

A close-up portrait of a woman with a white headscarf and a white garment. She has a small gold nose ring and is looking slightly to the right with a neutral expression. The background is dark.

Experiences and Lessons Learnt

in the project 'Managing HIV and AIDS
in the Workplace' in South Indian
Non-Governmental Organizations

End Report Applied Research

**STOP
AIDS
NOW!**

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Prepared by: Dr. Winny Koster, Nienke Westerhof

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Winy Koster
Nienke Westerhof

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome	MSM	Men Having Sex with Men
AR	Applied Research	NACO	National AIDS Control Organization
ART	Antiretroviral Treatment	NGO	Non-Governmental Organization
BIRDS	Belgaum Integrated Rural Development Society	OI	Opportunistic Infection
BT	Budget Tool	PC	Project Coordinator
CBO	Community Based Organization	PLHIV	People Living with HIV and AIDS
CHAI	Catholic Health Association of India	RNABS	Rapid Needs Assessment and Baseline Survey
CSO	Civil Society Organization	SACS	State AIDS prevention and Control Society
FBO	Faith Based Organization	SAN!	STOP AIDS NOW!
FGD	Focus Group Discussion	SANISIP	STOP AIDS NOW! South India Project Society for Integrated Development in Urban and Rural Areas
FPP	HIV and AIDS Focal Point Person	SIDUR	SAN! South India Project Group
FSW	Female Sex Worker	SSIPG	Sexually Transmitted Infection
GDG	Good Donorship Guidelines	STI	Strengths, Weaknesses, Opportunities, Threats
GIPA	Greater Involvement of People Living with HIV and AIDS	SWOT	Technical Assistance for Policy Services
HIV	Human Immunodeficiency Virus	TAPS	Terms of Reference
ICTC	Integrated Counselling and Testing Centre	TOR	Joint United Nations program on HIV and AIDS
IDI	In-Depth Interview	UNAIDS	University of Amsterdam (Universiteit van Amsterdam)
IEC	Information, Education and Communication	VCT	Voluntary Counselling and Testing
ILO	International Labour Organization	WHO	World Health Organization
INP+	Indian Network for People living with HIV and AIDS	WPP	HIV and AIDS Workplace Policy
INSA-India	International Services Association India	YRG CARE	Y.R. Gaitonde Centre for AIDS Research and Education
LHIV	Living with HIV and AIDS		
MIPA	Meaningful Involvement of People Living with HIV and AIDS		



Executive Summary

This report presents the experiences of the STOP AIDS NOW! project ‘Managing HIV and AIDS in the Workplace’ in thirty-five non-governmental organizations (NGOs) in South India (SAN!SIP) that lasted from 2007 to 2010. The overall goal of this project was to strengthen the capacities of partner NGOs in South India to develop and implement HIV and AIDS related workplace policies (WPP), in order to create an enabling environment for the prevention of HIV, and care and support for people living with HIV and AIDS (PLHIV) among staff and their families.

The objectives of this end of project report are to:

1. Review the experiences of SAN!SIP, focusing on the structure, processes, and effects;
2. Focus on some specific themes which are important issues in workplace projects;
3. Identify promising practices and challenges, and so be able to provide recommendations for future projects for WPP development and implementation.

Study methodology

This report is based on findings from the applied research (AR) that was part of the project. The AR – in two phases, AR1 (2008) and AR2/3 (2010) – used quantitative and qualitative data collection at project, NGO, and staff levels. In AR1, fourteen NGOs and 138 staff were sampled; in AR2/3, twenty-four NGOs and 315 staff. Other sources of information for the end report were SAN!SIP project and workshop reports, the project baseline study of 2007, and case studies conducted in 2009. To fill some gaps in information,

self-administered questionnaires were sent to the different stakeholders in India, and those in the Netherlands were interviewed.

Project structure and approach

The SAN!SIP project structure was developed by the participating NGOs in several workshops, with facilitation by the Dutch project coordinator (PC). The project structure includes the local PC, his team, the host organization INSA-India, and the STOP AIDS NOW! South India Project Group (SSIPG) which is the deciding, facilitating and governing body with representatives from seven organizations. Another structure was added for effective implementation of the project and for sustainability and scale-up: the Technical Assistance for Policy Services (TAPS). The SAN!SIP project receives advice from the Dutch PC and the Dutch policy officers from STOP AIDS NOW! partners (Oxfam Novib, ICCO, Hivos, and Cordaid).

One of the main thrusts of the SSIPG was to organize capacity building programs. SAN!SIP organized several workshops, first to sensitize NGO directors for addressing HIV and AIDS in the workplace and then to build NGO capacity to do this. Regional language workshops aimed to sensitize and build the capacities of staff. During workshops and meetings, NGOs received various IEC materials and documents, with directions and guidance on WPP development. This toolkit comprised: the ILO document ‘ILO Code of Practice on HIV/AIDS and the World of Work’; the STOP AIDS NOW! documents ‘Good Donorship in a time of AIDS’ (Good Donorship Guidelines – GDG) and the Budget Tool (BT) ‘What’s it likely to cost?’; examples of WPPs of NGOs and corporate houses; and WHO documents.

WPP development and activities in NGOs

NGOs developed their WPP in a participatory way with involvement of staff at all levels, from directors to support staff. In AR2/3, 75% of NGOs had a final draft or a fully functional WPP in place. Most NGOs mainstreamed the WPP within other organizational policies, including those on gender, welfare, or health, or were planning to do so.

SAN!SIP considers it essential for effective WPP development and implementation for NGOs to have a focal point person for HIV and AIDS (FPP) and a committee. FPPs and the committee are the NGOs’ liaisons with the SSIPG and local PC, and oversee the

development and coordination of addressing HIV and AIDS in the workplace. In AR2/3, 70.8% of NGOs had appointed an FPP.

NGOs considered the resource package received useful for policy drafting. The ILO document was the most used and preferred, while NGOs made less use of the BT and GDG: these were considered too long and complicated, and some cited language as a barrier for usage. STOP AIDS NOW! launched the new ‘CSO guide for workplace policy development and implementation’ in June 2010.

Some NGOs started HIV and AIDS related activities for staff even before funding had been received. Awareness building of staff was the most common activity, and this increased over the course of the project. All NGOs conduct training programs and workshops for staff on HIV and AIDS issues. Almost all (96.8%) staff reported receiving information about basic facts of HIV and AIDS, and a high 88% of all survey staff in AR2/3 reported having received training in HIV and AIDS.

Effects

More openness about HIV and AIDS

The major effect of WPP development and implementation is increased awareness among staff about HIV and AIDS issues. More than half of the managers reported that the availability of IEC materials for staff had increased. This was reported by a similar 52.2% of staff in FGDs, and by 84.9% of staff in the survey. Because of increased awareness and knowledge, managers and staff reported more openness to talk about HIV and AIDS in the workplace; 54.5% of managers, 61.9% of staff in FGDs, and 87.6% of surveyed staff in AR2/3. Increased openness was most reported in non-HIV NGOs.

Linking, learning, and social networking

Linking, learning, and social networking are some of the main thrusts of STOP AIDS NOW! and SAN!SIP. SAN!SIP developed partnerships with different national and international organizations. The SAN!SIP workshops for partner NGOs helped in building linkages, and sharing experiences and knowledge. NGOs in AR2/3 mentioned that increased networking for services and information was an effect of the project. They network with a host of public institutions, such as the State AIDS Prevention and Control Society (SACS), ART centres, VCT centres, and other NGOs for project related work.

Access to services

Over the course of the project, more NGOs facilitated access to treatment, and VCT information and promotion have also greatly increased. VCT is promoted through training, encouragement, and by providing information on where to access it. NGOs facilitate access to treatment through medical reimbursements, networking with service providers, and supporting staff through leave and transport allowances. The medical schemes in most NGOs cover all staff, and sometimes also family members. Condom provision in the office remained a contested issue. While all NGOs promote condom usage in the community, only six organizations made condoms available for staff. However, a majority of staff, both men and women, were in favour of condom provision in the workplace.

Involvement of PLHIV

SAN!SIP actively promotes the GIPA (greater involvement of PLHIV) principle. SSIPG invited the three state networks for PLHIV to be SAN!SIP partner NGOs, and invited the Indian Network of People living with HIV (INP+) to be a member of SSIPG. PLHIV have been increasingly involved in the NGOs in different ways, either passively, as motivation for managers to develop a WPP, or actively, facilitating during workshops, engaging in advocacy to make staff aware of HIV and AIDS, and addressing the importance of tackling stigma and discrimination.

HIV stigma and discrimination

Stigma and discrimination reduction is a key component of effective HIV and AIDS management in the workplace. NGOs reported a shift in the mindset of staff with regards to HIV, in the form of reduced stigma and discrimination in the workplace. AR2/3 shows a very positive response to recruiting PLHIV, with very low or no reported stigma in work settings and highly positive attitudes expressed regarding working with HIV positive staff. In all NGOs, stigmatization and discrimination is considered a serious disciplinary offence that will lead to stringent action, up to and including termination of employment.

Disclosure and confidentiality

In AR2/3, three (13.6%) NGOs reported increased disclosure of HIV status as an effect of the WPP. In the initial research stages, some NGO managers had mentioned confidentiality as a possible challenge, and staff did not regard confidentiality as a priority.

However, AR1 found that seven out of ten NGOs had confidentiality as an element in their WPP, and three NGOs in AR2/3 had guidelines for maintaining confidentiality. A large majority of staff (96.2%) trust their organization to preserve confidentiality, and 52.1% believe that their NGO will take punitive measures if confidentiality is breached. A majority of 68% of surveyed staff confirmed increased confidentiality in their NGO; this is a very important indicator. Staff feel that their workplace is conducive for disclosure, as there is complete acceptance of HIV positive staff and confidentiality will be maintained.

Gender

Four NGO managers in AR1 (29%) and eleven in AR2/3 (46%) reported addressing gender issues in their NGO. They address gender as an element in their WPP, have a gender policy, have a committee to examine gender related issues and sexual harassment, and/or have sexual harassment guidelines. There were hardly any gender differences in terms of HIV and AIDS related knowledge, attitudes, and practices in the surveys. Managers and staff across all NGOs and levels felt that the WPP had not had an effect on gender in the workplace, since gender equality and equity in most NGOs is already practiced.

Sustainability

Lack of finances and waning interest of staff were considered a challenge and threat to sustainability. However, NGOs had started activities without receiving donor funds, and were clearly interested in making the WPP an institutional policy, which would be continued irrespective of funding availability. NGOs have measures in place or have thought of measures for continuing the policy. Sustainability strategies include: lobbying with other donors; earmarking part of the general organizational funds; raising money from the 'for profit' sector; and implementing activities that do not require additional money. So far, NGOs with a fully functional WPP have had to meet few or no policy related expenses, and therefore have not yet acted on these measures. NGOs have managed to implement effective, low cost activities by making use of their own strengths, for example by facilitating linkages with service providers from their own network, using internal capacities, or having committed staff contribute to a health fund; and by creating opportunities, such as inviting trainers from related organizations and investing in trainings for staff.

India is one of ten countries in the scaling-up of the STOP AIDS NOW! addressing HIV in the workplace project, building on the experiences of the pilot projects in Uganda, India, and Ethiopia (STOP AIDS

NOW! 2009). The scaling-up response in India which will involve 35 non-SANISIP NGOs across India and also PLHIV networks in Nepal, is spearheaded by INSA-India, including the SANISIP PC.

Promising practices and successes

Local ownership

The Indian structure has been implemented and operated well to create local ownership of the project. From the beginning of the project, the structure has been developed by the involved organizations and people.

WPP in a low HIV prevalence country

A project success is that 82% of the 35 SANISIP NGOs set up a policy on HIV and AIDS in the workplace in a low prevalence country. This means that NGOs see and integrate the importance of wellness and wellbeing for staff.

Participation of staff at all levels

Most NGOs involved staff in WPP drafting, either through consultation with all staff members or by sharing the policy with all staff once it was developed. Staff inputs were taken into consideration and incorporated into the policy. Translating the WPP into the local language facilitates broad accessibility. SANISIP facilitated the involvement and motivation of directors and senior managers through a sensitization workshop for them, and by involving them in setting up the project structure.

Adhering to GIPA principles

Involvement of PLHIV – either as staff members or representatives people from positive networks invited as speakers – is a good practice to sensitize staff members on the importance of addressing HIV and AIDS in the workplace and reducing stigma and discrimination.

Not waiting for donor funding to start WPP activities

It was a promising finding that NGOs started implementing HIV and AIDS related activities, mainly awareness raising and sensitization, even without receiving donor funds. This mainly involved discussions among staff and hanging posters on the wall.

Providing condoms for staff

Although a contested issue in some NGOs, providing condoms for staff is considered a promising practice because most staff are in favour of doing so.

Continued capacity building based on needs and upcoming issues

Continuing capacity building by SANISIP and flexibility in responding to upcoming issues is a good practice.

For instance, SANISIP responded to challenges brought up by the AR, and paid more attention to the appointment and roles of FPPs in NGOs, and the promotion of VCT.

Taking sustainability measures

Planning for and taking sustainability measures is a good practice. SANISIP and NGOs provided various good examples, in particular aiming for a low cost WPP that does not require external funding. NGOs facilitated access to free or low cost services by providing staff with a directory of (free) HIV and AIDS related services; wrote proposals for funding; mainstreamed HIV and AIDS in other organizational budgets; and engaged in internal fundraising mechanisms. The project installed the TAPS as a measure to ensure sustainability of knowhow and to scale up the response.

Measures against stigma and discrimination

Less stigma and discrimination of PLHIV was found in SANISIP NGOs than generally in the community. This was a result of awareness raising among staff and sensitization on the realities of living with HIV and AIDS. In addition, organizational regulations, highlighted for instance in appointment letters, help to reduce stigma and discrimination.

Guidelines for disclosure and confidentiality

WPPs specified to whom staff can disclose, and contain guidelines for (breach of) confidentiality. Staff experienced the workplace as a safe environment for disclosure, for access to benefits and support, and felt ensured of confidentiality. This is a great success.



Linking and learning with outside public and private organizations

Linking and learning with public and private organizations was a good practice by SANISIP. This was done for information sharing, access to free IEC, condoms, training, and referral services (for instance for VCT and treatment).

Applied research

The PC and SSIPG took up most AR recommendations, including sharing promising practices between NGOs during training and meetings; intensified networking with state level AIDS related institutions and international organizations; sharing networks with partner NGOs; and promoting the appointment of an FPP in NGOs. The founding of TAPS was the answer to AR recommendations to share experiences and enhance awareness about the FPP and his or her roles. The AR could have been even more effective if reports had come out in a more timely way. However, the PC and YRG CARE shared findings with NGOs, so messages have come across.

Challenges

Lack of time

NGOs felt that they did not have enough staff-hours to devote to WPP development and implementation, while at the level of SSIPG members could not always free up time for meetings. In the beginning of the project, lack of time was combined with NGOs not having an FPP. This was resolved later in the project.

Financial constraints

Finances were reported as a constraint over the course of the project, although not unanimously. Some NGOs successfully developed a low cost WPP. Despite this, in AR2/3, finances were reported as a possible future constraint, when and if more staff required support and benefits.

Fear of misuse and conflicts

In AR1, some NGOs feared a misuse of the benefits by staff. No actual cases of misuse were reported, however. In AR2/3, NGOs feared possible conflicts between staff when benefits were accessed. Furthermore, some NGOs experienced or anticipated challenges in striking a balance between confidentiality and HIV positive staff accessing benefits.

Negative stance on condoms

The provision of condoms is reported as a promising practice, but is still a contested issue in some NGOs,

especially Faith Based Organizations (FBO). It is a challenge that some NGOs are against the provision of condoms at the workplace while many staff members are in favour of doing so.

Main recommendations to SANISIP stakeholders

To NGOs

- Continue to raise awareness of staff on HIV and AIDS, the WPP, and related issues; translate the document if needed;
- Continue or start implementing WPP activities that do not require (much) funds;
- Specify the job description of the FPP and/or the committee, with attached time allocation;
- Continue to deliberately involve PLHIV and positive networks;
- Open or continue dialogue with donors and other funding bodies about managing HIV and AIDS in the workplace.

To Indian PC, SANISIP secretariat, and SSIPG

- Continue enhancing awareness in NGOs about the FPP and his or her roles;
- Advocate usage of the new STOP AIDS NOW! CSO guide to NGOs;
- Organize smaller regional meetings to understand why some NGOs are not interested in developing a WPP, and involve those NGOs that have experienced positive effects from their WPPs;
- Facilitate forming meaningful linkages and channels for cross-learning among NGOs, and help NGOs to network with service providers within their respective geographical areas;
- Encourage employers to offer free condoms as both a family planning and HIV prevention tool, to enhance uptake and lessen inhibition;
- Keep paying attention to lobbying and involve other organizations in lobbying activities. Making use of each others' networks can create a multiplier effect;
- Let TAPS work with a wider range of NGOs, not only organizations working in the health sector or with high risk groups. The TAPS program can increase the reach of the SANISIP project, and hence is a good way to scale up the project;
- Have an open attitude to share and learn from others, including from those outside the partnership and the Indian context, to increase conditions for success and innovation;
- Keep the steering role in mind, but also be flexible towards the other actors in the project structure, and give them a feeling of confidence to do their work.

To STOP AIDS NOW! donors (Cordaid, Hivos, ICCO, Oxfam Novib)

- Screen submitted budgets in a timely fashion and release funds promptly;
- Open/continue dialogue with partner NGOs about managing HIV and AIDS in the workplace;
- Have a role in keeping partner NGOs updated and supporting them, rather than leaving it all up to the project.

To STOP AIDS NOW! Netherlands PC

- Organize more meetings in the Netherlands with the STOP AIDS NOW! partners' program officers, to increase cooperation with equal trajectories in the region and avoid duplication;
- Share results and lessons learnt of the project earlier.

Suggestions for (future) similar projects

Project set-up

- Make sure that the project is based on local needs, and fits the context;
- The beginning is important. Let the NGOs in the partnership select the host organization and the core/steering group from among their midst according to criteria they set. Let them decide on the roles, responsibilities, and key thrust areas of the project and TOR for all stakeholders;
- Appoint a PC who is accountable to the steering group and participating NGOs.

For steering group

- Select a project name, vision, and key thrust areas;
- Involve NGOs with experience in the field and let them share their experiences – learn from them;
- Agree on the roles of all members;
- Operate on a regular basis, and be realistic about the time members can put aside – make firm agreements on this;
- Make feasible budgets for training and sensitization;
- Keep the donor agencies of partner NGOs involved in the project.

For host organizations

- Keep the steering group informed of all updates and challenges faced;
- Keep the programs participatory and use the assistance of partners to accomplish the objectives and strengthen the program;
- Try to be objective and focused on the vision in order to keep organizations with varied backgrounds, budgets, philosophies, and cultures together.

For local PC

- Ownership by local NGOs is key. Give them enough room to decide on their WPPs;
- Try to move things in such a manner that they are not offended, and let the NGOs actively pursue inputs from you;
- Partners are associated voluntarily, so do not impose too much work on them;
- Make yourself available whenever they need you.

1 Introduction

This report presents the experiences of a three year STOP AIDS NOW!¹ project addressing HIV and AIDS in thirty-five NGO workplaces in South India. It focuses on the project structure, and the processes that led to development and implementation of HIV and AIDS workplace policies (WPPs) in NGOs. The report elaborates on promising practices and challenges – both of which can serve as lessons for present and future stakeholders in HIV and AIDS WPP programs. This introductory chapter sets the context and the background of the project in India and introduces the study questions for this report.



1.1 HIV and AIDS in India and South India

The HIV prevalence rate among adults in India is 0.36%. While this seems low, it translates as 2.5 million people living with HIV (PLHIV) (UNAIDS 2008). Most infections – eighty-seven percent of all cases – occur through heterosexual sex, including paid sex. Other important drivers are unprotected sex between men and injecting drug use. Women account for around thirty-nine percent of HIV infected adults. HIV prevalence varies greatly between states and regions.

The four major states that comprise South India – Andhra Pradesh (76 million people), Tamil Nadu (62 million people), Karnataka (53 million people), and Kerala (31 million people) – account for twenty-two percent of India's population and are among the five highest HIV prevalence states. Andhra Pradesh comes after Manipur in North-East India as the second highest HIV prevalence state, with a prevalence rate of 0.97% among people aged 15 to 49 years (IIPS 2008a). Karnataka ranks third with 0.67%, almost twice the national average (IIPS 2008b). In Tamil Nadu, 0.34% of 15 to 49 year olds live with HIV infection; the prevalence rate in this state is slightly higher than in India as a whole (IIPS 2008c).

The Indian government's multi-sectoral strategy for the prevention and control of HIV and AIDS in India is implemented through the National AIDS Control Organization (NACO) at the national level, and through AIDS cells at the state level. The national AIDS control policy aims to prevent and control the epidemic in India, through prevention of further spread of the disease, creation of an enabling socio-economic environment, and improvement of care services for PLHIV. Under the Ministry of Health and Family Welfare, NACO and the Ministry of Labour and Employment recently jointly developed a national policy guideline on HIV and AIDS interventions in the world of work, informed by employers' and workers' organizations, PLHIV, the International Labour Organization (ILO), and UNAIDS. These guidelines are implemented and monitored at the national, state, and workplace level, and aim to: 1) prevent transmission of HIV infection amongst workers and their families; 2) protect the rights of those who are infected and provide access to available care, support, and treatment; 3) protect workers from AIDS related

stigma and discrimination by assuring them equity and dignity in the workplace (Government of India, Ministry of Labour and Employment undated).

1.2 HIV and AIDS as a workplace issue

HIV and AIDS have a negative impact on workplaces because they mostly affect people of reproductive age – who make up the majority of the workforce. Where staff are directly or indirectly affected by HIV, organizations suffer from higher costs and lower productivity, and thus it can threaten an organization's ability to achieve its goals. The main effects of HIV and AIDS on organizations relate to: more staff absences, because employees become ill, have to look after ill relatives, and attend funerals; higher staff turnover, because staff leave due to illness or death, resulting in loss of skilled labour and institutional memory; lower morale, because of the psychological impact of illness and death, stigmatization, and an increased workload (Holden 2010).

The ILO 'Code of Practice on HIV/AIDS and the World of Work' describes fundamental principles for policy development and offers practical guidance for responses to HIV and AIDS in the workplace. These include: prevention of further spread of HIV; mitigation of the socio-economic impact of HIV and AIDS; care, treatment, and support; reduction of stigma and discrimination; promotion of gender equality; and confidentiality (ILO 2001).

Managing HIV and AIDS in the workplace reduces their negative effects on an organization. A WPP benefits staff members, their families, and the wider community by defining an organization's position and practices in regards to HIV and AIDS, and gives direction on how to protect, care for, and support affected or infected workers and their families. In addition, a WPP informs staff about their responsibilities, rights, and benefits, and gives guidance to managers on how deal with issues and problems that arise in the workplace (Holden 2010).

The argument for managing HIV in the workplace is strongest in high HIV prevalence rate nations. However, it is also important to manage HIV in the

¹ STOP AIDS NOW! is a partnership between Aids Fonds and four Dutch development organizations: Cordaid, Hivos, ICCO, and Oxfam Novib.

workplace in a country such as India, where the HIV prevalence rate is relatively low but HIV related stigma is universal. While NGO employees in a low prevalence country are less likely to be either infected or affected by HIV and AIDS, the need for proactive steps towards managing HIV is still important. The challenge of HIV to the Indian working population is evident from the fact that India has a working population of over 400 million, and nearly ninety percent of reported HIV infections are amongst the most productive age group of 15-49 years.

HIV is not a condition that NGOs can turn a blind eye to. In addition, AIDS is not a disease that NGOs can ignore; it directly affects their workforce and their workers' families. Donors, for their part, need to acknowledge the reality of a possible increase in expenses and decrease in productivity of their partners in South India due to HIV and AIDS, and consider how practically to (continue to) supporting their partners working in these conditions.

1.3 STOP AIDS NOW! project 'Managing HIV and AIDS in the Workplace' in South India

The STOP AIDS NOW! project 'Managing HIV and AIDS in the Workplace' aims to support partner organizations in South India in developing and implementing policies on, or addressing in other ways, HIV and AIDS in the workplace. This project was developed under the theme of 'access to treatment'. The overall project consists of three sub-projects: 1) developing Good Donorship Guidelines and implementing them; 2) supporting partner organizations in three countries – Uganda, Ethiopia, and India – in the development and implementation of HIV and AIDS WPPs; and 3) providing linking and learning events between the sub-projects, different partners, and different countries.

The STOP AIDS NOW! South India project (SANISIP) involves thirty-five NGOs which are funded by the Dutch STOP AIDS NOW! partners. The project management consists of a local program coordinator (PC), an assistant program coordinator, and the STOP AIDS NOW! South India Project Group (SSIPG), the latter of which is the deciding, facilitating, and governing body. The project's secretariat is based at

the host organization INSA-India in Bangalore. The overall goal of SANISIP is to strengthen the capacities of partner NGOs to develop and implement WPPs related to HIV and AIDS, in order to create an enabling environment for the prevention of HIV, and for care and support for PLHIV, among staff and communities aligned to these organizations.

The objectives for the three year (2007-2010) SANISIP were to:

- Facilitate sensitization programs on internal mainstreaming for SANISIP partners;
- Facilitate internal mainstreaming programs, with follow-up mentoring for key staff from SANISIP partners, to prepare their WPPs, working in collaboration with the Indian Network of HIV Positive People (INP+) and the SSIPG;
- Organize linking and learning programs.

1.4 Applied research

Part of the SANISIP project was an applied research (AR) component. The aim was to describe and analyse the experiences in SANISIP at the three levels of staff, NGO, and project management, and so provide information for all levels on how to direct or redirect activities for successful WPP development and implementation. The AR furthermore intended to identify promising practises and challenges in the development and implementation of NGO's WPPs and their effects on the workplace and staff, which could be used for similar projects.

The AR component was divided according to the phases of the project. Phase 1 was to measure the process of the development of NGOs' policies, Phase 2 the start of policy implementation, and Phase 3 aimed to focus on the implementation and effects of WPP on staff and organizations. Due to time constraints, Phase 2 and 3 of the AR were combined (see section 2.1).

YRG CARE (Y.R. Gaitonde Centre for AIDS Research and Education) was responsible for data collection, processing, and writing of (draft) reports. An Indian NGO which offers a broad array of client friendly HIV and AIDS related services, YRG CARE is also a leading training and capacity building institute and is internationally recognized for its clinical and behavioural research. The YRG CARE team was advised by consultants from the University of Amsterdam (UvA), Department of Anthropology and Sociology, who were responsible for the final reports and factsheets.

1.5 Objectives and study questions of the AR end report

The objectives of this end of project report are to:

- Review the experiences of SANISIP, focusing on the structure, processes, and effects;
- Focus on some specific themes which are important issues in workplace projects;
- Describe promising practices and challenges, and so provide recommendations for future projects for WPP development and implementation.

Some main themes for study were formulated in consultation with the SANISIP, Indian PC, SSIPG, and Dutch PC. These included: project structure; supporting documents; FPP; capacity building; PLHIV; sustainability; linking and learning; access to services; HIV related stigma and discrimination; disclosure and confidentiality; gender. The following are the specific study questions, related to the main themes:

- Does the SANISIP project design and structure adequately support and facilitate the desired results of the WPP? What have been the benefits and constraints of the project support structure? How do different levels of support and management evaluate their own role and practices?
- How useful were the supporting documents 'Good Donorship in a time of AIDS' (Good Donorship Guideline – GDG), 'What's it likely to cost?' (Budgeting Tool – BT), and other documents distributed by SANISIP?
- What have been the roles of the FPPs in the development and implementation of WPPs?
- How useful have the capacity building activities been for developing and implementing WPPs?

- How have PLHIV been involved in the project?
- What measures have organizations and the SSIPG put in place for sustainability of their WPPs?
- How has the project facilitated linking and learning and networking? What types of networks have been created, and how have they been facilitated (at project and NGO level)?
- How has the WPP influenced/facilitated access to services for staff members (IEC, prevention (condoms), VCT, ART)?
- How have HIV related stigma and discrimination been influenced by the WPP?
- How has the WPP influenced disclosure of HIV status, and how is this related to confidentiality in NGOs?
- How has gender been addressed in the project?

1.6 Report structure

After this introductory chapter the report comprises of six chapters. Chapter 2 describes the study methodology, after which Chapter 3 zooms in on the SANISIP project structure and approach. Chapter 4 presents a summary of findings of the two AR reports on WPPs in the NGOs. This summary is divided into the sections Initiation, Development of WPP, Content, Implementation, and Effects. The findings on special themes related to WPPs will be addressed in Chapter 5. In Chapter 6 the lessons learnt from the SANISIP project will be analysed, focusing on the promising practices and the challenges. This final chapter is rounded off with recommendations to various stakeholders interested in WPP development and implementation.



2 Methodology

This chapter explains the data sources for the end report, as well as how data were analysed and how the information is presented in this report. The first step was to scan available project and AR documents for information. The two researchers scanned AR1 and AR2/3 raw data and reports, the project baseline report, annual project reports, minutes of SSIPG meetings, and workshop reports for information. All information from the documents was mapped in a template (with the rows consisting of topics and themes) and gaps in information were identified. Most required information was available but appeared to be lacking, especially regarding project structure and perspectives of the Indian PC, SSIPG, donors, and the Dutch PC. Thus the second step was to identify respondents and design tools to collect additional data.



The first sections of this chapter explain the methodologies of the AR studies (2.1) and the other studies conducted in SANISIP (2.2), after which the additional methods of data collection for this end report are presented (2.3). Section 2.4 explains the data analysis and presentation of findings in this report

- Table 1 summarizes the techniques used by AR phase, and the number of NGOs and staff involved. Two NGOs participated only in AR1, twelve participated in both phases, and twelve NGOs only in AR2/3.

AR1

Fifteen NGOs – five in each state – were purposely selected to include a mix of NGOs with a (draft) WPP and those which had not yet started WPP activities. One NGO was not interested in participating in SANISIP or developing a WPP, and was taken out of the sample, leaving fourteen. In each NGO a senior manager was interviewed. This manager was asked to select two groups of six to eight staff members (one of mid-level and one of lower level staff) to participate in FGDs, and ten staff members for the survey, taking gender into consideration. Data were collected in the period May to December 2008 by a team from YRG CARE. The objectives of this phase were to:

- Provide a baseline of staff knowledge and attitudes related to HIV and AIDS;
- Describe the process of developing WPPs and start of implementation in NGOs;
- Document and analyse promising practices and challenges;
- Provide recommendations to SSIPG and NGOs for WPP development and implementation.

AR2/3

Because the AR1 report had been delayed and the SANISIP project was coming to a close in December 2009, AR Phases 2 and 3, which were planned to be separate, were combined. Twenty-four NGOs – ten from Andhra Pradesh, eight from Karnataka, and six

2.1 Applied research study methodology

The study methodologies were designed in two five-day workshops (in March 2008 and June 2009) with the whole YRG CARE team, including data collectors, the SSIPG, SANISIP secretariat and project coordinators, and the consultant from UvA. The tools developed were pre-tested during the workshops. This participatory process enabled all data collectors to be fully aware of the questions and the sensitivity with which data should be collected (in particular regarding consent).

Qualitative and quantitative data collection methods in both AR phases were similar. They included:

- In-depth interviews (IDI) with senior NGO managers, using a semi-structured questionnaire. They reported on NGO level;
- A survey of staff, using a questionnaire with structured questions. They reported on their personal knowledge and perceptions;
- FGDs with mid-level and support staff, following a topic guide. They discussed their views of WPP processes in their NGO.

Table 1: Applied research in SANISIP

Data collection techniques	Number NGOs	Number respondents/FGDs
AR Phase 1	14	
• IDI with managers		15
• FGD with staff		27 (159 participants)
• Survey staff		138
AR Phase 2/3	24	
• IDI with managers		38
• FGD with staff		40 (289 participants)
• Survey staff		315

from Tamil Nadu – were purposely selected to include those with a fully functional WPP, those with a draft, and those without a draft but willing to start. The same selection criteria as for AR1 were applied for staff participation in the FGD and survey. Data collection took place between July and November 2009 by the YRG CARE team. The objectives of AR2/3 were to:

- Describe and analyse the implementation and effects of WPPs,
- Document NGOs' experiences with STOP AIDS NOW! and SANISIP support structures and documents;
- Identify promising practices, facilitating factors, and challenges in the implementation of WPPs;
- Give recommendations to SANISIP and NGOs for sustainable and effective WPP development and implementation.

Reflection on AR methodology

Concerning AR methodology and analysis, comparison between IDI, FGD, and survey findings found that in general, survey respondents gave higher figures than the managers. This may be due to the way in which questions were asked – it culturally being easier for respondents to answer affirmatively – and due to the probing in the survey, whereby an open question would first be asked (for instance, 'What do you see as effects of the WPP?'), followed by specific questions (for instance, 'Have there been any changes in attitude towards staff living with HIV?').

A study limitation was that Indian members of the research team and the Indian PC considered it culturally inappropriate to ask too many personal questions, particularly regarding getting condoms from the workplace, HIV preventive measures taken by the respondent, and accessing VCT. We therefore cannot draw conclusions on personal changes because of the WPP. There were also limitations to an analysis of changes within NGOs: 1) not all of the same NGOs were involved in both AR phases; 2) NGO names were purposely left during data entry of AR2/3 survey data for privacy reasons, which made it impossible to compare survey data with FGD and IDI information by NGO.

2.2 Methodologies of other studies and an exercise

Project baseline

Before the start of the project, but after the first workshop in 2005, a rapid needs assessment and baseline survey (RNABS) was conducted to assess whether and how NGOs involved in SANISIP address HIV and AIDS in the workplace, as well as whether they were willing

to do so. Data were collected at the organization and staff levels. The SANISIP project coordinator and assistant interviewed 434 staff members and thirty-five managers of thirty-five NGOs in three states. The questionnaires contained closed questions.

360 degree review

An interesting exercise was conducted in the 2009 second central workshop: a 360 degree review. This exercise is also known as 'multirater feedback', 'multisource feedback', or 'multisource assessment', and is used for employee development feedback. In SANISIP, the feedback came from the NGOs. Members rated each indicator on a scale of 1-10, with 1 as the minimum rating. For review purposes, ratings of 1-3 and 8-10 were counted for discussion. Based on the ratings, analysis of the project was conducted in terms of strengths and weaknesses, promising and not so promising practices, possible actions, etc.

Case studies

In November and December 2009, the Indian PC and Nienke Westerhof conducted case studies on low cost WPP activities and lessons learnt. The SANISIP PC identified six NGOs in Karnataka and Andhra Pradesh based on their experiences and availability. Interviews were held with the organizations' FPPs, guided using a semi-structured topic list that was developed for each specific NGO. In one NGO, an FGD took place with nine staff members. If necessary, additional information was collected later by email. The case studies are integrated in a Praxis Note, published on the INTRAC website (Westerhof & Azashe 2010).

2.3 Additional data collection

Self-administered questionnaires

Self-administered questionnaires were sent by email to SSIPG members, the host organization, and the Indian PC. Respondents were asked to give their opinions on the functioning of the SSIPG, and on the SANISIP project structure and STOP AIDS NOW! documents. They were also asked to give their recommendations for similar projects. Four of the eight SSIPG members (BIRDS, Myrada, YRG CARE, INSA-India), the host organization, and the PC returned the completed questionnaires.

Interviews

Interviews were conducted with five representatives from three STOP AIDS NOW! partner donor organizations and the Dutch PC, guided using a semi-structured topic list. They were asked about their role in the project, communication with local NGOs, financing of NGOs' WPP activities, their evaluation of

the project and project structure, and how they share their experiences of SANISIP with other partners.

2.4 Data analysis and presentation of findings

Information from the documents was extracted and entered into Word documents according to theme. Data from the self-administered questionnaires and the interviews were summarized and combined with information from the various documents. Analysis was done of the project progress over time and at the staff, NGO, and project levels.

The information in this report is presented by theme. Information from different sources and levels is combined and described over time to see the possible effects of the WPP. AR1 and AR2/3 refer to applied research Phase 1 and Phase 2/3 respectively. WPP refers to HIV and AIDS workplace policy, or addressing HIV and AIDS in the workplace in other ways. In this report, only a few cases are given – readers interested in these are hereby referred to the AR1 and AR2/3 reports (STOP AIDS NOW! 2010; Westerhof & Koster 2009).

Following the advice of SSIPG members, no names of NGOs or NGO's reference to State are mentioned in this report. However, Annex 2 gives the names of NGOs by State which were involved in the different AR phases, RNABS, and case studies.

3 SAN!SIP project structure, approach, and support

This chapter provides information on the SAN!SIP project structure and approach – as it was designed in the STOP AIDS NOW! project proposal (section 3.1), how SAN!SIP developed it in practice (3.2), and how it was perceived by NGO managers, FPPs, and staff (3.3). The project structure was also evaluated by the Indian PC, the host organization, SSIPG members, the Dutch PC, and the Dutch policy officers (section 3.4).



3.1 Introduction: STOP AIDS NOW! project structure, support, and approach

The Dutch Project Coordination Group manages the overall project design process for 'Managing HIV and AIDS in the Workplace', and is responsible for the project in Uganda, India, and Ethiopia. Members of this Project Coordination Group include the Dutch PC and the HIV and AIDS policy officers of STOP AIDS NOW! partners. In addition, program officers from each STOP AIDS NOW! partner are specifically responsible for each country. Dutch donors gave their commitment to: 1) supporting partners in mainstreaming HIV internally as part of Good Donorship Guidelines; 2) providing four percent of NGOs' total payroll as additional funds for mainstreaming HIV in NGO workplaces supported by them; and 3) providing assistance and information to develop low cost workplace programs.

The project nurtures local ownership in the three countries through a national project structure, including a full-time local PC and a steering group with representatives from participating NGOs and PLHIV networks. In the project initiation meeting in each country, with facilitation and technical support from the Dutch PC, representatives attended from Dutch STOP AIDS NOW! partners, the Ministry of Health, ILO, INGOs, the local steering group members were democratically selected by the NGOs present. This steering group writes the country project proposal, including the terms of reference (TOR) for the local PC, and is responsible for selecting the PC. The local steering groups and PC receive advice and technical support from the Dutch PC and the Dutch policy and program officers.

Capacity building at all levels – project, NGO management, and staff – is central to the project and is an important strategy for building knowledge and motivating and involving stakeholders. STOP AIDS NOW! strongly emphasizes that the WPP process is in no way mandatory for the partner organizations. Each NGO decides whether or not they fit into the program and what type of WPP would be best. However, a participatory approach while developing a WPP is recommended to ensure that all staff feel a sense of ownership. Furthermore, involvement of PLHIV is recommended, and NGOs are encouraged to think about sustainability of their activities.

3.2 SAN!SIP activities and support

3.2.1 SAN!SIP project structure

The SAN!SIP project structure was developed by the participating organizations in several workshops. At the one day workshop in Bangalore in November 2005, all fifty organizations present, from Andhra Pradesh, Karnataka, Tamil Nadu, Orissa, and Kerala, indicated their interest in moving forward together on an initiative related to managing HIV and AIDS in the workplace. Each state agreed on several representatives from different types of organizations, and an ad hoc committee of fourteen NGOs was formed. The committee defined its roles and responsibilities, a basic timeline, and basic guidelines for how a networked initiative could proceed. They decided that two or three members of this executive committee would need to take the lead as a smaller working group to develop a rough action plan or draft recommendations that each organization would choose whether or not to sign on to.

However, although the selected committee worked hard, they found it difficult to get the required response from the larger group, even for acceptance of the project they had formulated. The committee hence wound up its role and requested STOP AIDS NOW! to re-convene a three day meeting where all members would be invited by their Dutch project coordinator to design the project (vision, structure, and approach) in-house.

The three day workshop took place in October of 2006. In the workshop, INSA-India was selected as the host organization, and the core group (SSIPG), was elected, consisting of seven organizations: SIDUR and CHAI from Andhra Pradesh; INSA-India, Myrada, and BIRDS from Karnataka; and NESA/Arogya Agam and SEARCH from Tamil Nadu. The vision, approach, roles, and responsibilities were all decided upon and drawn up in a participatory manner through an external facilitator. SSIPG membership has been constant, though right at the beginning of the project formulation INP+ was invited, and later the research institute YRG CARE was included.

By the end of 2006 the SSIPG recruited the PC. He is supported by an assistant PC, a program officer, and a part-time secretary seconded by INSA-India. This project team was accountable to INSA-India on a day to day basis, to the participating NGOs, the SSIPG, and to STOP AIDS NOW! Netherlands. Decisions regarding implementation of project activities were taken in concurrence with the SSIPG and the host organization. NGO heads were informed twice a year about the project activities, through consultation, reports, and email.

The TOR for the SSIPG, the host organization, and the PC were formulated by the larger group of NGOs during the three day workshop in October 2006 (see Annex 3). The SSIPG meets quarterly to monitor the implementation of the project and to plan for the future. It is responsible for, among other things, the development of the project, facilitating linking and learning, and providing and taking the lead in advocacy and lobbying. INSA-India is responsible for financial and administrative issues, day to day management of the PC, providing technical support to the PC, and advocacy. The PC and project team have an office in the INSA-India building, and the administrative procedures for imprest requests, billing, documenting, and rules of INSA-India were extended to staff of this project too. The PC and his team participate in the weekly Monday morning meetings in which they share what has happened during the previous week and what are the onward plans. The SSIPG delegated the responsibility of taking a lead in advocacy and lobbying by and large to the host organization.

SSIPG members report that they have been monitoring the implementation of project activities through regular quarterly meetings, phone calls, and email communication. The SSIPG members are also actively involved as facilitators or translators in state based capacity building workshops. They provide input on reports made by the SANISIP secretariat before they are sent to STOP AIDS NOW! in the Netherlands. The SSIPG monitors accountability of the project, and the members have access to all project files and vouchers. The host organization also made accountability of the project part of the agenda of the meetings of SANISIP NGO heads. Any partner is welcome to provide input on the way the project is functioning and what needs to be done. SSIPG members have played an active role in trying to mobilize resources for project sustainability by twice applying for GFATM fund rounds, advocating in their respective states, and trying to get unresponsive NGOs to participate.

The PC is responsible for project management, providing technical support to NGOs, coordination, project administration, communication, collaboration

and networking, fundraising from local donors, accountability, representation, and lobbying. He is secretary to the SSIPG. INSA-India leadership provided induction when he started working, because he was not part of the October 2006 planning workshop. There he was given updated records and information related to internal mainstreaming, selection of the organizations, and certain unwritten policies developed by SANISIP partners and the SSIPG. They explained to him the need to develop strong relationships with the SANISIP partners, and initially mentored follow-up visits. The secretariat deputed work as per his capacity and the needs of the project, and today that includes preparing proposals, budgets, modules, and workshops (INSA-India and Myrada facilitated the first workshop). The PC's communication with STOP AIDS NOW! and the AR advisor in the Netherlands, is copied to INSA-India.

Over the course of the project, a structure has been added for effective implementation of the project, sustainability, and scale-up, in the form of the Technical Assistance for Policy Services (TAPS). Seven NGOs were selected and accepted to provide TAPS, based on set criteria and willingness. They are SANISIP NGOs with a developed and implemented WPP, at least three years' experience and technical expertise in working with NGOs targeting health sector or high risk groups, existing infrastructure facilities to provide TAPS, and they have actively participated in developing SANISIP (even after project closure). These NGOs have committed to depute an FPP to manage the TAPS program from April 2010 to June 2011. These FPPs train NGOs in their area – not necessarily participating SANISIP organizations – using a specially developed handbook (TAPS Facilitator Handbook, 2010 – unpublished)².

The goal of TAPS is to facilitate NGOs who work in the health sector or with high risk groups to develop an enabling workplace which addresses HIV vulnerability and reduces stigma internally and externally. The seven TAPS providers identified about 150 NGOs to be involved in the program. The main functions of the TAPS are to:

- Organize in-house training/exposure;
- Update information dissemination;
- Depute trainers for training programs;
- Provide counselling services to staff of targeted NGOs and networks;
- Linking and networking with positive network groups, collectives, etc.;
- Mentor/facilitate WPP processes in their targeted 25-30 NGOs.

The TAPS providers are specific to the structure of the India project, and are focused on effective

² The handbook is available from the SANISIP secretariat.

implementation; they are comparable to the lead organizations in the Uganda project. The Dutch PC explained that there had been discussions on:

“...how to bring structure into the project, besides the SSIPG, to provide organizations with information and services. So once you increase capacity of people, how can they in turn serve others?” The TAPS are the answer to this question, and according to the Dutch PC “a logical step”.

3.2.2 Capacity building

Capacity building has taken place at all levels of the project through training workshops, on the job training, sharing of experiences, and technical advice. The Dutch PC has given technical advice to the local PC, host organization, and SSIPG by email and telephone, during international conferences, and while on visits to India. The local PC reported that he actively sought the Dutch PC's opinion on project related issues. The SSIPG learned from the Uganda project structure and implementation when the Uganda coordinator came in person to share his experiences during the three day workshop in October 2006. Furthermore, during international conferences, the PCs and steering group members of the three project countries had opportunities to learn from one another.

One of the main thrusts of SANISIP was to organize capacity building programs, with follow-up mentoring for key NGO staff in preparing their WPPs. SANISIP sensitized and motivated NGOs' directors on the importance of addressing HIV and AIDS in the workplace, and gave them and/or other representatives knowledge and guidelines on how to develop and implement a WPP. Capacity building of NGOs by the PC and SSIPG has taken place through annual consultation with NGO heads and senior managers, annual central skills building workshops for key staff, state level vernacular workshops for key staff, follow-up mentoring in individual meetings, and through a peer mentoring process.

Starting in 2007, SANISIP organized several annual workshops, first to sensitize NGO directors about the need for addressing HIV and AIDS in the workplace and then to build NGO capacity to do this. Regional language workshops with translated handouts aimed

to sensitize and build the capacities of staff. These were organized in the specific language of the state, which helped staff who were less equipped in the English language to open up and be more participatory. Cluster meetings were organized for more detailed discussions on the draft WPPs, with input from a smaller group of partner organizations. In 2010, the NGOs selected as TAPS were trained by SSIPG and the PC (see Annex 1 for a list of workshops).

Capacity building was not limited to the partner NGOs, because SANISIP shared information about WPPs and related findings with the government and various development players, nationally and globally, to build capacity, assist these partners to better tune their programs, and to act together for mainstreaming HIV in the workplace. Furthermore, a skills building workshop was facilitated by the host organization and PC at the International Conference on HIV and AIDS in the Asia Pacific (ICAAP) in Colombo in 2007.

Initially, forty-five NGOs funded by Dutch STOP AIDS NOW! partners were targeted for capacity building and to become partners in the project; however, for varied reasons ten NGOs were resistant to the idea of participating in such a project. Several attempts to involve them over the first year elicited minimal response. The PC reports that reasons given by the NGOs included: “I have other things to do and cannot spend time talking about HIV”, “I have well qualified staff in my organization and do not want someone from outside to come and tell us what to do”, “Our funding is over and we are no more your partners”, and “It was a small grant for a study that's over long back”. For two NGOs, there was absolutely no response. After SSIPG and the project team had unsuccessfully tried their best to include them, they decided to concentrate on the thirty-five which were responsive.

3.2.3 Supporting documents

During workshops and meetings NGOs received various IEC materials and documents. When the project was initiated, member organizations received a toolkit with directions and guidance on WPP development. This toolkit comprised: the ILO document ‘ILO code of practice on HIV/AIDS and the world of work’; the STOP AIDS NOW! documents ‘Good Donorship in a time of AIDS’ (Good Donorship Guidelines – GDG) and the Budget Tool (BT) ‘What's it likely to cost?’; examples of WPPs of NGOs and corporate houses; and WHO documents.

The GDG document is aimed at donor organizations, but is also useful for local NGOs, governments, and businesses in developing a WPP. The guidelines explicitly state the principles and commitments from the STOP AIDS NOW! partners, including financial and other support that can be given. The BT is an addition to the GDG and is about budgeting for workplace programs and how to estimate the costs. It also talks of what makes a good budget and what should not be included. The tool is useful for local NGO staff who do the budgeting, and for program officers of donor organizations who assess and fund the budgets. In 2009, a document with the lessons learnt from the project 'Managing HIV and AIDS in the Workplace' (Ghielen 2009) was developed, and recently the new 'Managing HIV and AIDS in the Workplace: A Guide for CSOs' (Holden 2010) was launched, that guides organizations through the process.

3.2.4 Building structures in NGOs: FPPs and committee

In the project plan (2006/7), one of the expected outcomes was that each NGO would have an FPP and committee/taskforce overseeing the development and coordination of addressing HIV and AIDS in the workplace. This person and committee are the NGOs' liaisons with the SSIPG and PC. Having an FPP (and installing a committee) is regarded as essential for effective development and implementation of the WPP, and are therefore strongly advocated by the project. The state specific capacity building workshops (in the regional languages) held once a year in each state target FPPs and discuss their roles and responsibilities. They are not given a written TOR; FPPs are deputed by their NGO and usually this is an unpaid added responsibility. They must act as the representatives of the workforce, and so must gather first hand information from all staff levels (not only managers).

3.3 NGOs' perspectives of project structure and support

As explained in section 3.2, building the capacity of NGOs and maintaining support for them is one of the main aims of the project. This is done through workshops, by the PCs, SSIPG support visits, and by explanation and reference to STOP AIDS NOW! documents. In this section, the NGOs report their use of SAN!SIP's support structures and documents.

3.3.1 NGOs on capacity building and technical assistance

In AR1, managers and staff of ten out of fourteen NGOs reportedly appreciated the advice, motivation, inputs, and ideas from the SAN!SIP workshops. In AR2/3, twenty NGOs reported on the important role of SAN!SIP in developing their WPP; twelve elaborated that they valued the capacity building and technical assistance in workshops, training, and meetings; three appreciated the usefulness of the information materials made available by SAN!SIP; two said they had received SAN!SIP assistance in getting financial support, through explanation of the 4% additional funding; and three NGOs valued the support of SSIPG in providing feedback on reports. Results of the '360 degrees' exercise showed that partners gave an exceptionally high ranking to the topics related to 'learning from the project'; the rankings were high in NGO consultation workshops, regional language workshops, and the resource pack.

One FPP explained how SAN!SIP helped in developing and implementing a WPP:

Definitely SAN!SIP has motivated us a lot in implementing WPP, secondly they have given us immense opportunities to attend trainings to gain knowledge; we then implemented WPP and asked for their suggestions, they helped us in that too.

Five NGOs appreciated support visits by SAN!SIP, and especially valued were the explanations of WPPs and the interaction with staff members. NGOs also appreciated support from SAN!SIP in linking them with partner NGOs, and facilitating linkages with public institutions (see section 5.1).

Only two NGO heads were not very happy with the support. It is important to add that these two NGO heads only attended the first workshop and did not actively participate in meetings. One worried about the continuation of the support after the end of the project:

Despite the overall positive feedback on participation in SAN!SIP capacity building workshops, most NGOs in AR1 and AR2/3 indicated that they needed more technical support. Some NGOs still needed support with policy drafting, while others wanted input and advice on implementation, report writing, documentation, preparing budgets, training of staff, and how to deal with confidentiality and

tolerance; or they wanted literature in their regional language. NGOs also wanted SAN!SIP to facilitate more experience sharing between the member organizations. A secretary gave an example:

They can start a newsletter and can circulate it. They can give information on how organizations are implementing the WPP.

Since financial constraints were among the most expressed (expected) challenges, many NGOs had certain expectations from SAN!SIP and donors concerning this topic. Thirteen NGOs in AR2/3 indicated that they expected financial support to either develop or implement the policy. One NGO head worried that:

...tomorrow I have twenty positives and thirty suffering from cancer and I don't have the money to support them. What is the use then to have a WPP? I think SAN!SIP should take the lead role of getting the 4% of budget sanctioned by donors into a central account, which should be then distributed by them to the NGOs.

3.3.2 NGOs on SAN!SIP resource package and STOP AIDS NOW! documents

AR1 found very little utilization of the toolkit with directions and guidance on WPP development that NGOs received; only two NGOs had used the SAN!SIP documents for WPP development, only one used GDG, one organization used the ILO Code of Good Practice, and one NGO reported having used CDs with information on PLHIV and WPP. AR2/3 found more utilization of the resource package. Overall, respondents were aware of it and considered it useful. IDI respondents in nineteen NGOs had referred to these documents during their policy drafting. Out of the three main documents, the ILO Code of Good Practice was most used (by fourteen NGOs) and preferred – possibly because it is a familiar and user friendly document. An FPP explained:

ILO Code of Practice in the SAN! resource package was very useful.

I went through the ten principles in the ILO code of conduct and saw how I could come up with a good policy using what is mentioned in the document.

Respondents made less use of the STOP AIDS NOW! documents. Still only one NGO referred to the GDG when developing the WPP. Four IDI respondents explained why they did not use the BT and GDG: two considered the documents too long and complicated, while the other two cited language as a barrier. One secretary stated that:

The toolkit is very nice but according to me it's difficult to use. Somebody should come and sit with the person who is developing the policy.

3.3.3 NGOs and HIV focal point persons

It is a project success that in AR2/3, out of the twenty-four organizations, seventeen (70.8%) had appointed an FPP – one of the recommendations of AR1 being to install such a person. In AR1, NGOs reported that it was difficult to appoint an FPP and allocate time to the person. Of the AR2/3 survey respondents, 72.2% were aware of the FPP in their organization, 22% said there is no such person, and 4.8% did not know whether there was.

NGO managers explained that they appointed FPPs to be key drivers of the policy. Usually the FPP is responsible for their NGOs' HIV and AIDS committee and so has the overall responsibility for the implementation of the WPP. FPPs furthermore play the role of liaison officer between management and staff, and in some cases between the organization and project, as explained by an FPP from a development NGO:

My role is to attend meetings conducted for WPP as a representative, disseminate information, prepare a report on it, encourage the organization about the WPP, and involve all staff in the development process.

Both men and women are appointed as FPPs. Most FPPs had already been working for their NGO for quite some time. It is important that staff members trust the FPP, and an argument could be that staff members would feel more familiar with a colleague they have known for a while than with someone who just entered the organization. In one NGO, the FPP was newly appointed. This man has a background in HIV work, but there was no further information on whether he was specifically hired as an FPP for the WPP project. One man described how he became the FPP by chance:

When we started this in 2006 or in early 2007 I was very much involved in the WPP, and we nominated one of my colleagues in [the] finance program. But he also couldn't attend the SAN! meetings regularly, and I could. Hence I was the Focal Point Person here.

The functioning of an FPP partly depends on the size of the NGO. The manager of an NGO with one hundred staff members reported that the FPP was unable to reach out to all:

What can one person do to reach out to all, for instance the forty-five support staff, since they cannot read mails he sends around?

Another big NGO solved the problem by appointing two FPPs. In contrast, the experience of an FPP in an NGO with a small staff number (22) makes clear that all staff can approach and confide in the FPP:

From the beginning I was there. I was not in programs, but from the administration team, and I knew what were the office problems, like of secretaries, office help, and the program staff It doesn't take much of my time, not every day, weekly one hour, but the discussion with the staff usually they feel very free to come in and talk to me from the beginning. Because I don't travel outside, I am always here from the time the office opens

until it is closed (9-16), I am always available for them. I give time for them every day, maybe during lunch time they will come with me with some small issues or problems. For all kind of problems. I don't take it to the higher level, I try to sort it out then and there only. If it cannot be handled by me then I take it to the directors. Then they tell me how to handle it and I will do it.

3.4 Stakeholders' views on overall project structure and STOP AIDS NOW! documents

3.4.1 Views by Dutch and local PC, host organization, and SSIPG

The Dutch PC has the overall responsibility of the project in Uganda, India, and Ethiopia. As she describes it, "in the end, our role is to facilitate the project". This means that there are trajectories at two levels: project level in India, and in the Netherlands with the Dutch STOP AIDS NOW! partners.

The contact person in India for the STOP AIDS NOW! Netherlands PC is the Indian PC. However, especially in the beginning of the project, there was also contact with the host organization, mostly for financial issues and specific issues regarding content. One of the issues that STOP AIDS NOW! supported was lobbying to the ILO, to the Dutch embassy, and to other like minded organizations. There are now many linkages with other organizations, and while STOP AIDS NOW! did have a role in this, the Dutch PC emphasized the importance of the host organization's own network:

INSA did have a role in that. They have a very good network in India. But those networks that they were not yet involved in and that were relevant for the WPP and from Dutch donor perspective, there we had a role. But apart from



that, all credits are for INSA as host organization, because they are very good in networking.

Apart from making use of the network of the host organization, it was often suggested to involve one of the SSIPG members in lobbying activities, especially in those places where they have influence. This is an issue that can still be strengthened.

The STOP AIDS NOW! Netherlands PC reported that her role changed over the course of the project:

In the beginning you are very much involved, and you give technical support and advice about lobby[ing]. But if you see that the project is running your involvement becomes less. And that is good. It needs to be a project of their own, otherwise there is no ownership.

The project structure in the Netherlands consists of the Dutch PC and the policy and program officers of the STOP AIDS NOW! partners. According to the Dutch PC, there were:

...a lot of contact moments in the beginning, a lot of meetings, because of the structure, and we have had a lot of specific events in the Netherlands.

The host organization reports that STOP AIDS NOW! played a significant role in the technical support lent to the Indian PC and the host organization, and that the relationship was cordial and professional. If issues arose they could be frankly discussed and resolved. The Dutch PC updated them with publications and facilitated linkages, for instance with the Uganda project which had a head start on implementation. STOP AIDS NOW! also helped increase the visibility of the project, for instance through enabling them to attend and present in international conferences in Mexico and Vienna. The Indian PC reports that both the project and he personally benefited from the immense experience of the Dutch PC, who gave non-interfering and constructive feedback and had a supportive attitude. SSIPG members reported less of a relationship between the Dutch STOP AIDS NOW! partners and SSIPG; they had contact through their NGO but not as SSIPG. SSIPG members think that the way the project was structured enabled a sense of local ownership. They are very happy with the TAPS and say:

We are reaching groups we never thought possible and the response for partnerships is encouraging. This approach does not have the 'donor driven' slant either!

However, some felt that there should have been more SANISIP personnel at the state level to work with all forty-five NGOs, because of large distances. This could also have enabled closer monitoring of the project. The Indian PC was of the opinion that there are pros and cons to having a large governing structure at the project level. One con, for example, is that sometimes it becomes difficult to satisfy the 'ego' of each and every member; this is applicable for any group working with a network of organizations, however a steering committee is necessary for lobbying at national level.

The SSIPG and local PC promoted the GDG and BT documents during workshops. They found them good, very informative, and useful, though they realized that for NGOs they were difficult to use without further explanation. The BT was considered especially difficult and too technical for everyday use by NGOs. The PC reported that NGOs' general feedback was that "they are a treat to read", but, "are too lengthy", and for some the language was a challenge. The PC encouraged translating these tools into regional languages. SSIPG members were very hopeful about the new CSO guide and believed it to be easier to use – they promised to play an active role in facilitating acceptance. Overall, the Indian PC, host organization, and SSIPG reported having been able to meet their TOR and felt ownership over the project. In the self-administered questionnaire, SSIPG members reported on what they considered the strengths (S) and weaknesses (W) of the SSIPG, and identified opportunities (O) and threats (T) for their positive functioning. These were important considerations when formulating recommendations, given in Chapter 6. The results of the self-SWOT analysis are presented in Table 2.

3.4.2 Views of Dutch policy and program officers

The Dutch policy officers were involved in the start of the project 'Managing HIV and AIDS in the Workplace', but were not specifically involved in the SANISIP project. One of the policy officers described her role as an "intermediary of information and questions"; she shared issues that were raised during the Coordination Group meetings with the colleague involved at country level. Both HIV and AIDS policy officers who

were interviewed explained that they were not much involved in the project in India. As one of them argued, this could be because:

The project started in Uganda, hence the start up phase was mainly focused on Uganda. After Uganda, the trajectory started in India, and I have the feeling that I was less involved in this trajectory. Perhaps there was less attention for the project in India?

The Dutch PC also admitted that the project in Uganda received more attention at project level in the Netherlands, because it was the first trajectory, it provided the first new results, and because there were many good practices to learn from. A different argument offered was that the project in India was well managed by the host organization and the Indian PC, hence much involvement at the Dutch level was not required.

Overall, the Dutch policy and program officers were enthusiastic about the project structure in the Netherlands. Everybody who was involved was motivated. At the start of the overall project in 2005, the Project Coordination Group gathered every two to six months. The goals of the Coordination Group were, among others, to discuss the format and structure of the project, to discuss the expected results and how to share them (i.e. products). Over the course of the project, the frequency of gatherings diminished, mainly due to time constraints, but also because the trajectories in the three countries were set up and working well, so active involvement was less necessary. When there were fewer Coordination Group meetings, feedback on the process and results of the project were shared during other existing meetings and through email.

Three India program officers were interviewed about their role in SANISIP. Two of them became involved after the project had already started. The program officer who was involved from the start describes her role as follows:

Table 2: Self-SWOT of SSIPG by SSIPG members

Strengths	Weaknesses
<ul style="list-style-type: none"> Experienced members/NGOs (in health, development, HIV) Credible NGOs which are respected by NGO community and (local) governments NGOs have a wide network NGOs have WPPs themselves Selected by all STOP AIDS NOW! partner NGOs in a democratic process Heads of SSIPG member NGOs are committed to SANISIP 	<ul style="list-style-type: none"> SSIPG members have limited time to give to SANISIP (because they are senior officials) – thus difficult to agree on dates that everyone is available FPPs for some of the SSIPG member NGOs have changed, which breaks continuity and makes decision making difficult In some states SSIPG members were not spokespersons for the state SANISIP partners SSIPG members do not have enough interactions with SANISIP partner NGOs
Opportunities	Threats
<ul style="list-style-type: none"> Meetings in different places was an opportunity for networking for individual SSIPG members NACO third phase focused on HIV mainstreaming, which made advocacy of the project easier After the third year partner NGOs chose the same SSIPG members 	<ul style="list-style-type: none"> Competition from other partner NGOs to be SSIPG members Other NGO responsibilities that cannot always be foreseen Staff change in NGOs Because of far distances SSIPG could not visit all NGOs Phasing out by Dutch donors – making the NGOs unresponsive

It was important to promote communication [with the local partners], especially with regards to logistics, and to guide local partners. My own role in the project can best be described as a mediator [between the local project structure and the project structure in the Netherlands]. This role contains, for instance, informing partners and focusing on workshops and training activities.

Face to face interaction between the Dutch program and policy officers and the local project structure (host organization, PC, SSIPG) was minimal. One Dutch program officer did participate in the introductory WPP workshop. Another program officer had a partner visit at the host organization, and through this visit she met the Indian PC and became more involved with the different actors at local level. The third program officer reported that she only had email contact with the PC and host organization.

There were several issues that influenced and hindered their role and involvement in the project. ICCO had its own, similar WPP trajectory in northern India, that started one year before the SANISIP project. Despite several attempts, cooperation between these two trajectories was minimal; both projects were too distinct in their own coordination and dynamics. At the time that the SANISIP project started, Oxfam Novib decided to focus more on North India, with the argument that more support was needed by NGOs in this part of the country. As a result, funding for many of the partners in South India ended. The timing was also difficult for Cordaid; just after the start of the WPP project, the other AIDS and health programs of Cordaid in India were completed. Furthermore, the decentralization process, by which projects and trajectories of the STOP AIDS NOW! partners were assigned to the local level, influenced the level of involvement within the project.

For the three Dutch program officers of the Dutch donors, active involvement in SANISIP was mainly through communication with the local partner NGOs. Contact with the local partners sometimes changed over the course of the project, when for instance financial support ended, or depending on how actively involved the partners were in the trajectory. Program officers were of the opinion that the NGOs needed to function as a network, and one of them reported:

The network [of NGOs participating in SANISIP] should be built and work separately. We ask: what HIV and AIDS related activities do you do, how can we help? And we inform about the workplace policy activities, but that's it.

She furthermore stressed the difficult role of a donor:

It is difficult to push the organizations in India. It is not only about the WPP, but it is also important that other policies are developed within the organizations. If we push them too much then it will become donor driven, and that is not what we want to achieve.

Although they were not all equally aware of the WPP in their partner NGOs, Dutch program officers reported that most local organizations developed a WPP plan and budget and that they did receive financial support. One of them stressed, however, that she saw how partners came up with a budget that was, according to her, too high.

Dutch policy and program officers were happy with the knowledge sharing component of the project, especially with regards to trainings and workshops organized in the Netherlands (for instance when the GDG was launched). They also perceived the structure of the project, both in the Netherlands and in India, as good, although sometimes more interaction was needed. One policy officer commented:

There is always the difficulty that, on the one side, you are wondering whether you are informed and involved sufficiently, and on the other side, you are too busy to attend all meetings and go through all information.

A promising effect of the project that was reported is that programme officers sense a more general interest in HIV and AIDS within the local NGOs, and that there are more activities and benefits for PLHIV in the workplace.



4 HIV and AIDS workplace policies in NGOs

This chapter provides a summary of the findings of the AR reports. It covers what motivated NGOs to address HIV and AIDS in the workplace (4.1), how they developed (4.2) and implemented (4.3) WPPs, how activities were funded (4.4), and what the effects were on staff and NGOs (4.5). This chapter presents only outlines of the findings on the specific themes, and refers to Chapters 5 for in-depth information.



4.1 Initiation and motivation for WPP

Eleven NGOs had started the process or had a final WPP in AR1, while two had not yet started and in one NGO discussions were going on. Within most of the NGOs with a (draft) WPP, the WPP was initiated after some staff members, generally management staff (directors, coordinators), attended the SANISIP trainings, in which they were sensitized to and made aware of the need to address HIV and AIDS in the workplace. Some NGO managers said the workshops made them realize the need for a more focused policy. The manager of an NGO in Tamil Nadu said that they were already planning to have a policy for HIV, and SANISIP came “as a catalyst and triggered the initiation”.

Managers reported specific motivating factors for their NGO in initiating WPP development. Six managers mentioned material and ideological benefits of a WPP, including more opportunities for PLHIV, medical treatment for HIV positive staff, and less stigma and discrimination. Other benefits were enhanced job security, reducing the effect of HIV on staff, greater confidentiality, and insurance. Five NGOs recognized that risk of HIV infection for staff could be mitigated by having a WPP. One manager argued that the NGO’s high staff number increased the probability of having staff living with HIV (LHIV), especially in high prevalence areas. In another NGO it was argued that staff members working with vulnerable people were more susceptible themselves. In three NGOs, having a staff LHIV was the motivation to develop a WPP. Generally, however, risk of HIV infection among staff was not considered higher than for the general population.

Staff members were interested in and positive about having a WPP. Basically, staff arguments for having a WPP, as expressed in FGDs, were the benefits to staff and family, the encouragement to disclose, more awareness about HIV and AIDS, and reduction of stigma and discrimination. One staff member argued:

I used to have worries about my family, if I would pass away because of AIDS. Now, because of the WPP, I feel confident that my family will be taken care off.

IDI and FGD respondents of two NGOs reported having or expecting difficulties promoting the WPP. An FGD participant explained that initially staff members did not feel the need for a WPP, as there were no PLHIV within the organization. However, they were finally convinced of the necessity of having a WPP. Also an FBO director explained that it took him a long time to motivate his staff for a WPP. Staff reasoned that they were not directly involved because they do not work with HIV and AIDS related issues, and furthermore that it was against the ethos and tradition of the organization; talking about susceptibility of staff to HIV and AIDS was an insult and lack of faith in their personal behaviour. Staff thought that a WPP would be something imposed by the management and a benefit for only a few among them, and they also feared losing their job because their family members would not endorse them working on HIV and AIDS.

In the three NGOs in AR1 which had not started the WPP process talks were ongoing. They participated in workshops and staff said they were interested. FGD respondents of two of these NGOs stressed the SANISIP workshops as a motivation to raise questions and start to think about WPPs. Furthermore, in both NGOs, benefits for HIV positive staff – such as monthly medicines, ART, and counselling – were mentioned as motivation, as well as the risk of getting HIV. FGD respondents in NGOs without a WPP were not always positive; they argued, for instance, that a WPP is not necessary for an NGO not directly involved in HIV and AIDS work. In another FGD, some participants felt no priority should be given to a written WPP, as their organization already had some HIV and AIDS related facilities in place. FGD participants in another NGO all realized the necessity of having a WPP and argued that such a policy could have saved a colleague who had died of AIDS.

4.2 Development of a WPP and communication to staff

Nine of the eleven NGOs in AR1 with a (draft) WPP followed the SANISIP guidelines and developed the WPP in a participatory process – enhancing broad ownership and commitment. In just a few NGOs, managers and FGD staff differed in opinion on

the level of participation, but usually they agreed, indicating validity. Generally, in smaller NGOs all staff were actively involved in the drafting process, while in most NGOs with a larger staff size staff could give comments on the drafts written by a committee or senior staff members. In one NGO with a large number of staff, the draft was made at top level management without staff participation.

Four NGOs formed a committee for WPP development and involved all staff members, either in the whole process, later stages, or through staff meetings. Comments were given orally in meetings or in writing after the draft had been distributed. Sometimes drafts were discussed in different meetings with different levels of staff. A grassroots level FGD participant said:

The draft WPP was first discussed with the senior administrative staff, then with the middle level managerial staff and then with support staff.

An IDI respondent in AR2/3 explained how the WPP was developed by staff members themselves:

Initially, we had workshops with the staff at different levels and managers. First stage, we had managerial level separate, supervising level separate, and the field staff separate. Then we integrated all the staff and then we had series of workshops. As a precaution we felt that let us not first go and talk about workplace policy on HIV. Let us first sensitize them all, so slowly we have brought up the issue and that was one way in the beginning. Then while in the process of evolving the workplace policy, it was entirely developed by the staff. We formed a committee of five people at that time plus some more people like senior staffs who were looking into it, and I was not much involved in the process. There were lot of confusions and

questions on the minds of the staff which were taken care by the senior staff who took up the responsibility of discussing with them and solving them. At last everyone decided to make the draft for the workplace policy so from that day till the day the first draft came up I did not involve in it. The staff purely did it and I feel proud to have a look at the policy. They have done a good job.

Findings from the staff surveys support that the WPPs were developed in a participatory way: 83.5% (n=86) of 103 staff think the development of the WPP happened in a participatory way, of which a vast majority (96.5%) thought all staff levels were included. Only eight respondents (7.8%) said there was no participatory development, of which seven were from the NGO in which the WPP was primarily drafted by top level management. Nine respondents did not know about participatory WPP development.

AR2/3 found that eleven out of twenty-four NGOs had a fully functional WPP (approved by board members and management), seven NGOs had developed a final draft WPP, and four did not yet have a final draft. Two NGOs had not yet initiated the WPP drafting process. NGO managers reported specific reasons why they had not progressed to a fully functional WPP; some needed external help to guide them through the development process, while in other NGOs the board and management temporarily stalled WPP development because other staff welfare policies were not yet in place. The director of one such NGO said:

We submitted the draft policy for approval but they [management] felt that since none of the [other] policies were in writing we should first begin with writing all the policies in the organization and then move to the WPP. For the last one year we have been writing out all policies and welfare schemes to make them into policies.

It is interesting to note that the two NGOs in AR2/3 which had not initiated the WPP process have HIV and AIDS as their core area of work. Although they do not have a policy in place, both organizations employ

HIV positive staff and provide benefits for them. The director of one of these NGOs commented:

I have HIV positive staff and there are benefits for them. So why do I need a policy?

Awareness about the WPP and its status was very high (92.4%) among all staff members, regardless of time on the job or type of contract. However, awareness levels were directly proportional to job level; the higher the job category, the greater the awareness. Although large NGOs have not been able to involve all staff levels in WPP development, they have taken efforts to communicate the WPP to all staff. Most NGOs made a copy of the policy available to staff, and three NGOs translated the policy into the local language. One NGO with a large number of staff decentralized WPP dissemination: field level coordinators were informed about the WPP and they in turn were responsible for discussing it with their respective teams. Respondents from smaller NGOs with fewer than ten employees preferred dissemination through staff meetings.

Most staff members were happy with their NGOs' efforts to include them in WPP development and implementation. Staff meetings, trainings, workshops, and informal discussions were the most preferred modes of disseminating information. The following quote from a female program officer highlights the general opinion of staff members.

We were involved while preparing the draft and so we know about the policy. It was a collective process where we discussed and developed the policy called WPP for HIV/AIDS. Even after the draft got finalized, they discussed with us about the components [which] need to be added, need to be deleted, whether it is socially accepted, and all. After that we made the final version.

Staff of three NGOs felt that communication about WPP issues was inadequate. They suggested ways to improve communication about the policy, for example by sending letters or emails to all staff, and providing training programs.

During participatory WPP development some contentious issues came up, which mostly included access to services and health coverage and who should

benefit, whether to have a separate policy for HIV and AIDS or have it integrated in general health or human resources policies, and provision of condoms for staff. These issues will be further discussed in the remainder of this chapter, and Chapters 5 and 6.

4.2.1 Stand-alone or integrated WPP

NGOs that are part of SANISIP are free to develop a WPP according to their specific needs. However, based on experiences from the project in Uganda, it was recommended to develop an integrated policy. At the WPP introduction workshop in 2005, it was suggested that an HIV policy should be part of a larger package of WPPs. In a workshop in 2008, the PC and SSIPG insisted that HIV needs to be integrated with other policies, and that there should be no separate policy as such.

The idea that the WPP should be integrated into other guidelines or policies is broadly shared among the NGOs. The HIV WPPs that were developed over the course of the project were named as 'general wellness policies' or 'staff health policies'. NGOs did not name it an HIV and AIDS policy, since this was believed to be stigmatizing. Rather, HIV and AIDS were treated as any other chronic illness.

During a workshop in 2006, an NGO which already had a WPP shared that it should be linked and built upon human rights, gender, and Dalit policies, rather than be isolated. Another organization shared in a central workshop for NGO heads how they were going to integrate HIV and AIDS into a broader policy, because a stand-alone policy would increase stigmatization:

Our organization treats HIV and AIDS as any other chronic illness to check further stigmatization within the workplace. We also discuss HIV and AIDS in our workplace and on safe sex practices, as providing information on safe sex practices is a human rights issue. Soon, the organization will have its own policy on health, and HIV and AIDS will be addressed as a separate chapter.

One NGO conducted a small study within the organization to assess staff's vulnerability to HIV, while keeping in mind the gender component. This study

was not only an eye opener for the staff, who started to realize the need for a WPP on HIV and AIDS, but also informed the NGO about the type of WPP they would need. The management decided for a comprehensive WPP, including HIV and AIDS, human rights, gender, and other health issues.

In AR1, the format of the WPP was not discussed as a separate topic in all organizations. Four NGOs reported integration of HIV into other policies or activities, and even mentioned this as an argument for starting WPP development. One manager argued that his NGO was very much concerned about staff health, and therefore made the HIV and AIDS policy an extension of the health policy; one NGO reported that they linked the WPP with their gender mainstreaming program; one linked the WPP with guidelines for the prevention of Tuberculosis; while in another, the NGO's main focus on health was the basis for developing a WPP.

In AR2/3, half of the twenty-four NGOs mainstreamed the WPP within another policy. Eight NGOs integrated the WPP into the existing gender or welfare policy, two mainstreamed it into their health policy, and two others integrated the WPP into other organizational policies. The director of an NGO explained that "it [gender equality] is almost the same right. Women are more vulnerable, especially single women". The director of a non-HIV organization reported again the reduction of stigma:

We decided that we needed to have an HIV and AIDS policy integrated together, if not it would be an issue of discrimination. The HIV and AIDS policy will be a part of the WPP integrated along with all other policies like gender, human resource, health, and other things.

Five organizations in AR2/3 did have a stand-alone WPP. However, one of these was planning to mainstream the WPP, and in another discussions were ongoing about whether to have an integrated or separate WPP. In one of the two organizations that had not yet initiated the WPP process, the WPP would be mainstreamed in the human resources policy.

4.2.2 Formal or informal WPP

NGOs were encouraged to develop a formal WPP. This is preferred over an informal policy because (among others reasons): it makes sure that staff are aware

of their rights and duties; it is accessible to all staff (while the risk of an informal policy is that benefits are only known by higher level staff); and it makes the perspective of the NGO explicit with regards to HIV and AIDS.

At the start of the project, only two NGOs already had a formal WPP in place. Other organizations were already doing activities related to HIV and AIDS in the workplace, and were also trained on how to build on informal responses to HIV and AIDS, including awareness raising, (referral to) VCT and treatment, and care of HIV positive staff.

Unsurprisingly, over the course of the project more NGOs developed and implemented formal WPPs. Organizations often combined certain activities that are part of these policies with informal activities, for instance informal discussions to raise staff awareness. In AR2/3, two HIV specific organizations had not yet initiated the process of drafting a WPP and did not feel a pressing need to do so; both NGOs have informal guidelines, employ HIV positive staff, and provide benefits. Except for these two NGOs, the majority felt the importance of having a formal WPP.

4.3 Implementation of WPP activities

Findings indicate that HIV and AIDS related activities for staff do take place, even when NGOs do not yet have a formal WPP; thus, the data cannot show whether these activities took place because of the WPP or whether they were already happening before. Table 3 summarizes the HIV and AIDS related activities taking place in NGOs, as reported in AR1 and AR2/3 by managers and staff. Only the first – awareness raising and education – will be expanded upon in this section, while the others are dealt with in Chapter 5. The differences between AR1 and AR2/3, in brief: condoms for staff have not been provided in more NGOs, though facilitation of access to treatment and VCT information and promotion have both greatly increased.

IDI, FGD, and survey data all highlight awareness building of staff as the most common HIV and AIDS activity, and this has increased over the course of the project. All NGOs conduct training programs and workshops for staff on HIV and AIDS issues. In the survey in AR2/3, almost all (96.8%) staff reported receiving information about basic facts of HIV and AIDS. They get information through resource materials, informal discussions, updates on notice boards, a movie program on AIDS, wall paintings on HIV and

Table 3: HIV and AIDS related workplace activities for staff, reported in IDI, FGD, and survey in AR1 and AR2/3 (multiple response)

Activity	AR1		AR2/3		
	IDI (N=10)	Survey (N=138)	IDI (N=24)	FGD (N=24)	Survey (N=315)
HIV and AIDS information	8 (80.0%)	89.9 %	100%	87.0%	96.8%
Condoms in the workplace	5 (50.0%)	39.1 %	25.0%	26.1%	41.3%
Prevention activities	Not asked	Not asked	37.5%	56.5%	94.9%
Referral to ART information and services	3 (30.0%)	84.1 %	70.8%	78.3%	76.5%
VCT information and promotion	1 (10.0%)	81.9 %	58.3%	17.4%	77.1%
Involvement of PLHIV	Not asked	Not asked	58.3%	4.3%	Not asked

AIDS, street plays, trainings, routine staff meetings, awareness programs, and workshops. One NGO arranged exposure visits for staff to other NGOs that have internally mainstreamed HIV, to understand how they work without stigma and discrimination, and conducts training for family members.

A high number (88%) of all survey staff in AR2/3 reported having received training in HIV and AIDS; this training mostly covered HIV prevention, as was also reported by NGO managers and FPPs. Other common topics of training were VCT (40%), followed by STIs (30%) and WPP (30%). Less than one-fifth of staff received training in prevention of mother to child transmission of HIV (PMTCT).

4.4 Funding for WPP activities

4.4.1 Funding as a challenge

At the start of the project, NGOs expressed various concerns about leveraging adequate resources (e.g. funds for ART, services, competency) to implement a WPP, especially in the Indian context where basic health care is not a given, and particularly for NGOs that do not work in the field of HIV and AIDS. For some organizations, fear of financial implications was the main reason for not starting the process of WPP development.

Over the course of the project financial constraints remained among the most anticipated and experienced challenges. These challenges related to the end of financial support from donors and thus sustainability, as NGOs feared not having resources to continue WPP activities once funding was over. In AR1, lack of financial support was the most reported challenge, with six NGOs stating that

they required financial support for the development and implementation of a WPP. In AR2/3, thirteen organizations indicated that they expected financial support to develop or implement a WPP. Three of these organizations cited financial constraints as their major challenge.

4.4.2 Resources for WPP

The GDG and the BT were developed by STOP AIDS NOW! to support partners in budgeting for a WPP. NGOs shared their experiences with budgeting and financing their WPPs in workshops, and discussed how to get resources for interventions. SAN!SIP furthermore facilitated linking and networking among partners to develop low cost models for sustained WPP programs, and strengthen TAPS for low cost sustainable WPPs. In spite of these supporting structures and documents, some NGOs did not develop a budget for their WPP. In AR1, the status of the budget was discussed in nine NGOs; four organizations did not (yet) have a budget. In AR2/3 it became clear that not all NGOs had yet developed a budget for their WPP. From the thirteen organizations in AR2/3 with a fully functional policy, only two availed funding from their donors and secured four percent of the total payroll towards WPP development and implementation, as promised in the GDG. One of these NGOs received the funding for 2009, while the other availed funding in 2007 to conduct workshops for the WPP. The Dutch policy and program officers, however, indicated that all partner NGOs that developed a WPP and a budget did receive financial support. Two NGOs in AR2/3 applied for funding, while two others were unsure of how to go about applying for funds, but supported their existing HIV and AIDS activities with their own resources. In spite of reported financial constraints, many NGOs managed to implement HIV and AIDS workplace

activities with their own resources, at low cost. In AR1, it was a promising practice that eleven out of fourteen NGOs had started activities without receiving donor funds. A similar trend was seen in AR2/3. According to the director of an HIV integrated organization, funding is not necessary:

We have money for external purpose, but we have not taken any money for our internal purpose. Even for applying also now we are not interested.

The manager of an HIV organization reported that the NGO had approached the donor and:

...they told that already you are practicing, you are working and you are implementing and executing, so [there is] no need of having again a proposal or budgeting. Those things are not necessary for your organization.

One of the Dutch program officers reported that some NGOs developed budgets that were too high:

Many organizations are quite opportunistic with regards to WPP budgeting. Of course there are costs involved when you start implementing a WPP, but it is not intended that partner organizations receive money for their WPP every year. The focus should also be on sustainability.

Indeed, the HIV NGO discussed above is currently managing without funding.

4.4.3 Implementing cost effective and low cost activities

At the first workshop in 2005, it was already stressed that in a supportive environment there is no need for massive financial implications for an organization, since a great deal can be done using existing resources. One NGO that already had a WPP before the start of the project shared how they used organizational resources in the form of a positive living fund, whereby funds are raised internally. In AR1, directors and managers of six organizations reported having a medical scheme or health insurance in place. In most cases, these cover all staff. One of these organizations currently supports one HIV positive field staff member, and two families of staff members who died. To cover these costs, the NGO set up an in-house health insurance system that combines contributions from the staff and the NGO. As part of the organization's health policy, staff members contribute 20 rupees (€0.32) each month to the health fund (regardless of job level and years of service). The organization then matches this contribution of 20 rupees per staff member. As there are about 700 employees, the Health Fund increases by almost €450 each month. Medical costs are paid from this fund. Staff members can get fifty percent reimbursement for each claim, and family members thirty percent. If the fund is over spent, the NGO replenishes from other sources.

There are more relatively inexpensive ways to develop and implement WPP activities. The examples show how some NGOs manage to implement HIV and AIDS related activities at low cost and in a cost effective way, by making use of their own strengths and creating opportunities. These include making referrals and linking to other service organizations, making use of internal capacities, and in-house awareness and education sessions.

Since HIV and AIDS testing and treatment services are provided by the public health system, NGOs are not constrained to meet treatment related expenses. Most organizations refer staff to government run centres for (free) testing and treatment. The executive officer and FPP of one of the NGOs in AR2/3 explained that the organization therefore does not need financial support to facilitate care and treatment for HIV positive staff (see further in 5.2).

Another NGO makes use of internal capacity and networks to ensure low cost WPP activities. Because the staff have expertise in different HIV and AIDS issues, they have the skills to do many of the WPP activities themselves. Every month, there is a training in which staff members share their knowledge and counsel colleagues on their area of expertise with regards to HIV and AIDS and other health and lifestyle issues. All staff members participate in trainings, meetings, and workshops, and family members are invited for certain events. For instance, a life skills development workshop was organized for teenage children of staff. As a linking and networking organization, the NGO has an extensive network of contacts. As the FPP said, "With networks only, we have survived". For certain topics in which the organization does not have internal expertise, the organization invites people from other NGOs and institutions. They rarely charge for their services, but when they do, the NGO has a fund to cover these costs. It earns money from selling its workshop facilitation skills and training materials.

4.5 Effects of WPP activities

Although development and implementation of WPPs had just begun during AR1, effects were already noticeable in the eleven sampled NGOs with (draft) WPPs. Managers and staff reported that the policy improved the position of PLHIV and that stigma was reduced. Furthermore, managers in five and staff in six of the eleven NGOs experienced more openness and more opportunities for discussions about HIV and AIDS, in meetings or informally among staff. Three managers and staff of six NGOs reported more awareness about HIV within the organization. AR2/3 found more effects, as summarized in Table 4. Answering about whether they felt the issue had improved, stayed the same, or decreased, managers and FGD participants reported on the general situation in the workplace, while survey staff reported on themselves.

Table 4: Effects of WPP on staff and organization, reported by managers and staff in AR2/3

Effect	IDI (N=22)	Staff in survey (N=291)	FGD (N=21)
Increased knowledge and awareness of HIV and AIDS issues	77.3%	91.1%	81.0%
More IEC materials / access to information about HIV and AIDS	54.5%	84.9%	52.2%
More openness to discuss HIV and AIDS	54.5%	87.6%	61.9%
More access to services (VCT, ART, STI, OI)	45.5%	Not asked	42.9%
More access to benefits / (trust in) support	40.9%	88.2%	47.6%
More job security if found HIV positive	27.3%	88.4%	23.8%
More taking of HIV prevention measures	22.7%	80.6%	14.3%
More networking for services and information	22.7%	Not asked	9.5%
More disclosure by HIV positive staff	13.6%	78.0%	14.3%
Increased confidentiality of HIV positive status	Not asked	68.0%	23.8%
Negative effects	4.5%	12.0%	33.3%

Level of awareness raised regarding HIV and AIDS

The major effect of WPP development and implementation is increased awareness about HIV and AIDS issues; 77.3% of managers, 81% of FGD staff, and 91.1% of staff in the survey reported increased knowledge of HIV and AIDS. This was especially the case in organizations with small or no HIV and AIDS projects.

More IEC materials available

More than half of the managers reported that the availability of IEC materials for staff increased. This was reported by a similar 52.2% of staff in FGDs, and by 84.9% of staff in the survey. Generally, HIV integrated NGOs have greater availability of IEC materials than non-HIV NGOs. Furthermore, staff in higher job categories reported more access to IEC materials due to the WPP than staff in lower job categories.

More openness about HIV and AIDS

Because of increased awareness and knowledge, managers and staff reported more openness to talk about HIV and AIDS in the workplace; 54.5% of managers, 61.9% of staff in FGDs, and 87.6% of surveyed staff. Increased openness was most reported in non-HIV NGOs.

Job security if found HIV positive

Surveyed staff (90%) were very confident about their job security if found HIV positive, while only 27% of managers and 23.8% of FGD staff reported job security as a WPP effect. Staff from non-HIV organizations reported the highest impact of the WPP on job security. This could mean that employees of HIV or HIV integrated organizations already had trust in their organizations to support them in case they are found positive or if they suffer from any illness.

More access to benefits and (trust in) support

40.9% of managers, 47.6% of FGD staff, and a high 88.2% of survey staff reported that there would be more access to benefits and (trust in) support if they discovered they were HIV positive.

Effects on external mainstreaming (not in table)

Managers generally reported that internal mainstreaming of HIV had an effect on the overall NGO activities, i.e. external mainstreaming. This is evident from the following comments.

For the last nineteen years, we have held many programs and these programs were for different purposes regarding disabled children and special care for vulnerable children. Only after the WPP we had trainings on HIV and AIDS, and only after the WPP we had an idea on integrating HIV and AIDS and disability together.

In some cases, staff training provided by NGOs as a part of internal mainstreaming has enhanced staff skills that could be appropriately translated into action in the communities they serve. One manager explained the influence of discussing HIV and AIDS related issues in the WPP on staff attitudes with their target groups:

Framing this workplace policy has made another staff member to look with a different lens to female sex workers. This because of the link between gender, human rights, and HIV/AIDS. HIV/AIDS is not only a health issue. Framing workplace policy has led to a behavioural change in staff.

Negative effects

Negative effects were reported by only one manager, by twelve percent of survey respondents, and by one-third of the FGD respondents. Negative effects referred to (potential) misuse of benefits, breaches of confidentiality, and conflicts among staff as more benefits are given only to certain people. Negative effects were mentioned mostly by men, and more in HIV integrated NGOs and FBOs. The lower the staff level, the lower the percentage of respondents that saw negative effects.

In Chapter 5, the effects of WPP on HIV prevention, disclosure, confidentiality, access to services, networking, involvement of PLHIV, gender relations, and HIV related stigma will be discussed.



5 Focusing on specific themes

This chapter zooms in on themes which were specific objectives of the SAN!SIP project. The project aimed to increase linking and learning and social networking between partner and outside organizations (5.1), access to HIV and AIDS related services (5.2), and involvement of PLHIV (5.3). The project aimed to reduce HIV and AIDS related stigma and discrimination (5.4), and facilitate disclosure of HIV status while paying attention to confidentiality (5.5). A cross cutting issue was attention to gender (5.6). Finally, from the start of the project stakeholders have been advised to think about sustainability – financially, organizationally, and regarding knowledge (5.7).

5.1 Linking and learning and social networking

Linking, learning, and social networking have been taking place between different stakeholders and in different ways: within and beyond the partnership of SAN!SIP NGOs. This section describes how the SAN!SIP project actively facilitates linkages and learning, and also which initiatives NGOs take.

5.1.1 Activities by SAN!SIP

The project plan specified the following ways to facilitate linking and learning:

- Regular interactions through an e-group and newsletters;
- Disseminating best practice materials on the development of WPP;
- Participating in local and national meetings;
- Identifying at least five partner NGOs in each state to become information centres on WPP;
- Sharing the project with national organizations, to tap their resources.

SAN!SIP has developed linkages and partnerships with different national and international organizations, including Caritas India, KPMG, ILO, CBCI, CMAI, Alliance India, DFID, UNDP, NACO, PSI, TISS, UNDP, Concern Worldwide, and networks of PLHIV. They jointly facilitate workshops, or facilitate in one another's workshops, on all issues related to WPPs. To publicize the experiences, SAN!SIP organized media workshops in the three states with the theme 'Managing HIV and AIDS at the Workplace', which were widely covered in all the three states by leading dailies and brought linkages with the media, a member of the Indian Parliament, and a member of the Legislative Assembly in Andhra Pradesh.

The SSIPG members reported that they initiated dialogue with state AIDS control societies and sought their cooperation, and that they organized a workshop in Delhi for promoting linkages and networking among different stakeholders, including participating NGOs, donors, and government.

The SAN!SIP workshops for partner NGOs helped in building linkages, sharing experiences and knowledge between NGOs, and allowed sharing with other organizations. One of the main objectives of the

second workshop was for partner NGOs and others invited to 'learn and share experiences'; thirty-five participants from twenty-two different organizations participated. NGOs appreciated these; in AR2/3 IDI respondents mentioned the role of SAN!SIP in getting to know how other NGOs are implementing the WPP, and what their experiences and challenges are.

In 2008 SSIPG established TAPS in every state to increase and improve the flow of updated information on preventive care, support for HIV and related concepts, and promote positive speaking bureaus with readily available resource materials. In an April 2008 meeting, different reading material, tools, and other publications were reviewed to be used in the resource centres. TAPS are also useful in developing low cost models of consultancy by bringing organizations together to work on their comparative advantages. Up to February 2011, the TAPS have reached out to a total of 170 other organizations and networks and completed a preliminary workshop for them, a rapid needs assessment with them, and the beginnings of a pledge for 'enabling workplaces' (see Box 1). The TAPS were not fully functional during data collection for AR2/3, so we do not have data on the use of TAPS by NGOs.

Box 1: Pledge for 'enabling workplaces'

All targeted NGOs or CBOs commit to:

- a. Not discriminating through**
 - No pre-employment screening for HIV
 - No termination based on a person's HIV status
- b. Ensure that all staff/members are sensitized through specific programs on at least**
 - HIV and AIDS
 - Addressing stigma
 - Gender equity
 - HIV related services
- c. Agree that if a staff is a PLHIV or found to have HIV while in employment**
 - Access and linkages for HIV related services will be facilitated
 - Confidentiality will be promoted

5.1.2 Linking activities by NGOs

Most NGOs already network, are members of larger social movements, and interact in various ways with government. However, NGOs present in the 2006 workshop regarded the STOP AIDS NOW! workplace initiative as an opportunity to elaborate larger social support structures for workers in formal and informal sectors in India, and as an opportunity to work together more broadly on HIV, particularly in terms of advocacy.

In developing their WPPs, four NGOs in AR1 reported having received advice, input, and ideas from other NGOs (not only SAN!SIP). Generally, all NGOs considered mutual sharing between SAN!SIP NGOs to be important, in order to share both positive and negative experiences with WPPs and get ideas. NGOs in AR2/3 reported having networked with other SAN!SIP NGOs for developing and implementing their WPP; in particular, they used the policy documents of other NGOs as a reference when developing their own. Networking among the SAN!SIP NGOs for issues unrelated to the WPP was also reported to be good.

NGOs in AR2/3 explicitly mentioned that the increased networking for services and information was an effect of the WPP project. They reported networking with a host of public institutions, such as the State AIDS Prevention and Control Society (SACS), ART centres, VCT centres, and other NGOs for project related work. Commonly, they network in order to be able to

refer their staff, when needed, for care, testing, and nutritional support services, which are mainly free. The WPP process also meant that some NGOs networked with PLHIV – they learned from them the realities of living with HIV, and this also worked for stigma reduction (see section 5.4).

5.2 Access to services

During SAN!SIP workshops and within NGOs, discussion has been ongoing concerning to which services access should be provided or facilitated through the WPP. For instance, in the 2005 workshop with directors it was questioned whether it is an NGO's role and responsibility to encourage workers to become part of a larger network of health care, for example by offering new workers a medical check-up including VCT. There were also discussions about whether and how care for HIV is different from other diseases, and how to explain this to staff. In a workshop in October 2006, the participants agreed that the objective for SAN!SIP would be advocacy of an inclusive insurance policy, and also linking and networking for services. Some NGOs shared the ways in which they were already doing this, for example by referring their staff to free public services, and by making available a list with contact details and other information on HIV related public and private services.

Table 5 presents the HIV and AIDS related services for staff provided by NGOs, as reported by respondents in the RNABS, AR1, and AR2/3. Unfortunately, these data were not asked consistently in all tools and in all phases (see cells left blank in Table 5), thus comparison is not always possible.

In the RNABS, closed questions were asked to the thirty-five managers and 438 staff of thirty-five NGOs about whether specific AIDS related services were available for staff. The service which NGOs provided most was counselling (62.9%), followed by sex education (54.3%). Less than one-third of NGOs reported facilitating access to RTI/STI services. Just more than one-third provided condoms for staff. The staff were not asked whether condoms were provided, but only 22.8% said they think condoms should be provided – together with sex education. More than half of staff reported that the NGO provided opportunities for VCT and two fifths opportunities for ART (40.6%).

5.2.1 Prevention: condoms

Condom provision has been a contested issue during the SAN!SIP workshops, with some NGOs in favour and saying that they have boxes of condoms for target groups and staff in their offices, and others in opposition. During WPP development, it was also an internally contested issue within some NGOs whether or not to provide condoms for staff.

AR2/3 findings show little increase from AR1 in condom provision. While all NGOs promote condom usage in the community, only six in AR2/3 had made condoms available for staff; and only in one NGO was condom provision an effect of the WPP, while in others condoms were already being provided.

The survey findings show that while the actual provision of condoms for staff members is low, employees express high levels of interest in obtaining condoms from their work settings. A majority of staff (63.8%) in AR1 and 80.5% in AR2/3 are or would be very or moderately comfortable with accessing condoms at the workplace. There were no differences by age category and gender, but (surprisingly) support staff were less in favour of condoms (33.3%). Survey respondents (in NGOs with condoms) reported that a public corridor take away box is the most common place where condoms are accessed (31.8%), followed by the storeroom (20.9%), and cupboards (13.2%). Providing condoms in restrooms, as is commonplace in other countries, was much less common in India, mentioned by only 10.1% of respondents.

Staff arguments against the provision of condoms were that it would affect the organization's value system, would bring disrespect for women, that condoms can be got elsewhere, and that it would promote free sex. However, other staff thought it would be easier to have them at the workplace. Even in FBOs, a majority of staff in AR2/3 were for condom provision.

In eighteen NGOs in AR2/3, condoms were not provided. In fifteen of these, managers said they are not against condom promotion but have not made it available for staff in the workplace. The IDI respondent of one of these organizations argued that:

In terms of condoms also there are two points of view – if people know about condom promotion then it is their responsibility to protect themselves. When we asked about this in discussion they said there is no need to keep it in toilets because they have the responsibility to protect them[selves] so they will get condoms as some medicines for illness. They did not want the organization to provide condoms. It is a privacy issue here.

In the case studies, an NGO manager said that they had planned to display condoms in the field offices. However, field staff did not feel this was necessary, firstly because of shyness of field staff, secondly, they felt they were already aware so there was no need to provide condoms, and thirdly, the NGO works as a child organization and therefore felt that displaying condoms could be interpreted incorrectly by the target group.

Three NGOs showed strong disapproval of condom promotion in the workplace, as illustrated in the following opinion of a program officer who is also an FPP:

Though we promote condoms as an organization, we have never made it accessible for staff. I am totally against that and I raised my voice in the last consultation workshop too. Promoting condoms, I agree, is a norm in preventive methods

Table 5: Access to HIV and AIDS related services for staff, reported by managers and staff in RNABS, AR1, and AR2/3

Services	RNABS		AR1		AR2/3		
	Managers (N=35)	Staff survey (N=438)	Managers (N=10)	Staff survey (N=138)	Managers (N=24)	Staff FGD (N=24)	Staff survey (N=315)
Condoms	37.1%		5	39.1%	25.0%	26.1%	41.3%
Condom promotion should be available		22.8%		63.8%			80.5%
Sex education (should be provided)	54.3%	22.8%					
AIDS information			8	89.8%			
Access to RTI/STI services	34.3%						
HIV and AIDS counselling	62.9%						
Promotion of, and opportunities / referrals for VCT		53.2%	1	81.9%	58.3%	17.4%	77.1%
Opportunities / referrals for treatment / ART		40.6%	3	84.1%	70.8%	78.3%	76.5%
Health insurance / medical scheme		29%	7	76.8%	33.3%		

but we cannot make people accept condoms within the premises of the office. I am particularly against that because again it will lead to sexual harassment. It is also very disrespectful to keep condoms; on one hand we are having [a] sexual harassment policy and again on another hand we are giving access to condoms within the staff, within the office premises. So, personally and professionally I am against it.

Because a majority of staff were found to be in favour of condom provision in the workplace, the AR recommended that the PC and SSIPG encourage employers to offer free condoms as both family planning and as an HIV prevention tool, to enhance uptake and lessen inhibition. NGOs were advised to understand from employees which places are most suitable for condom placement. The PC reported that the issue of accessing condoms in a friendly manner was discussed on several occasions during workshops and training. However, since condom provision in the workplace is still a contentious issue for some partners and/or staff, it was left to the employers and staff to decide.

5.2.2 Voluntary Counselling and Testing

The importance of VCT promotion has been discussed in SANISIP workshops with NGOs, and was highlighted in the AR1 recommendations. It is a project success that in AR2/3 many more NGOs were promoting VCT for staff than in AR1, when only one NGO manager and staff said that VCT information was provided. The fourteen NGOs in AR2/3 which reportedly promoted VCT did this through training, encouragement, and/or giving of information on where to access it. Two have made a directory of HIV and AIDS services and circulated it to staff; two NGOs had organized a VCT session for staff, and one plans to do so; and in two NGOs, VCT was one of the health tests that staff are recommended to go for. In one of the latter two NGOs, the management facilitated medical check-ups and blood tests for staff (not specifically for HIV); interested staff were asked to register with the FPP and were given contact details of HIV testing centres. This small NGO with about fifteen

staff members had raised funds through workshops and by selling materials, and used part of this to offer staff a full health check at a specific clinic. More than three-quarters of survey staff in AR2/3 reported receiving VCT information through the workplace.

5.2.3 Treatment

Ten of twenty-two IDI respondents in AR2/3 (45.5%) reported increased access to services to be an effect of WPP activities, while in nine of twenty-one FGDs (42.9%) this was mentioned. One program officer explained that:

We have [a] directory in which we store all the number[s] of institutions where you can go and avail services for opportunistic infections or psychosocial or recreational or psychological needs. Though we had this earlier, it was only available with the project staff, but now it's circulated to all.

NGOs facilitate access to treatment in various ways, such as the provision of medical reimbursements, networking with service providers to secure treatment for staff, and supporting them through leave and transport. The medical scheme in most NGOs covers all staff, and sometimes also family members. Eight NGOs bear the (total or partial) medical expenses of staff, either through the WPP, medical reimbursements, or other schemes, as illustrated in the following quote of an FGD respondent:

For two or three months they will pay my salary. The office will decide about paying a part of my medical allowance. In case I don't have a family or I don't have support, the office will bear a larger portion of the medical expense.

One NGO arranges access to services through the organization's health fund, to which every staff member contributes 10 rupees a month (this provision was already in place before the WPP). Staff can go for any medical treatment and send their medical bills, and up to a maximum of 10,000 rupees per claim is paid; for family members, 50% of this is covered (family

initially included spouse and children, and later was extended to include parents). However, for HIV and AIDS medical bills there is no maximum limitation. The NGO also has linkages with government hospitals for free treatment, counselling, and for VCT. They motivate and assist staff to go to the hospital.

Some NGOs do not see the necessity of bearing the medical expenses of staff, as one NGO manager explained:

Medical reimbursement I don't think has been made a part of the policy. One thing is if the person would require leave to attend to any of his medical needs, then that would be sanctioned, but since most of these services are free of cost so I don't think there is a necessity for medical reimbursement.

The project director of another organization explained:

There will be no special allowances for ART, the organization cannot afford that; allowance will be on [a] similar line for any other medical problem. In every office, we have asked them to maintain a list of

what is called the resource directory, in which information about the nearest ICTC centres, counsellors, ART centres, doctors are available.

Thus access to HIV and AIDS related services should no longer be a problem in most states, since they are available and free. The role of NGOs is then to provide information about where services are available and facilitate access for their staff by building linkages with service providers and giving support through transport allowances and time off. One large NGO with seventeen partner NGOs does this, but reports that they offer extra counselling if staff want it, because counselling services in many public institutions are sub-optimal. Over three-quarters of survey respondents reported that their organization offers them information about ART access.

However, not all NGOs are happy with the free public services. For instance, one NGO in the case studies said that they cannot refer their staff to government hospitals because of the high stigma and discrimination in those places. They said they had written a complaint letter against a doctor in a government hospital after an HIV positive female sex worker (FSW) went there for ART and was sexually harassed by her doctor, who told her that this was her work and that she would die soon anyway. They now refer their staff to other centres with better services and provide staff with money to reach the places based on need.



5.3 Involvement of people living with HIV and AIDS

One of the global principles in addressing HIV and AIDS is GIPA (the greater involvement of PLHIV), and later MIPA (meaningful involvement of PLHIV). The SAN!SIP project considered that applying these principles would help strengthen mainstreaming processes. In the October 2006 workshop leading to the proposal, two SAN!SIP NGOs shared their experiences of how they secure the dignity of staff LHIV, and keep HIV status confidential (according to the person's wishes). One NGO created a fund for positive living, addressing the lack of financial stability for HIV positive staff. The other NGO believed that exposure and interaction of staff with PLHIV, whom they had invited to events (not necessarily related to HIV), acted as a preventive measure, because staff risk perception changed. During subsequent SAN!SIP workshops for NGOs, attention was paid to how to apply the GIPA and MIPA principles. However, some NGO representatives during the workshops noted that they faced resistance from staff to appoint HIV positive staff.

The SSIPG applied the GIPA principle by inviting the three state networks for PLHIV to be SAN!SIP partner NGOs, and by inviting INP+ to be a member of the SSIPG (although they were not one of the organizations funded by STOP AIDS NOW! donors). Although the GIPA and MIPA principles were adopted by SAN!SIP, there were also some reservations. During group work in the 2006 workshop, it was concluded that PLHIV should not become display material, and that their identity should not be defined by HIV infection or AIDS.

PLHIV have featured and are involved in the NGOs in different ways, either passively, as motivation for managers to develop a WPP, or actively, facilitating during workshops, engaging in advocacy to make staff aware of HIV and AIDS, and especially in addressing stigma and discrimination, and working on the development of a WPP. As mentioned in section 4.1, for three NGOs in AR1, having staff LHIV was their motivation to start developing a WPP. In AR2/3, 12 respondents in twelve NGOs reported to have staff LHIV.

PLHIV have been increasingly actively involved at various levels and in various ways in the SAN!SIP project. In AR1 just one NGO mentioned actively seeking involvement of PLHIV in development of the WPP. In AR2/3 more than half (14) of the NGOs said that they actively try to involve PLHIV. Twelve have staff LHIV who they try to involve, while two other NGOs invited PLHIV to sensitize staff and to obtain information on how the WPP should assist

staff LHIV. Based on these experiences, their policies were designed. In one NGO, a staff member disclosed her HIV positive status during the process of WPP development. Her experiences were used in drafting the policy:

There was good involvement of the staff LHIV. She narrated stories about how she was treated by her mother-in-law and how she went for a job and she was not given [it], etc.

One NGO collected essential inputs from INP+ and a member of the men having sex with men (MSM) network, before developing the WPP. Case studies show how NGOs actively seek the involvement of PLHIV. One FPP reported that over a period of six months, about five sessions with HIV positive speakers were provided for staff; the first two sessions being formal and the latter three informal. These were repeated for new staff. Support staff were given the opportunity to discuss with PLHIV separately, as a group, as they could not sit with the others for more than half an hour due to their work obligations. One NGO recounted how PLHIV speaking to staff made a huge difference.

Normally people are thinking of imagined persons, now they saw the reality. Seeing is believing!

5.4 HIV stigma and discrimination

Reducing stigma and discrimination is one of the key components of effective management of HIV and AIDS in the workplace, has been focused on in most workshops, and was a specific theme in data collection in AR2/3. In the first workshop with NGO directors, Indian positive networks shared their experiences of workplace related stigma and discrimination and commented that, "In the workplace, we can have a policy, but we also need a [positive] culture". They shared that increased visibility of PLHIV in the NGO also increased social acceptance and reduced stigma and discrimination, so giving the advantage of public disclosure. The SAN!SIP project facilitated workshops in the respective states, especially for state and district level networks. This two day workshop focused on themes of gender, stigma, and discrimination, the need for workplace programs in the networks, and

promoting leadership. The project also identified the need to strengthen the second line leadership for more exposure, positive speaking, and representation at various fora. One thing which came out from these workshops was that even in the networks, stigma and discrimination needs to be properly understood in its entirety. Stigma against HIV and AIDS is present in Indian society, which was illustrated by the experiences of one FBO mentioned before, whose staff members were hesitant to start developing a WPP as they feared losing their job because their family members would not endorse them working on HIV and AIDS.

In the RNABS, staff did not consider HIV related stigma and discrimination as important; only two-fifths of staff thought that in an HIV and AIDS policy there should be attention to non-discrimination. One-third (32.3%) of staff expected some sort of stigma and discrimination if management recruited an HIV positive staff member; they thought that co-staff would bother, protest, neglect, or refuse to work with the person. Most staff members (77%) were of the opinion that PLHIV do not have the right to work. However, a majority (72.7%) of managers in the baseline study thought that co-staff would support the HIV infected person. The difference between the views of managers and staff may lie in the issue of whether it concerns a newly recruited HIV positive person or an existing staff member who becomes (known to be) HIV positive; 85.3% of staff felt that both males and females were empathic towards an HIV positive staff member, only 6.9% thought they were not, 1.4% said the situation did not apply to them, and 6.5% did not know. A positive finding of the RNABS was that a large majority of staff (90.3%) generally thought that their management stands for a positive approach towards staff LHIV, and 84.3% thought their organization provides space for staff LHIV to continue working.

FGD participants of all NGOs in AR2/3 agreed that in India there is widespread stigma attached to HIV and AIDS. They explained that the main reasons for this are people's low awareness of HIV and AIDS, associations of HIV with wrongful conduct, and misconceptions regarding the modes of transmission. However, with the exception of one NGO, FGD participants reported that there have been no previous instances of stigma and discrimination in their workplaces, and that there will also not be any in the future. They are of the opinion that this is because staff have more awareness of HIV; in some cases because of the WPP. Similarly, 94.2% of the survey respondents never noticed any discrimination based on HIV status in their organization. Survey questions in AR1 related to stigma and discrimination show that it is low in

the workplace: only 8% of staff said that they mind or would mind working with staff LHIV, only 2.2% thought discrimination of staff LHIV is acceptable, and only 2.2% thought PLHIV should not be recruited. Despite these generally positive findings, eight managers and staff in five FGDs in AR1 mentioned that stigma and discrimination were challenges for WPP development and implementation. Three managers thought that some staff may have problems accepting a staff LHIV. In the FGDs it was suggested that staff's lack of knowledge on how to deal with staff LHIV could result in stigma and discrimination. The challenge was perceived as even greater in NGOs which did not yet have a WPP.

One project director reported experiences of enacted and perceived HIV related stigma:

Initially staff used to pass comments saying that these people [outreach workers] are positive and they were very cautious when they talk to them. There was also a case of perceived stigma as one of the HIV [positive] staff felt that no one likes him because he's positive.

FGD participants for this NGO did not mention this. Thus we cannot conclude whether there really is no stigma in the NGOs; on this matter an NGO head commented that:

There might be perceptions in people's minds which are not openly stated due to political incorrectness.

Staff attitudes on working with HIV positive staff – either practical or theoretical if there is no known staff LHIV – are important to consider in WPP development. Unlike fears expressed by managers during SAN!SIP workshops, the surveys found that attitudes of staff were positive towards having staff LHIV. In AR1, nearly all staff in the survey said that they did not mind working with staff who are HIV positive (92%), were of the opinion that discrimination of PLHIV is not acceptable (97.8%), and that PLHIV should be recruited if they had equal qualifications (97.8%). However, participants in one FGD mentioned that showing favour to HIV positive staff above staff with other diseases may pose a challenge. A case study also found a negative attitude of some staff members. In one NGO, for example, about four years ago, a staff member was found to be HIV positive. Not all colleagues could deal with it, and two even quit their

job because of it. On the other hand, this lady also got a lot of support. For instance, she received nutrition support, and her children got the opportunity to go to school. Later, the HIV positive staff member passed away. Although there were no guidelines and rules at the time, the NGO has learned from the experience and their WPP basically contains what the NGO did for this particular staff member: amongst others, providing time flexibility and sharing work.

AR2/3 survey findings also show a very positive response to recruiting PLHIV, with very low or no reported stigma in work settings and a very positive response to working with HIV positive staff. A high 93.3% of respondents felt that the organization should recruit a person who is HIV positive. This number is similar for each state and all genders. In NGOs with staff LHIV, 94.8% of survey respondents said that they are comfortable working with them, and a majority of 94.2% never noticed any discrimination based on HIV status in their organization. In NGOs without known staff LHIV, 93.8% said that they would feel comfortable working with PLHIV if there would be any in the future.

5.4.1 Measures to reduce stigma and discrimination in NGOs

One of the key components in the developed WPPs is a stigma and discrimination related guideline. This is to ensure that HIV positive staff have an enabling environment for themselves and their families. Six out of ten NGOs in AR1 had anti-stigma and discrimination measures, including equal treatment of staff irrespective of HIV status, and statements that staff can be terminated after complaints of stigma or discrimination. In five NGOs' WPPs it was spelled out that PLHIV have the right to work, to a good working environment, and to have equal chances as staff not LHIV. Staff in the survey were generally aware of these measures and guidelines.

In all NGOs, stigmatization and discrimination is considered a serious disciplinary offence that will lead to stringent action, up to and including termination of employment. The severity of action varies between NGOs. Two managers said that they were unsure of the measures they would take; it would depend on the nature of the case. Other NGOs believe in giving the accused staff member a fair hearing by setting up an enquiry. An NGO secretary said she would first try to establish a good rapport with the individual and then address the root cause of the discrimination instead of resorting to termination. A program director

explained how he ensures that there is no stigma and discrimination:

When we started to look at the policy, we came to an overall decision that the policy should focus on employment [of PLHIV] and no screening and the second was zero tolerance of discrimination. In case someone discriminates the person will be terminated just on that ground. An enquiry will be set up and this is there in the draft [WPP] itself.

5.4.2 Effects of WPP on HIV stigma and discrimination in the workplace

During the course of the project, the continuous efforts in WPP have yielded fruits as NGO employees are engaging themselves in discussions on HIV, whether or not they work in HIV involved organizations. In different SAN!SIP workshops, NGOs reported a shift in the mindset of staff with regards to HIV, which was actually reducing stigma and discrimination in the workplace. The 2008 annual report noted 'a transformation from HIV scared staff to HIV informed staff' in most NGOs. Furthermore, already in AR1 all managers of NGOs with a WPP reported a change in staff attitude towards PLHIV: they are more empathetic towards them. The same was reported by staff in FGDs, where participants would say things such as "It [the WPP] made us realize that everyone is equal", and "With the WPP the infected person is treated with dignity as he/she is accepted in the workplace".

NGO managers in AR1 reported that trainings and sensitization programs helped to create more awareness of HIV and AIDS issues, and this in turn they believed to be a key reason why the WPP has had a positive effect on reducing stigma and discrimination. One manager explained that:

The WPP has a positive effect on stigma and discrimination as it increases staff awareness on HIV and AIDS issues and reduces

fear they have. This was evident in the recent workshop that we had where our staff mingled with PLHIVs well as compared to the earlier workshops.

In a case study it was mentioned that:

Before the WPP, there was some kind of HIV related stigma and discrimination – PLHIV were considered as having conducted a crime. The WPP changed this attitude.

In addition to enhanced awareness, IDI respondents felt that the WPP will itself act as a safety net for HIV positive staff. Since it is mentioned clearly in the WPP that stigma and discrimination will not be tolerated and/or accepted, staff will naturally comply and refrain from any form of discrimination.

Two managers did not report a positive effect of the WPP on stigma reduction because they said that stigma and discrimination were never really problems in their NGOs. The supervisor and FPP of one of these NGOs argued:

We have always been having rules and regulations regarding this. It is certainly not because of the WPP.

Participants in two FGDs concurred with these two managers above, saying that there was never any stigma and/or discrimination in their workplace, and therefore the impact of the WPP in this area had been negligible. Participants of thirteen FGDs in AR2/3, however, said that the WPP had reduced stigma and discrimination because it helped to increase awareness about HIV and AIDS issues. A male FGD participant explained the effect of the WPP as follows:

Earlier we wouldn't talk much about HIV because we did not know so much. Now after the policy, we have got to know a lot about HIV because of the training programs. All of us have accepted the policy and everybody is cooperating which was not there

earlier. So the WPP has an effect on HIV and AIDS stigma because of this increase in awareness.

The following case study, recounted by a manager, illustrates the opinion of some managers and staff that positive discrimination of staff LHIV should also be avoided, and that all staff – HIV positive and negative – should be treated equally:

Before we developed the WPP, we employed a woman who was asking for help as an office attendant, following our policy of helping the vulnerable, especially women and PLHIV. However, the woman was misusing the benefits. Staff members did not like her behaviour, as she was being too personal with them. I did not know about this, because my staff didn't tell me because they did not want to give the impression that they were discriminating because of her HIV status. Although they were not happy with her behaviour, staff members helped her. At the same time, the lady was taking many leaves, did not do her work properly, and in addition harassed other staff and took her children to the office. This affair led to a lesson learnt in a positive way: to be compassionate, but everyone should be treated equally and should have the same benefits. This event made me realize that I should not hire someone because he is either HIV positive or negative, but because of his or her capacities. The same applies for access to benefits; everybody should have access, both HIV positive and negative. This experience made us formulate in our WPP that we do not positively

discriminate PLHIV. We give medicines for everyone – not only PLHIV. The WPP is being mainstreamed in other policies, there is no focus on HIV and AIDS alone. We believe that only in this way discrimination can be reduced; just treat PLHIV like everyone else will help to reduce stigma and discrimination.

Because purely focusing on HIV and AIDS was considered discriminating in itself, half of the NGOs in AR2/3 did not develop a stand-alone WPP, but integrated it into other organizational policies such as health.

5.5 Disclosure and confidentiality

Disclosure and confidentiality stand in an ambivalent relationship to one another. Staff usually have to disclose to someone in the NGO if they want to access benefits. They have to trust that this person will keep their HIV status confidential and protect their rights to privacy. On the other hand, staff disclosing to all staff may help to reduce the stigma of HIV and AIDS and make others confident to disclose. Managers of two NGOs in AR1 mentioned confidentiality as a possible challenge for WPP implementation, because it is difficult to maintain if staff want to access benefits, including adjusted work hours.

However, disclosure in times of free services is not always necessary, as the following experience shows. The manager below explains that all the NGO's staff are given information about what services can be provided and where. If asked for, the NGO provides assistance, for example legislation or family support. In that case, however, disclosure to someone from the HIV and AIDS committee is required.

My motto is to empower them regarding the available services. We clearly explained in informal sessions about the services' need for positives, and the places in Andhra Pradesh and even in Orissa. We clearly told them there is no need to share your status. Of course you can do if you are otherwise unable to face your problem. For counselling services, if you feel you can come. For care and support [the]



government established nearly forty-four care and support centres in Andhra Pradesh. If you want ART, free of costs, there are many services in Hyderabad. So all this information has been shared to them. If they want any leave, relaxation of hours, special care and support for family, that's for finance. Apart from the regular reimbursement, they can come to me, to the accounts officer or to anyone.

Other NGOs have guidelines that staff LHIV should disclose to certain persons. These persons must maintain confidentiality, and the experience is that only few staff LHIV are open about their status to others. They trust that their status will be kept confidential. One NGO head explained that they have punitive measures against breach of confidentiality, which they had to take once when a staff member revealed the status of a colleague; the offender was dismissed. Three other NGO heads reported that they would take punitive measures if confidentiality was breached; however, up to now this has not been necessary.

Concerning confidentiality, the RNABS found that for staff, confidentiality and VCT were among the least prioritized issues in the WPP, with only 21% of staff thinking confidentiality should be an element and 19.9% that voluntary testing should be an element of the WPP. However, NGOs do have confidentiality as an element in their WPP: seven out of ten NGOs in AR1 reported so; 53.4% of staff in the survey spontaneously reported knowing about this and 38.8% after probing, totalling 92.2%. Asking staff about the WPP's influence on confidentiality in AR1, 74.6% thought the WPP would not cause any change or that confidentiality would increase, 21.7% thought it would decrease confidentiality, and 3.8% did not know.

In AR2/3, disclosure and confidentiality was a special theme. Explored were the relationship between disclosure and access to benefits, confidentiality measures at NGO level, and staff ideas about confidentiality and disclosure. Three (13.6%) of the twenty-two managers in IDIs mentioned increased disclosure of HIV status as a result of the WPP. In one NGO, HIV positive staff voluntarily disclosed during the WPP discussions. The program director of another NGO which has HIV positive outreach workers and staff explained:

I don't think they [outreach staff] know that there is something called the WPP but I say that the indirect effect is there in the environment of the organization, enabling them to feel comfortable about disclosing.

NGO heads and managers agree that disclosure to the management, the FPP, accounts or administration, or the immediate supervisor is needed to access benefits. Five IDI respondents openly acknowledged the challenges in maintaining confidentiality. Two of them felt it would be beneficial for the NGO if HIV positive staff would disclose to all. According to them, it would be misconstrued as favouritism if HIV positive staff who did not disclose their status received benefits, and it would affect the performance of other staff. Some respondents indicated that they would like to have more guidelines from SAN!SIP on drawing a balance between confidentiality and benefits. An SSIPG member commented:

I have often asked this question in the SSIPG meeting and have not been able to get a conclusive response.

Another NGO manager asked the interviewer:

I would like to know of some guidelines that can be used for preserving confidentiality. Please let me know if you are aware of any.

IDI respondents of three organizations confirmed having guidelines in the WPP for maintaining confidentiality. FGD participants in ten NGOs thought so. In addition, IDI respondents of two NGOs reported that in future they will develop guidelines. In four NGOs, new employees are informed about the organizations' rules, for instance through an appointment letter; however, there are no formal guidelines concerning confidentiality. Having information about HIV positive staff in employee files was seen as an effective way of maintaining confidentiality in two organizations. The FPP of an NGO gave her personal phone number to staff, so that they could contact her at home should they feel uncomfortable disclosing at the workplace. IDI respondents of ten NGOs reported that there are no guidelines in place for maintaining confidentiality, because "staff always maintained confidentiality", "everybody understands that such behaviour is not

tolerated", or "it is based on individual agreements". In one organization, a question box method was used for answering questions staff have about sexuality, living positively, and problems they are afraid to ask openly. These are answered by the directors and FPP after consultation with resource agencies, if necessary.

Most staff in the survey were of the opinion that an employee's HIV positive status should and will be kept in confidence. Only in two NGOs did staff differ in their opinion, in that they thought that making the HIV status known to all would be beneficial for the staff and organization. The survey reflected that a large majority of staff (96.2%) said that they trusted their organization to preserve confidentiality. A slight majority of 52.1% of respondents believe that their organization will take punitive measures if confidentiality is breached.

Staff in five FGDs (23.8%) believed that the WPP had an effect on confidentiality. A staff member confirmed that:

Earlier we never paid attention to maintaining confidentiality and if we come to know that staff member is positive, we will tell others. But [now] we will not do it. We have got awareness through this policy.

In seven NGOs there were mixed opinions about the effect of the WPP on confidentiality. In the survey, 214 participants (68%) confirmed increased confidentiality, and this is a very important indicator. Around forty-nine individuals (16%) felt there had been no impact, and twelve (4%) did not answer.

The majority of survey respondents (83.4%) feel that their workplace is conducive for disclosure, as there is complete acceptance of HIV positive staff and confidentiality will be maintained. Staff members, however, also feel that since there are no guidelines, disclosure of one's status is an individual decision and is left to the discretion of the individual. From the FGD data, it is evident that disclosing to someone with authority gives staff a sense of relief that they can avail benefits. This is reflected in the survey. By far, most survey respondents (63.2%) would prefer to discuss their HIV status with their NGO head, followed by 28.3% who would prefer talking to their peer staff. It is very clear that individuals do not see the FPP as a key player; only 19.4% of staff in NGOs with an FPP would prefer to talk to this person (32% are in NGOs without an FPP). Respondents furthermore did not see

a major role for counsellors, AIDS committees, or their immediate supervisor.

FGD participants in sixteen NGOs felt that the WPP has had an effect on disclosure, in that HIV positive staff may voluntarily disclose because of the benefits available. Furthermore, the organizational environment, as an outcome of this policy, will promote disclosure, where PLHIV will be assured of complete acceptance by management and staff. The senior coordinator from an NGO that does not work with HIV and AIDS explained the effect on disclosure:

Earlier they would not have disclosed their status [out] of fear of discrimination. Since there was no awareness amongst staff, stigma and discrimination could have been there. But now because of the WPP they need not to worry about that, there is no problem in disclosing their status.

There were ambivalent responses in six NGOs, where some staff felt that the WPP has or will have an effect and others did not. The latter group felt that the environment in the organization was already conducive for disclosure.

5.6 Gender

NGO participants in the first workshop in 2006 recognized that gender (and caste) inequalities make people more vulnerable to HIV and AIDS, and thus reducing gender inequality was recognized as a major tool in reducing the spread of HIV; the WPPs should be developed to reflect this. According to the Indian PC, gender equity and a rights based approach have been cross cutting themes during all trainings and workshops; this is also obvious from workshop reports.

In the AR, questions were asked about gender relations, and analysis of quantitative data by gender was conducted, as elaborated below. However, the RNABS data cannot be analysed by gender because of the way in which questions were framed, always asking 'Do both males and females...' For instance: 'Do both male and female staff have access to services?' Thus the question could be interpreted as asking whether both sexes have equal access, or whether there is access in general. One RNABS question related to gender was whether the NGO has a sexual harassment policy; one-

third of the NGO managers reported that they had one, but only one-fifth (20.7%) of staff members reported so.

AR1 and AR2/3 collected gender specific data, and gender differences were explored in answers about knowledge, attitudes, and practices. Very few staff reported to be transgender; no one in AR1, and in AR2/3 only 5.9% of FGD participants and 0.6% of survey respondents. All reported that transgender staff come from Karnataka. Nine NGOs in AR1 said that they work on gender and women's issues with their target groups as one of their programs, or had mainstreamed gender in all programs.

Four NGO managers in AR1 and eleven in AR2/3 reported addressing gender issues in their NGO. They do this by addressing gender as an element in their WPP, having a gender policy, having a committee to examining gender related issues and sexual harassment, and/or having a sexual harassment guideline/policy. Some NGOs look at the specific susceptibility of women for HIV, while others say that all genders are equally susceptible.

There were hardly any gender differences in terms of HIV and AIDS related knowledge, attitudes, and practices in the surveys, most data are therefore aggregated for men and women. Furthermore, most AR1 survey respondents (90.6%) thought that there was equal gender participation in WPP development. There was no difference in opinion on condom provision in the NGO (for both, about 65% were in favour). Equally, the majority of both men and women thought that there are equal job opportunities for men and women (88.4%), and that decision making opportunities were considered to be gender neutral (92.7% of survey respondents thought so).

AR1 data show that in workplaces there is much less sexual harassment than generally in society; 91.3% of male and female staff recognize sexual harassment in society, but only 5.1% see it in their NGO – both female and male staff reported so. Although sexual harassment was not reported as a problem in the NGOs, 64.5% of staff still thought that a sexual harassment policy is important to have.

Exploring the gender differences in fringe benefits, AR2/3 found that in most NGOs there is gender equity. However, in two NGOs women who work extra hours are compensated, while men are not, as the management reasons that women hold larger responsibilities at home. One NGO has a policy to provide work opportunities to vulnerable women. Respondents of two organizations explained that Dalit staff receive preference. According to the director of one of these organizations:

In another organization, while there are no gender differences when it comes to promotions or fringe benefits, Dalit candidates are given more preference.

Another respondent explained that:

If people are competing for a particular position and each one is quite efficient, the preference is given to the Dalit candidates.

Three NGO managers argued that they strive to achieve a gender balance across all activities within the workplace. Gender audits are done in one NGO, which helps the organization assess gender equity across all NGO activities. Corrective actions are taken based on the findings, according to the secretary:

We do gender audits every year and if the audit findings reveal that female staff do not benefit from trainings, we will take a conscious effort to send them to trainings thereafter. [...] All women have a synergy meeting in which the recommendations have been made and carried to the management for necessary provision.

Nearly all AR2/3 surveyed staff agreed that there are no gender differences in opportunities in their workplaces: 97.8% of staff felt that there are equal promotion opportunities by gender, and 98.7% indicated that there are equal training opportunities. Opportunities for training and promotions are instead based on competencies and skills. The survey found a gender balance among staff who participated in training, with 96.5% of female respondents in the survey and 92.9% of male staff participating.

While there is no reported gender based discrimination in workplaces, staff of three NGOs emphasized that their organization tries to achieve gender inclusion by striving for a fifty percent representation across all aspects. One manager commented that there may be gender differences as the organization is gender sensitive:

Since our organization is gender sensitive, there might be possibilities to help women. I will not say it's always there. But there are chances.

IDI and FGD respondents across all organizations and levels felt that the WPP does not have an effect on gender in the workplace, since gender equality and equity in most organizations is already practiced. This is illustrated by the following quote:

We have been giving equal opportunities to men and women and there is no gender based difference even before the WPP implementation.

However, in contrast to the IDIs and FGDs, the survey data shows that there is a perceptible increase in staff awareness of gender issues after WPP initiation. A majority of 78.3% of respondents that were aware of a WPP in their organization think that there has been an effect on gender issues, with more female (83.9%) than male staff (71.4%) reporting so.

In NGOs with HIV positive staff, females and males felt about equally comfortable (93.6% and 96% respectively) working with staff LHIV. Where there were no known staff LHIV, the same was the case, with 95.8% of women and 90.8% of men feeling comfortable. Furthermore, both had equally positive opinions on recruitment of PLHIV (female 92.5%, male 94.3%). Females appeared to take more personal HIV preventive measures because of the WPP (with 86.4% reporting so), than men (73.7%). However, these findings are not necessarily conclusive, because the men were possibly already taking measures. The survey data show that 25.6% of men and 13.6% of women use the same prevention as before the WPP. The data unfortunately do not specify what this prevention entails. With regards to the provision of condoms at the workplace, comfort level is higher among men (76.3%) than among women (57.8%); and more women (14.5%) than men (4.4%) feel very uncomfortable with the provision of condoms.

Exploring the gender differences in HIV stigma in the FGDs, all participants agreed that there is a strong correlation between gender and AIDS related stigma in society. Women are often accused of acquiring HIV infection and bringing it into the family. Deep rooted patriarchy and cultural biases that place a man higher than a woman, as well as the association of women with sex work, are some of the reasons attributed to this. With regards to gender and stigma

in the workplace, the director of only one NGO said that there might be gender differences within the workplace; however, not as much as in the community. All other IDI respondents clearly said that there would be no difference in the way an HIV positive man and an HIV positive woman is or will be treated. One respondent, however, felt that if the woman is a single parent, the organization might look at specific support, like education for the children. In one NGO, the management was looking at promoting an HIV positive staff member, but this staff member felt that she could not cope with the additional responsibilities because of her deteriorating health and therefore did not take it up.

Exploring gender and stigma in the FGDs also discovered an absence of gender related stigma in most NGOs. Some participants said that they favoured HIV positive single female staff with children regarding access to benefits and help, because they usually have a bigger responsibility for taking care of their families. As suggested by a female FGD respondent:

Men and women are different. A woman has to take care of her children. Her children are dependent on her. [...] She is the only person for her children.

5.7 Sustainability

At the 2006 sensitization workshop, various concerns related to sustainability were expressed. There was a fear that as a donor initiative, the project cannot be sustainable. Problems with sustainability were also envisioned at NGO level. For an NGO not currently working on HIV and AIDS, the concern related to adequate internal resources to create and sustain such a policy while also continuing to deliver on existing programs. During other SANISIP workshops, financial sustainability was addressed.

5.7.1 Sustainability in NGOs

In AR1, most NGOs considered lack of finances a challenge and threat to sustainability. Another mentioned challenge was the possible waning interest of staff; within six organizations, lack of interest of staff or conflicting ideas about the WPP was mentioned. According to an FGD participant, “The initial enthusiasm for implementing the WPP will fade away as time progresses”. Another FGD participant said that “Motivating staffs who are not very much interested is a challenge”. One of the AR1 recommendations to NGOs was to write proposals for funding to bodies other than STOP AIDS NOW! donors.

Managers’ opinions about sustainability were less pessimistic in AR2/3. NGOs are clearly interested in making the WPP an institutional policy, which will be continued, irrespective of funding availability. Respondents of all but one NGO were sure of being able to sustain the policy after the funding period. They either have measures in place or have thought of measures for continuing the policy. So far, NGOs with a fully functional policy have not been constrained to meet policy related expenses and therefore have not acted on these measures as yet. The following sustainability strategies are being taken or thought off.

Lobbying with other donors

NGO heads and FPPs feel they can convince their other donors to include the WPP in the project budget. They reason that having a WPP only increases the credibility of the NGO and therefore donors will support the activity. An IDI respondent explained:

Definitely we want to continue it. We may apply to other donors for financial help. So if one funding stops, we should apply to other donors. That kind of continuity we should plan.

The FPP of another organization had a similar idea:

We will implement the policy till then and then we will try and ask other donors to support. Once we show successful implementation of the policy, other donors may want to fund it.

Earmarking a part of organizational general funds for WPP

Some NGO heads decided to allot a part of their general fund – which they already have or will raise – towards the WPP. This is explained by the secretary of one organization:

Now and then wherever the necessity arises we are trying to raise money, but since we are nineteen years old now we are planning to have our own fund raising strategy not only for this [but] for many other things.

Raising money from the ‘for profit’ sector
Three NGOs plan to explore corporate houses and industries as an alternative avenue for funding. One NGO director explains:

We are seriously thinking about raising money from the industries in our area. We have the 80G provision [a section of the Income Tax Act which offers tax benefits to donor agencies] and this will help us to collect money.

Having a WPP that does not require additional money
Some NGOs are of the opinion that WPP implementation does not have (to have) financial implications. NGOs believe that awareness programs and facilitating services do not require any specific funding. Furthermore, HIV positive staff can be connected with public institutions that offer care and support services.

5.7.2 Sustainability at project level

Concerning sustainability of the SAN!SIP project, TAPS were set up to ensure knowledge base continuation and continued support for NGOs in low-cost sustainable WPPs and a TAPS handbook was developed (see section 3.2.1). The PC reported that from the TAPS program, financial sustainability became clear where partners readily added funds from their own resources to the seed money given – which proves their commitment.

The project also submitted two proposals for the GFATM round 7 and 8, involving formal and informal workplaces. Although the proposal was applauded by the technical review group of the India Country Coordinating Mechanism (CCM) as something unique, unfortunately it was not accepted.

India is one of ten countries involved in a three-year project of scaling-up activities to address HIV and AIDS in the workplace, building on the experiences of the STOP AIDS NOW! pilot project ‘Managing HIV and AIDS

in the Workplace’ in Uganda, India, and Ethiopia (STOP AIDS NOW! 2009). The project is coordinated by Oxfam Novib. The scaling up response in India, spearheaded by INSA-India and including the SAN!SIP PC, is called SIMPLE (Sustainable Internal Mainstreaming Programs in Local Entities). The proposal is to work with thirty NGOs and five networks of PLHIV, spread across India, which were not involved in SAN!SIP. These organizations should have the potential to lead between ten and twenty-five further NGOs, FBOs, and networks of PLHIV in HIV and gender mainstreaming. SIMPLE also aims to spread its activities to Nepal. In Nepal, the first step will be to explore the scope of NGOs and PLHIV networks. Thereafter, organizations will be identified which can form a critical mass of capacity building providers, to take forward HIV and AIDS workplace responses within NGOs and PLHIV networks. SAN!SIP and SIMPLE partners will constitute a national knowledge sharing and lobby group to address gender vulnerability, stigma, and management of HIV and AIDS in the workplace at zonal, regional, national, and international levels ³.



³ See: SIMPLE project proposal, submitted by INSA-India, for a copy contact: insaind@airtelmail.in

6 Lessons learnt and recommendations

This chapter draws out the successes, promising practices, and challenges of SAN!SIP, at project management, and NGO level. These are lessons learnt and have informed the recommendations to various SAN!SIP stakeholders and to consortia for similar (future) projects. The recommendations are also informed by suggestions from the SAN!SIP stakeholders, who were explicitly asked for these, including NGOs, SSIPG members, the Indian PC, the Dutch PC, and donor organizations' policy and program officers.



6.1 Successes and promising practices

WPP in a low HIV prevalence rate country
The first success of the project as identified by the Dutch PC has to do with the concrete result of NGOs setting up a policy on HIV and AIDS in the workplace in a low prevalence country.

Though it is a low prevalence country, they very quickly integrated the importance of wellness and wellbeing for staff. Especially in the beginning, people had some questions about it, but later on we saw that this helped them with developing a policy. [...] I think that is very interesting.

Local ownership

The Indian structure, as foreseen by STOP AIDS NOW!, has been implemented and operated well to create local ownership of the project. From the beginning of the project, the structure has been developed by the involved organizations and people themselves, and the STOP AIDS NOW! Netherlands PC has seen a process of learning.

Compiling a group [of NGOs], the contacts that are intensified or that derive from that, I really believe in that. I think that a project like this, with this scope and potential, is served by such a structure.

Participation of all levels of NGO staff

A good practice that was recommended, and which most NGOs applied, was to involve staff in drafting the policy. NGOs either developed the WPP in consultation with all staff members or shared the policy with all staff once it was developed. Staff inputs were taken into consideration and incorporated into the policy. It is important to involve all levels of staff, including support workers, but also managers and directors. If the NGO is too big to involve all staff members in

development, at least all should be informed and sensitized on the WPP. Translating the WPP into the local language facilitates broad accessibility. SAN!SIP facilitated the involvement and motivation of directors and senior managers by starting with a sensitization workshop for them and involving them in setting up the project structure.

Adhering to MIPA principles

Involvement of PLHIV – either as staff members or representatives from positive networks invited as speakers – is a good practice to sensitize staff members to the importance of addressing HIV and AIDS in the workplace and reducing stigma and discrimination. The involvement of a person delegated by the leadership of INP+ to be on the SSIPG aided with drafting the proposal, and with planning, implementation monitoring, and evaluating the program. Furthermore, the project later involved the state level positive networks of Tamil Nadu, Andhra Pradesh, and Karnataka in the WPP workshops, which brought in local grassroots involvement of PLHIV.

NGOs not waiting for donor funding to start WPP activities

It was a promising finding that NGOs started implementing HIV and AIDS activities, mainly awareness and sensitization, even before receiving donor funds. This was done through discussions among staff and hanging posters on the wall.

NGOs providing condoms for staff

Although a contested issue in some NGOs, providing condoms for staff is considered a promising practice, because most staff are in favour of doing so.

Continued capacity building based on needs and upcoming issues

Continued capacity building by SAN!SIP and flexibility in responding to upcoming issues is a good practice. SAN!SIP responded to challenges brought up by the AR, and paid more attention to, for instance, the appointment and roles of FPPs in NGOs, and the promotion of VCT.

Taking sustainability measures

Planning for and taking sustainability measures is a good practice. SAN!SIP and NGOs provided various good examples, and aiming for a low cost WPP that does not require external funding is one way. NGOs facilitated access to services for free or at low cost by

providing staff with a directory of HIV and AIDS related services, writing proposals for funding, mainstreaming HIV and AIDS in other organizational budgets, and through internal fundraising mechanisms. The TAPS are a measure to ensure sustainability of knowhow and to scale up the response.

Measures against stigma and discrimination

There was less stigma and discrimination of PLHIV found in SANISIP NGOs than generally in the wider community. This was a result of awareness raising among staff and sensitization on the realities of living with HIV and AIDS. Furthermore, organizational regulations against stigma and discrimination, outlined for instance in appointment letters, help to reduce stigma and discrimination.

Guidelines for disclosure and confidentiality

WPPs specify to whom staff can disclose, and contain guidelines for (breach of) confidentiality. Generally, staff experienced the workplace as a safe environment where they could disclose their status and access benefits and support, and would be ensured of confidentiality. This is a great success.

Linking and learning with outside public and private organizations

Linking and learning with public and private organizations was a good practice by SANISIP and NGOs. This was done for information sharing, access of free IEC, condoms, training, and referral services.

Applied research

The AR has served its purpose in the sense that the Indian PC and SSIPG members reported that they took up most of the AR recommendations, including sharing promising practices between NGOs during training and meetings; intensified networking with state level AIDS related institutions and international organizations; shared networks with partner NGOs; and promoting the appointment of an HIV and AIDS FPP in NGOs. The founding of TAPS was in response to AR recommendations to share experiences and enhance awareness about the FPP and his or her roles (see section 3.2). The PC, SSIPG, and YRG CARE coped with delayed final reports by sharing draft findings with SSIPG members and NGOs, so messages have come across in India before reports were out.

6.2 Challenges

In both AR phases, stakeholders reported challenges. Some of these challenges reduced or were solved over the course of the project. At the start of the project,

some NGOs experienced a lack of knowledge on the process of WPP development and implementation and a lack of interest for the WPP among staff. NGOs faced difficulties with a changed identity – instead of working for the community they were now caring for staff, or as an FBO they now had to talk about sexuality and HIV. These challenges were not reported in AR2/3. While in AR1 stigma and discrimination of fellow HIV positive staff was identified as a challenge, this was hardly a problem in AR2/3. Some issues remained a challenge over the course of the project. These are listed below.

Lack of time

A main challenge was lack of time. NGOs felt they did not have enough staff hours to devote to WPP development and implementation, while at the level of SSIPG members could not always free up time for meetings. At the beginning of the project, lack of time was combined with NGOs not having an FPP for HIV and AIDS. This was resolved later in the project.

Financial constraints

Finances were reported as a constraint over the course of the project, although not unanimously. Some NGOs successfully developed a low cost WPP. Despite this, in AR2/3 some NGOs reported as a challenge the unknown financial implications when and if more staff would need support and benefits.

Fear of misuse and conflicts

In AR1, some NGOs feared a misuse of the benefits by staff. No actual cases of misuse were reported, however. In AR2/3 NGOs feared possible conflicts between staff when benefits were accessed. Furthermore, some NGOs experienced challenges in striking a balance between confidentiality and HIV positive staff accessing benefits.

Negative stance on condoms

While the provision of condoms is reported as a promising practice, it is still a contested issue in some NGOs, especially FBOs. It remains a challenge that some NGOs are against the provision of condoms in the workplace, while many staff members are in favour of doing so.

Applied research

Reports have been delayed (although draft findings have been communicated in India), and Dutch program and policy officers all reported that they have not gone through the AR reports thoroughly. There are several reasons for this. Some of the Dutch partners were not aware when a new report came out. The project in Uganda started a year before the trajectory in India, and results of the former were shared earlier. This meant that the focus was mostly on these first results,

and that interest reduced when the results from India followed. Furthermore, lack of time was a reason for not reading the AR reports.

6.3 Recommendations to SANISIP stakeholders

To NGOs

- Mainstream the WPP in other organizational policies;
- Continue to raise awareness of staff on the WPP and related issues. Provide updated information on HIV and AIDS and access to services, for instance on a notice board;
- Discuss with staff the preferred method of WPP dissemination, and disseminate the WPP to all staff. Translate the document into the local language if needed. Provide new staff with a copy of the WPP and an explanation of the contents;
- Continue or start implementing WPP activities that do not cost money or that do not require much funds. Make use of internal capacity and resources, networks, and services that are accessible for free;
- Link with other stakeholders for services, including for training, condoms, VCT, and ART;
- Specify the job description of the FPP and/or the committee with attached time allocation, and make sure that all staff can approach the FPP;
- Continue to deliberately involve PLHIV and HIV positive networks;
- Share experiences and promising practices among partner NGOs, for instance on issues such as maintaining confidentiality. Continue linking and learning;
- Use the new STOP AIDS NOW! document CSO guide for the development of a WPP and budget;
- Open or continue dialogue with donors about managing HIV and AIDS in the workplace. Consider writing proposals for funding to bodies other than STOP AIDS NOW! donors.

To PC, SANISIP secretariat, and SSIPG

- Continue enhancing awareness about the FPP and his or her roles;
- Advocate usage of the new STOP AIDS NOW! CSO guide to member organizations that are yet to finalize their draft WPP, and recommend NGOs that have a fully functional WPP to review their policies against the backdrop of this document;
- Organize smaller regional meetings to understand issues around why some NGOs are not interested in developing a WPP, and involve those NGOs with positive effects. This could greatly help to encourage

other organizations to explore the possibilities of implementing a WPP;

- Facilitate the formation of meaningful linkages and channels for cross-learning among member NGOs, and continue to help NGOs to network with service providers within their respective geographical area to enable them to use HIV and AIDS services optimally;
- Encourage employers to offer free condoms as both family planning and as an HIV prevention tool, to enhance uptake and lessen inhibition. Advise NGOs to understand from employees which places are most suitable for condom placement;
- Lobbying is very important in the project, and requires continuing attention. Involve other organizations, for instance from the SSIPG, for lobbying activities. If you make use of each others' networks you can create a multiplier effect;
- Let TAPS reach out to a wider range of NGOs. The TAPS program can increase the reach of the SANISIP project, and hence is a good way to scale up the project;
- Have an open attitude, to share and learn from others, also outside the partnership and even the Indian context, to increase conditions for success and innovation.

To STOP AIDS NOW! donors (Cordaid, Hivos, ICCO, Oxfam Novib)

- Screen submitted budgets in a timely fashion and release funds promptly to allow NGOs to implement their WPP activities;
- Open/continue dialogue with partner NGOs about managing HIV and AIDS in the workplace;
- Read research reports and react to recommendations;
- Donors could also have a role in updating their partner NGOs on the process and supporting them, rather than leaving it up to the project;
- Build in a process of WPP programs in grants.

To STOP AIDS NOW! Netherlands PC

- Organize more meetings in the Netherlands with the STOP AIDS NOW! partners' program officers, to increase cooperation with equal trajectories in the region and avoid duplication;
- Share results of the project and lessons learnt earlier (than has been the case during this project).

6.4 Recommendations for (future) similar projects

Stakeholders in SANISIP gave some points of attention for (future) similar projects, based on their experiences.

Project set-up

- Make sure that the project is based on local needs, and fits the local context;
- A good start is crucial: let the group of NGOs in the partnership which want to be facilitated in the internal mainstreaming process select the host organization and the core/steering group from among their midst, according to criteria they set. Let them decide on the roles, responsibilities, and key thrust areas of the project, a vision, project name, and TOR for all stakeholders;
- Have a moderate sized steering committee of 8-10 members, because it helps in lobbying and advocacy at the national level;
- Appoint a project coordinator who is accountable to the steering group and participating NGOs, and give him or her an office in the host organization.

For steering group

- Involve NGOs with experience in the field and let them share their experiences – learn from them;
- Agree on the roles of all members;
- Operate on a regular basis, being realistic about the time members can put aside – make firm agreements on this;
- Make feasible budgets for training and sensitization;
- Keep donor agencies of partner NGOs involved in the project;
- Keep the programs participatory and use the assistance of partners for accomplishing the objectives and strengthening the program;
- Keep the partner organizations with you throughout the process. This can be done through ensuring that in each partnering organization there are (trained) FPPs and that regular meetings and communications are two way.

For host organizations

- Be transparent: keep the steering group informed of all updates and challenges faced so that decisions made have the backing of all;
- At the end of the project ask if they want to change the host partner for sustainability or scale up;
- Do not take sides but be objective and focused on the vision, in order to keep organizations with varied backgrounds, budgets, philosophies, and cultures together;
- Engage the support of others in carrying out the objectives of the TOR.

For local PC

- Ownership by local NGOs is key. Give them enough room to decide on their workplace programs. Try to move things in a manner in which they are not offended; rather, let the NGOs actively pursue inputs from you. Be one of them rather than an outsider;
- Partners are associated voluntarily, so do not impose too much work on them;
- Make yourself available whenever they need you.

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Annexes

Annex 1: List of workshops and meetings

- 22 November 2005, Bangalore, India: **Introduction workshop 'Managing HIV and AIDS in the Workplace'**. Outlined the need for internal mainstreaming programs for NGOs. After this workshop, INSA-India, in collaboration with lead partners from Andhra Pradesh and Tamil Nadu, prepared a proposal for strengthening HIV and AIDS initiatives in NGO workplaces.
- 17-19 October 2006, Bangalore, India: **Workshop 'Managing HIV and AIDS in the Workplace'**. The design and structure for a workplace policy program was determined and the STOP AIDS NOW! partners invited forty-five counterparts to participate in the project.
- 13-14 May 2008, New Delhi, India: **Workshop 'Managing HIV and AIDS in the Workplace'**. The workshop aimed at sharing experiences and knowledge, good practices, and challenges faced in addressing HIV and AIDS in the workplace, and building a better structured platform at the national level.
- 22 April 2008, Raipur, Chhattisgarh: **Workshop CGSACS-UNDP**. The program coordinator facilitated a workshop jointly organized by the Chhattisgarh State AIDS Control Society and UNDP. The objective of the workshop was to inform and engage the industries and other corporate houses on mainstreaming HIV and AIDS within their workplaces.
- Annual: **Workshop NGO Heads Consultation**
- Annual: **Workshop Central Skills Building**
- Annual: **Workshop State Level Regional Language**

Annex 2: NGOs involved in data collection in baseline, AR1, AR2/3, and case studies

NGOs, by state	Base-line	AR Phase 1			AR Phase 2/3			Case studies		
		IDI management	FGD staff	Survey staff	IDI management FPP	FGD staff	Survey staff			
Andhra Pradesh										
Aashray	X	X	1	2		X	2	2		
Action Fraterna	X									
CHAI *	X	X	1	2		X	2	0		
CORE	X									
COVA	X	X	2	2		X	2	2		
CPF	X					X	1	2	X	
CWS	X					X	2	2		
GRAMAM	X									
Hyderabad Council for Human Welfare	X					X	2	2		
LMSSS	X					X	2	2		
MV Foundation	X	X	1	2		X	1	2	X	
SEDS-AP	X	X	1	2		X	2	2		
SIDUR *	X					X	2	2	X	
Total Andhra Pradesh	13	5	6	10	50	10	18	18	135	3
Tamil Nadu										
Arogya Agam/ NESA *	X	X	1	2		X	2	2		
CATER Trust	X	X	1	2		X	1	2		
CCOORR	X									
Don Bosco Anbu Illam	X					X	1	1		
INP+ *										
PREPARE	X									
READ Agency	X									
RUCODE India	X	X	1	2		X	2	2		
SEARCH	X									
SIAAP	X	X	1	1		X	1	1		
SSH	X					X	1	2		
Total Tamil Nadu	10	4	4	7	40	6	8	10	71	0
Karnataka										
Belgaum Integrated Rural Development Society *	X					X	1	2		
Grameena Mahila Okkata	X	X	1	2		X	1	1		
IDPMS	X									
INSA-India *	X					X	3	2	X	
MASS	X	X	1	2						
MGRDSCT	X	X	1	2		X	2	1		
Myrada*	X					X	2	2		
NST	X					X	1	1		
REDS	X	X	1	2						
SAMUHA	X									
SANGAMA	X	X	1	2		X	1	2	X	
WHAD	X					X	1	1	X	
Total Karnataka	12	5	5	10	48	8	12	12	109	3
Grand Total	35	14	15	27	138	24	38	40	315	6

* SSIPG member

Annex 3: Terms of Reference

TOR for SSIPG

- Developing of the project proposal action plan
- Recruit and place suitable project coordinator and support staff
- Monitoring the implementation of the project activities
- Developing research and advocacy strategies which should be informed by issues
- Facilitating linking and learning
- Provide and take lead in advocacy in lobbying
- Reviewing reports made by the project coordinator to be submitted to STOP AIDS NOW!
- Meeting quarterly to review and discuss relevant issues
- Ensuring accountability of the coordinator and hosting organization

TOR for host organization

- Financial responsibilities and administrative responsibility
- Day to day management of the project coordinator
- Technical support to the project coordinator

TOR for project coordinator

Project management

- Lead on strategic and operational planning
- Mapping of participants
- Organize training
- Responsible for providing/organizing technical support

Coordination

- Organizing meeting with STOP AIDS NOW! South India Project Group
- Secretary to SSIPG
- Liaison with STOP AIDS NOW! project officer

Project administration

- Financial management
- Logistical support

Communication

- Organizing learning and sharing events
- Documentation of lessons learnt and best practices

Collaboration and networking

Fundraising from local donors

- Establish an overview on the profile donors' programs
- Arrange meetings with donors
- Writing proposal

Accountability

- Accountable to participating organization local project group, host organization, and STOP AIDS NOW!

Representation

- Linkages with government, INP+, private sector, STOP AIDS NOW! donors, and other forums

Lobbying and advocacy

- Specifically for this initiative on behalf of the participating organizations

Text: Dr Winny Koster, University of Amsterdam & Nienke Westerhof, STOP AIDS NOW!
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STOP AIDS NOW! aims to expand and improve the Dutch contribution to the global response to HIV and AIDS. In STOP AIDS NOW! five organisations, the Aids Fonds, Hivos, ICCO, Cordaid and Oxfam Novib have joined forces.

STOP AIDS NOW! aims to:

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

Visit our website for a wide range of downloadable resources on HIV and AIDS in the workplace, including this report:

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