stigma of HIV & AIDS?
- Revision of policy?

### **Advice to others?**

## ANNEX 4 OXFAM GB's RISK ASSESSMENT MODEL<sup>35</sup>

Oxfam GB developed a risk assessment model in 2002. The risk assessment quantified the impact of HIV/AIDS on staff absenteeism, staff turnover, death-in-service benefits, recruitment and training costs and HR resourcing. The model was also used to estimate the cost of ART provision.



<sup>35</sup> UK Consortium on AIDS and International Development 2003: 8.

### 3: The VSO mainstreaming model

At the VSO staff conference in October 2003, PO staff reviewed successes and discussed challenges in mainstreaming. The following areas were recommended as priorities:

- ★ taking staff awareness of HIV & AIDS issues beyond awareness to sensitisation (and ultimately mainstreaming at the PO level)
- ★ implementing comprehensive workplace policies that accurately reflect VSO's position regarding HIV & AIDS and are adapted to specific country contexts
- ★ planning and programme development that considers HIV & AIDS and its impacts at all stages
- ★ M&E (monitoring and evaluation) and learning, including how best to share the body of good practice that exists.

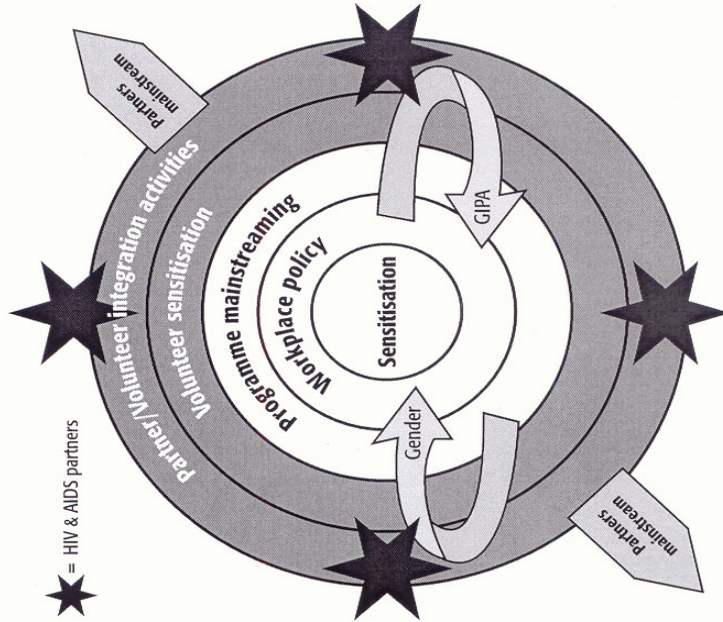
Participants developed a model shown in **Figure 2** to represent the stages of mainstreaming.

The model reflects the widely recognised view that any organisational body should look at internal mainstreaming first, before attempting to mainstream externally. Historically, however, many organisations, including VSO, introduced the theme of HIV & AIDS into programme work before looking at the structure and needs of the organisation.

The three inside rings of **Figure 2** refer to the internal parts of the organisation, the actual workplace. The third ring, 'programme mainstreaming', has an internal and external dimension, as the planning for programme work takes place at this stage. The two outer rings refer to the external environment in relation to, in this case, VSO programme offices. When it comes to 'partner mainstreaming', the model suggests starting with key partners. They can be encouraged and supported to look at their organisation using this model and to work through similar processes, putting their workplace at the centre and staff sensitisation as the first stage, then working towards organisational mainstreaming.

The stages do not necessarily constitute a chronological progression and activities from different stages may occur concurrently. Similarly, there may not be a very clear distinction between stages. Although this model was developed for use in mainstreaming HIV & AIDS, it can also be used for introducing mainstreaming around other themes, such as gender and disability.

**Figure 2: The VSO mainstreaming model**



<sup>36</sup> VSO 2004: 6.

## **ANNEX 6 CHECKLIST FOR DRAFTING AN HIV & AIDS POLICY <sup>37</sup>**

The points in the checklist can be considered paragraphs or provisions in the policy.

### **Introduction**

- Reason(s) why the company has an HIV & AIDS policy;
- Persons covered by the policy (some or all employees or different provisions for different categories of employees);
- Policy compliance with national and local laws and trade agreements;
- How the policy will be applied.

### **General considerations**

- Statement regarding the intent of the company to have an HIV & AIDS policy for application to company operations;
- Statement as to whether the policy is specific to HIV & AIDS or whether it incorporates HIV & AIDS into existing sections on life-threatening illnesses.

### **Elements relating to employment criteria**

- Statement that applicants and employees will not be screened for HIV as a condition of continued employment or promotion;
- Provision on circumstances under which an employee would be asked to be tested for HIV, including:
  - Explanation of the reasons why a request would be made for an HIV test;
  - Statement of whether the employer or employee would be responsible for paying for an HIV test;
  - Statement that pre- and post-test counselling would be provided for any employee who is asked (or asks) to take an HIV test;
  - Statement of the company response if an employee refuses to be tested;
  - Statement of the company's intention to keep all medical information, including results of HIV tests, confidential;
  - Statement of company intentions toward employees who, if required to be tested, are found to be HIV-positive;
  - Statement of the appeal, arbitration and resolution options for employees who refuse to be tested or who, if tested, are found to be HIV-positive;
  - Statement of the company's position toward insurance companies that may require an HIV test for various forms of coverage.
- Statement that the company is willing to make accommodations (such as less rigorous work or a different work environment) for employees who request such accommodations because of HIV infection;
- Provision that the company will maintain and enforce legal, acceptable and recognised occupational safety precautions to minimise risk of workplace exposure to HIV;
- Provision relating to the privacy of employee personnel records, including medical records;
- Statement prohibiting stigmatisation of and discrimination against employees who are (or who are suspected of being) HIV-positive.

---

<sup>37</sup> Rau 2002: 38-40

### **Elements relating to benefits and treatment for HIV-infected and HIV-affected employees**

- ❑ Provision of benefits related to HIV infection is likely to be an extension of existing benefit provisions. As part of an overall prevention programme, an HIV policy can explicitly refer to assistance in the treatment of STIs. As implied in the previous section of this checklist, workers with HIV/AIDS should receive the same type, level and form of benefits as other employees with serious illnesses.

#### ***Provisions include:***

- ❑ Statement about company and employee contributions to health and medical care, life and disability insurance, workers' compensation, social security and other retirement benefits, compassionate leave (for care-giving, funerals), death benefits for beneficiaries, treatment for opportunistic infections related to HIV and treatment for HIV;
- ❑ Coverage for dependents;
- ❑ Statement about company provision of or support for assistance in gaining access to life-saving treatments and drugs for HIV and opportunistic infections;
- ❑ Provision of or support for counselling and related social and psychological support services for HIV-infected and HIV-affected employees (and dependents);
- ❑ Statement that the company recognises the importance of peer-support groups and permits such groups to be formed and to meet on company property (during or outside of work hours);
- ❑ Legal support services. Although companies may worry about legal challenges, company support for employees (in-house or contracted out) to access legal advice can assist in safe-guarding dependents through preparation of wills, transfer of property and leveraging of public services.

### **Elements relating to workplace prevention**

- ❑ Statement that HIV & AIDS prevention is the responsibility of all employees, including senior management and supervisors;
- ❑ Statement about the leadership role of managers and worker representatives, both in the company and in the wider community, in addressing HIV & AIDS;
- ❑ Statement emphasising the importance of (and company expectations of) employees avoiding risky sexual behaviour;
- ❑ Statement referring to company and union responsibilities for maintaining an environment that reinforces safe sexual behaviours;
- ❑ Statement of company and union responsibilities for providing all employees with timely, accurate, clear and adequate information about HIV prevention, community support services, treatment options and changes in company prevention activities;
- ❑ Description of the HIV prevention components that will be available to employees. Recommended components include easy and regular access to male and female condoms, access to diagnosis and treatment of STIs, training of peer educators who will be accessible to employees and information about prevention and care services that exist in the community.

## **ANNEX 7      EXAMPLE ONE-PAGE TREATMENT REGULATIONS FORM<sup>38</sup>**

This is an example only. Each mission should draw-up its own 'treatment regulations form' and verify its legal implications with the national lawyer.

### **Treatment regulations form**

Below you can find the MSF regulations in regards of specific care for HIV & AIDS. You are requested to read these regulations attentively and make sure you understand the implications of these regulations.

- MSF commits itself to provide HIV & AIDS care and treatment for HIV-positive employees (and their legally defined close family members) as available at the location of the workplace.
- MSF will observe absolute discretion regarding the patient's medical status.
- Medical therapies prescribed should be in line with national guidelines or MSF guidelines. Alternative treatments will need prior approval from the medical department of the MSF head office in Brussels.
- MSF will reimburse the costs for available HIV analysis, care and treatment either through direct payment of bills or through reimbursement upon presentation of official receipts.
- The employee is requested to participate in maximum 20% of the costs (limited to maximally 20% of one's salary). The participation is independent of the number of persons per family under treatment.
- MSF commits itself for a period of maximum ... years for ARV treatment and treatment of opportunistic diseases for the MSF employee or his/her family members.
- In case of death of the patient, normal regulations as stipulated in the general health policy are applicable. Family members who are under ARV treatment or treatment of opportunistic diseases will continue to be paid for a period of maximum 12 months, the participation of 20% will be no longer required.
- In case the MSF mission stops or is forced to stop, the employment contract will automatically end, MSF will not be obliged to undertake payments other than those provided for in the internal regulations.
- Personnel leaving the organisation to work for another employer are requested to inform MSF on financial arrangements in regards of HIV & AIDS care with this new employer.

---

<sup>38</sup> MSFB 2001 HIV & AIDS care for national personnel – reference paper: 43.

**ANNEX 8  
FACT SHEET**

**PharmAccess**  
F O U N D A T I O N  
WFP HIV/AIDS Program  
ANGOLA

- Which clinic(s) provide reliable AIDS treatment, quality controlled by PharmAccess?  
Sagrada Esperanca Dr Rui Pinto – GP and Administrative Director  
Tel 309361 or Cell 91 501624 or Fax 309033  
[sagradaesp@ebonet.net](mailto:sagradaesp@ebonet.net)
  
- Which VCT centres can be recommended?  
IPMP Dr Manuel Pedro  
Tel 333346 or 92 327273  
[mpedro@netangola.com](mailto:mpedro@netangola.com)  
  
GOAL Mrs Juliet Wilson  
Tel 092 583993  
[goal-hiv@nexus.ao](mailto:goal-hiv@nexus.ao)
  
- Which prevention partners can be recommended?  
SOS International Mr Barry Nel  
Tel 311701/310131 or Cell 092 642601  
[barry.nel@internationalsos.co.ao](mailto:barry.nel@internationalsos.co.ao)  
  
GOAL Mrs Juliet Wilson  
Tel 092 583993  
[goal-hiv@nexus.ao](mailto:goal-hiv@nexus.ao)  
  
PSI Mrs Louisa Norman  
Tel 2443843 or 92 642661  
[louisa@psiangola.org](mailto:louisa@psiangola.org)
  
- Which labs provide reliable tests, quality controlled by PharmAccess?  
Sagrada Esperanca  
Tel 309361 or Fax 309033  
[sagradaesp@ebonet.net](mailto:sagradaesp@ebonet.net) (CD4 and VL test are sent to South Africa)
  
- Which (primary) health care insurance would be available for covering HIV/AIDS treatment and at which costs?  
None
  
- What are average prices of: clinical consultations, lab tests, counsellor visits, and insurance fees?  
Consultation: 45 US\$  
HIV test: 75 US\$  
CD4 test: 150 US\$\*\*  
Viral Load test: 250 US\$\*\*  
\*\*These tests are sent to South Africa

- Which 1<sup>st</sup> and 2<sup>nd</sup> line AIDS treatment schemes are realistic (approved by government, available, affordable, etc.)?

First line treatment Triomune from Cipla is prescribed - cost U\$45, or AZT, 3TC (or Combivir) + NVP or EFV – cost US \$125.

Second line treatment is also available, with various different ARV combinations, including protease inhibitors.

- Which pMTCT service can be recommended?

Sagrada Esperanca Dr Maria Elena Victoria-Pereira

Tel 309361 or Fax 309033

[sagradaesp@ebonet.net](mailto:sagradaesp@ebonet.net)

- Where to go in case of an emergency (rape, occupational hazard) to get post-exposure prophylaxis (PEP)?

Sagrada Esperanca Dr Maria Elena Victoria-Pereira

Tel 309361 or Fax 309033

[sagradaesp@ebonet.net](mailto:sagradaesp@ebonet.net)

- Which other local employers provide integrated HIV & AIDS packages to employees?

Royal Netherlands Embassy, American Embassy, WFP

- Where to go with (young) children?

Sagrada Esperanca Dr Maria Elena Victoria-Pereira

Tel 309361 or Fax 309033

[sagradaesp@ebonet.net](mailto:sagradaesp@ebonet.net)

- Where to find the UN clinic?

Name UN doctor: Dr Dario Alegria

Address UN clinic: UN Building, Luanda

02 331249 or 02 331181

## ANNEX 9 SHARE-NET MEMBERS AND OTHER ORGANISATIONS IN THE STUDY

members	HQ	HQ travel	expats	field offices	local staff	HIV & AIDS WPP
Aids Fonds-SOA Aids Nederland	90	2-4	-	-	-	Discussion operational staff with management to develop
MSFH	170		280	30	yes ???	Draft on hold since April 2003, mainly for local staff that has to be developed by country missions, DRC has draft policy
Cordaid	290		90	5 (Nairobi, Kinshasa, Afghanistan, Burundi, Indonesia)	about 140	WPP since May 2005
ETC Crystal						No
Hivos	94	10	3	4	52 (14 in Zimbabwe)	HQ no need, Harare office implements policy
ICCO	200		122 through PSO	Eritrea - DIA, Vietnam	11 in Eritrea)	No internal policy for HQ. Field office DIA – Eritrea, draft policy
KIT	460	40	-	-	no	No need, staff insured
KNCV	71	17	-	-	-	Interested, but have not yet thought about it
Nederlandse Rode Kruis	30	50			no	No, only International Federation has a policy, but not corporate for all national organisations
NOVIB	300	25-50	-	-	-	No, but document written by AIDS project group 2002 for AIDS competent organisations, that has to be discussed internally (OXFAM International has a policy– but it has field offices with national staff)
Plan Nederland	90	25	-	-	-	No, but PLAN International has a policy– also 9 field offices
Simavi	19	3-4		1 Tanzania	1	No, maybe for Tanzania
VSO Nederland (interviewed Malawi)		2-4	210	30	about 210	VSO International has corporate policy with guidelines for all national offices and field offices – VSO Netherlands will develop one
WPF	20	8	1-2	2	20	Not necessary – do AIDS work
PharmAccess international	30	yes nr??	yes ??	2 (Lusaka, Accra)		No
<b>Non-members</b>						
BZ – embassies Africa			232	21	343 + domestic staff 928	Yes – rolling out to 19 embassies since 2003
SNV			350	26	350	Yes 2003
PSO	30	400	-	-	-	No
MSFB (Ethiopia)			12	31	5500 (200)	Have corporate reference paper: HIV & AIDS care for national personnel, July 2001 – country missions to make their own WPP. 22 did; not monitored from Brussels