Implementation and effects
of the STOP AIDS NOW! project 'Managing HIV and AIDS in the workplace' in South Indian CSOs

Applied Research Phase Two and Three

Report

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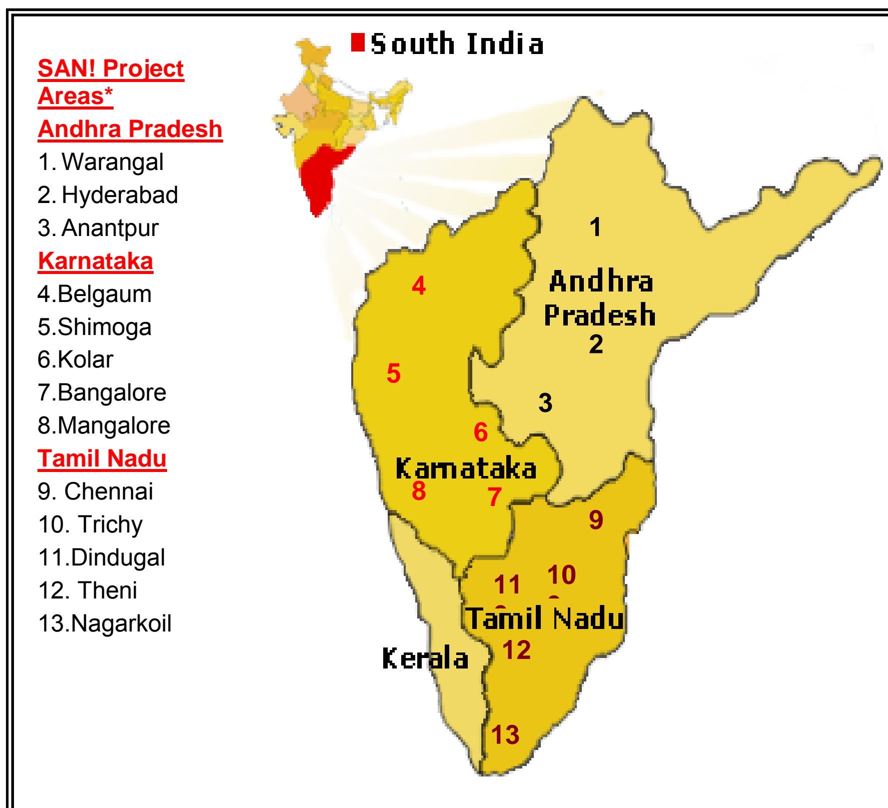

Figure 1: Map of South India with location of CSOs in AR Phase Two/Three

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
AR	Applied Research
ART	Antiretroviral Treatment
CBO	Community Based Organization
CSO	Civil Society Organization
HIV	Human Immunodeficiency Virus
HR	Human Resources
IEC	Information Education Communication
FBO	Faith Based Organization
FGD	Focus Group Discussion
FPP	HIV and AIDS Focal Point Person
ICTC	Integrated Counselling and Testing Centre
IDI	In-Depth Interview
ILO	International Labour Organization
INP+	Indian Network for People living with HIV and AIDS
MSM	Men Having Sex with Men
NGO	Non Governmental Organization
OI	Opportunistic Infection
PC	Project Coordinator
PF	Provident Fund
PLHIV	People Living with HIV and AIDS
PPTCT	Prevention of Parent To Child Transmission
SACS	State AIDS prevention and Control Society
SAN!	STOP AIDS NOW!
SAN!SIP	STOP AIDS NOW! South India Project
SSIPG	SAN! South India Project Group
STI	Sexually Transmitted Infection
TAPS	Technical Assistance for Policy Services
UNAIDS	Joint United Nations program on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WPP	HIV and AIDS Workplace Policy
YRGCare	YRG Centre for AIDS Research and Education

Executive summary

This report discusses the findings of the Applied Research (AR) Phase Two and Three of the STOP AIDS NOW! South India Project (SAN!SIP). The objectives of this phase are to measure the start of HIV and AIDS workplace policy (WPP) implementation and to focus on the effects of a WPP on staff members and organizations.

Data were collected from 24 partner civil society organizations (CSOs) in Andhra Pradesh, Karnataka, and Tamil Nadu, through in-depth interviews (IDIs) with managers and HIV and AIDS focal point persons (FPP), focus group discussions (FGDs) with staff members, and a staff survey. In total, 38 managers and FPPs were interviewed, 289 staff members participated in 40 FGDs, and 315 respondents were included in the staff survey. The representation of staff from different levels was fairly equal. The FGDs and the staff survey had a higher representation of women.

Main findings

A majority of 11 organizations have a fully functional WPP in place, which is a promising development. Seven organizations have a final draft, followed by four organizations with a draft WPP, and two CSOs have not yet started WPP development. These last two organizations have HIV and AIDS as their core area of work and already provide benefits for HIV positive staff. Andhra Pradesh has the highest percentage of organizations with a fully functional or final draft WPP, sixty percent and forty percent respectively. Three organizations in Karnataka (37.5%) have a fully functional policy, and one (12.5%) has a final draft policy. The two organizations that have not yet initiated the WPP development process are based in Tamil Nadu. In this state, one-third of the organizations have a fully functional WPP, and another one-third have a final draft.

A majority of the staff members (92.4%), regardless of job level or time on the job, are aware of WPP processes in their organization. Basically, managers and staff indicated that all staff members have been involved in the development process of the WPP. This is regarded as very important by all respondents. The resource package provided by SAN!SIP is used in drafting the policy. Of the three main documents given to the CSOs – the STOP AIDS NOW! documents ‘Good donorship in a time of AIDS’ and ‘What’s it likely to cost’ and the ILO document ‘An ILO code of practice on HIV/AIDS and the world of work’ – the latter is the most preferred.

Awareness raising and sensitization are the most reported WPP activities by managers and staff. All CSOs conduct training programs and workshops for staff on HIV and AIDS issues as a part of internal and external mainstreaming. Information on HIV prevention is primarily disseminated to staff through trainings. All organizations promote condom usage for the community, but only six organizations also make condoms available for staff within the workplace. These are all secular organizations. Three managers showed strong disagreement to condom promotion for staff. Employees, in contrast, expressed high levels of interest in obtaining condoms from their work settings.

A majority of 14 organizations promote voluntary counselling and testing (VCT) in their workplaces, for instance through training. Organizations facilitate access to treatment in various ways, such as the provision of medical reimbursements and supporting them through leave and transport. CSOs furthermore network with a host of public institutions, such as centres for VCT and for antiretroviral treatment (ART), for making referrals for testing, care, and nutritional support for staff members. Organizations with HIV and AIDS projects have wider and stronger liaisons with institutions that provide HIV and AIDS services. Over seventy-one percent of the survey respondents reported that their organizations offer them information about ART access. This is an encouraging trend that indicates comfort in discussing HIV issues.

Having an FPP and installing a committee are regarded as essential for the effective development and implementation of a WPP, and are therefore strongly advocated by the

project. Almost 80% of the organizations had an FPP, mostly reported by CSOs in Andhra Pradesh, followed by Tamil Nadu and Karnataka. A majority of the staff members were aware of the FPP in their organization.

There are noticeable effects of the WPP on staff and organizations. Organizations with a fully functional policy and CSOs with almost a draft reported a significant increase in levels of staff awareness. This is especially noticed in organizations that have small or no HIV and AIDS projects. CSOs furthermore provide information, education, and communication (IEC) materials on HIV and AIDS for staff. Access to these materials was confirmed by over eighty percent of all survey respondents. FGDs show that there is a positive response among staff in 13 organizations to discuss HIV, and this has greatly reduced inhibitions. Almost eighty-eight percent of the survey respondents reported increased openness to discuss HIV and AIDS as an effect of WPP implementation. Disclosure of HIV positive status is a reported effect in three organizations. Staff members indicated that their workplace is conducive for disclosure as there is complete acceptance of HIV positive staff and confidentiality will be maintained. Most staff prefer discussing their HIV status with their CSO head.

Managers and staff members across the CSOs and all 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, the WPP does not have any impact. Although staff acknowledge the stigmatization of people living with HIV and AIDS (PLHIV) in society, the majority of them believe there have been no earlier instances of stigma and discrimination in the workplace, and that there will not be any in the future. It is because of increased awareness and acceptance – in some cases because of the WPP – that organizations do not discriminate PLHIV.

Indirect effects of WPP development and implementation in organizations are: mainstreaming HIV into the organization's area of work (external mainstreaming); addressing general health issues; and building organizational systems and structures. Some managers and staff members reported negative effects of the WPP, such as misuse of benefits and staff conflicts because of unequal division of benefits. These negative effects are, however, mostly potential and not based on actual cases.

The reported effects of the WPP indicate that the WPP is a successful model for organizations to enhance awareness of HIV, acceptability of PLHIV, positive modification towards preventing HIV acquiring behaviour, gender issues, and to reduce negative perceptions about the WPP. If these positive effects are further strengthened through continued communication, training, mentoring, and essential technical assistance, the response will be very promising and the WPP highly sustainable.

CSOs are clearly interested in making the WPP an institutional policy, which will be continued irrespective of funding availability. Sustainability measures that are considered are: lobbying with other donors; earmarking a part of the general organizational funds for the WPP; and raising money from the 'for profit' sector.

Challenges in the development and implementation of WPP identified by CSOs were: expected financial constraints; time constraints; conflicting ideas about WPP among staff; supporting HIV positive staff members; positive discrimination of HIV positive staff members, which could lead to breaches in confidentiality or staff conflicts; maintaining confidentiality; and changed identity, for instance talking about condom use and HIV in FBOs.

The following good practices were reported by CSOs: staff involvement in drafting the WPP; involving PLHIV to sensitize staff and to draft the WPP; supportive environment for PLHIV; gender sensitivity; implementing the WPP without receiving funds; networking with service organizations for referring staff for VCT and ART; and planning for sustainability of the WPP.

Recommendations

To CSOs

- Use the STOP AIDS NOW! documents 'Good donorship in a time of AIDS' (good donorship guidelines) and the budgeting tool 'What's it likely to cost' in developing a WPP and budget;
- Establish committees and appoint an FPP to augment HIV and AIDS activities and services within the organization. Roles and responsibilities of the FPP and committees can be better defined or can be added to their job descriptions to effectively develop and implement a WPP;
- Discuss with staff the preferred ways for WPP dissemination and disseminate the WPP to all staff. Translate the document if needed;
- Provide information on HIV and AIDS and the WPP to staff – for instance on a notice board;
- Share experiences and promising practices with other partner CSOs, for instance on issues such as maintaining confidentiality;
- Start or continue implementing WPP activities that do not cost money;
- Link with other stakeholders for services, including for training, condoms, VCT, and ART;
- Open or continue dialogue with donors about managing HIV and AIDS in the WPP;
- Write proposals for funding to bodies other than STOP AIDS NOW! donor organizations.

To SAN!SIP Secretariat and SSIPG

- Enhance awareness about the FPP and his or her roles, since there seems to be a low understanding of this important factor;
- Advocate usage of the STOP AIDS NOW! tools 'Good donorship in a time of AIDS' and 'What's it likely to cost' to member organizations that have yet to finalize their draft WPP, and recommend CSOs that have a fully functional WPP to review their policies against the backdrop of these documents;
- Organize smaller regional meetings to understand issues around why some organizations are not interested in developing a WPP, and involve those organizations with positive impacts. This could greatly help to encourage other organizations to explore the possibilities of implementing a WPP;
- Facilitate forming meaningful linkages and channels for cross learning among member CSOs, and help CSOs to network with service providers within their respective geographical area to enable them to use HIV and AIDS services optimally;
- Give further training on gender equity and the WPP as change agent;
- Encourage employers to offer free condoms as both family planning and as an HIV prevention tool, to enhance uptake and to lessen inhibition. Advise CSOs to understand from employees which places are most suitable for condom placement.

To donors

- Consider extension of funding;
- Open or continue dialogue with Indian partner organizations about managing HIV and AIDS in the workplace.

1 Introduction

1.1 South India, an introduction

South India comprises four major states of India; Andhra Pradesh (76 million people), Tamil Nadu (62 million people), Karnataka (53 million people), and Kerala (31 million people). It roughly coincides with the Dravidian language zone, in spite of a sizeable Urdu, Oriya, or Marathi speaking population found in the northern fringes of Karnataka and Andhra Pradesh. As per the 2001 census, South India accounts for twenty-two percent of India's population. In terms of population density, Andhra Pradesh and Karnataka remain below the national average with 324 persons per square kilometre; the other two states have a much higher average, most notably because of their rural density which is ultimately linked to their agricultural productivity (irrigation, multiple cropping, cash crops) and favourable climatic conditions.

In South India as a whole, the density is 350 persons per square kilometre, slightly above the national average. South India has a higher proportion of women in its population than the national average. While the sex ratio in India in general is 933 females per 1000 males, the south India ratio is 988 females per thousand males. The highest sex ratio is found in Kerala with 1058 women per 1000 men, followed by Tamil Nadu, Andhra Pradesh and Karnataka. India's child sex ratio is 927 females per 1000 males as against 954 females per 1000 males for South India as a whole. Andhra Pradesh is the only South Indian state which has registered both male and female literacy rates below the national average of seventy-six percent for males and fifty-four percent for females.

1.1.1 HIV prevalence in India

Nationally, approximately 2.5 million people are living with HIV. This translates into a national adult HIV prevalence of 0.36%. The HIV prevalence is lower than previously estimated, but the epidemic continues to affect a large number of people in India. Important drivers are unprotected paid sex, unprotected sex between men, and injecting drug use, though heterosexual routes of transmission account for eighty-seven percent of all HIV cases. HIV prevalence varies greatly between states and regions. Below, the HIV prevalence data specific to the three states where the current project is running – i.e. Andhra Pradesh, Karnataka, and Tamil Nadu – will be discussed.

Andhra Pradesh

Andhra Pradesh ranks second among the five high HIV prevalence states – i.e. Manipur, Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu – for which the National Family Health Survey (NFHS-3) provides separate HIV estimates. Only Manipur state has a higher HIV prevalence. The HIV prevalence rate in Andhra Pradesh is higher than in India as a whole: 0.97% of adults aged 15-49 are infected with HIV. HIV prevalence is 0.75% among women, compared with 1.22% among men. Prevalence among youth aged 15-24, at 0.29% for women and 0.48% for men, is lower than for the reproductive age population as a whole.[1]

Karnataka

The HIV prevalence in Karnataka is 0.54% in urban areas and 0.79% in rural areas. Women (0.54%) are less likely than men (0.85%) to be HIV positive. HIV prevalence among youth aged 15-24 is 0.25%, which is lower than for the reproductive age

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[1] International Institute for Population Sciences (IIPS) and Macro International (2008). *National Family Health Survey (NFHS-3).* India, 2005-06: Andhra Pradesh. Mumbai: IIPS. http://www.nfhsindia.org/NFHS-3%20Data/ap_state_report_printed_version_for_website.pdf

population as a whole.[2] Karnataka ranks third among the five high HIV prevalence states. The prevalence in Karnataka is marginally higher than the prevalence for all five high HIV prevalence states taken together (0.67%), and is almost twice as high as the national average.

Tamil Nadu
In Tamil Nadu, 0.34% of adults aged 15-49 are infected with HIV, including 0.24% in urban areas and 0.44% in rural areas. Prevalence is 0.39% among women, compared to 0.27% among men.[3] Among the five highest HIV prevalence states in India, Tamil Nadu has the lowest prevalence. HIV prevalence among youth aged 15-24 is 0.13%, lower than for the reproductive age population as a whole. The HIV prevalence rate in Tamil Nadu is slightly higher than in India as a whole.

1.2 STOP AIDS NOW! South India Project

STOP AIDS NOW! is a partnership between Aids Fonds and four Dutch development organizations: Cordaid, Hivos, Icco, and Oxfam Novib. The STOP AIDS NOW! South India Project (SAN!SIP) was initiated in 2007 and is part of the STOP AIDS NOW! project 'Managing HIV and AIDS in the workplace'. This project is intended to support partner organizations in the South to develop and implement policies in the workplace on HIV and AIDS, and is developed under the theme 'Access to Treatment'.

SAN!SIP involves 35 CSOs that are funded by the Dutch STOP AIDS NOW! partners. The objectives for the three year (2007-2009) SAN!SIP project are to:
- Facilitate sensitization programs on internal mainstreaming for SAN!SIP partners;
- Facilitate internal mainstreaming programs, with follow-up mentoring for key staff from SAN!SIP partners, to prepare their workplace policies, working in collaboration with INP+ and the local STOP AIDS NOW! South India Program Group (SSIPG);
- Organize linking and learning programs.

The overall goal of this project is to strengthen the capacities of partner organizations in South India to develop and implement workplace policies related to HIV and AIDS, in order to create an enabling environment for the prevention of HIV and for positive living of staff and communities aligned to these organizations. The project management consists of a local program coordinator, an assistant program coordinator, and the SSIPG – the deciding, facilitating, and governing body with representatives of seven participating organizations and other stakeholders. The project's secretariat is based at INSA India, in Bangalore, and supported by a Dutch project coordinator.

1.3 Applied research

Part of the SAN!SIP project is an AR component. The aim is to provide information for project management, CSO managers, and beneficiaries in the local partner organizations on how to direct or redirect activities for successful HIV and AIDS WPP development and implementation. The AR furthermore intends to identify promising practises and challenges in the development and implementation of organizations' workplace policies and their correlation to contextual factors, such as organizational culture, perceptions of HIV, gender issues, human rights discussions, and ethical practices.

The AR component is divided into three phases, according to the phases of the project. Phase One measured the process of development of a WPP in organizations. The

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[2] International Institute for Population Sciences (IIPS) and Macro International (2008). *National Family Health Survey (NFHS-3).* India, 2005-06: Karnataka. Mumbai: IIPS. http://www.nfhsindia.org/NFHS-3%20Data/Karnataka_report.pdf

[3] International Institute for Population Sciences (IIPS) and Macro International (2008). *National Family Health Survey (NFHS-3).* India, 2005-06: Tamil Nadu. Mumbai: IIPS. http://www.nfhsindia.org/NFHS-3%20Data/TamilNadu_report.pdf

second phase intended to measure the start of WPP implementation. The third phase aimed to focus on implementation and the effects of a WPP on staff members and organizations.

YRG Centre for AIDS Research and Education (YRGCARE), based in Chennai, is appointed as the AR contractor. YRGCARE performs this task under the guidance of Ms Winny Koster, AR consultant from the University of Amsterdam, The Netherlands, assisted by Nienke Westerhof.

1.3.1 Findings of AR Phase On*e*

AR Phase One took place from June 2008 to March 2009. This phase mainly focused on the progress of policy initiation, development, and awareness levels of staff and managers about the WPP. Data was collected among fourteen organizations, through IDIs with fiteen managers, FGDs with 159 higher and lower level staff members, and a survey among 138 respondents, using a structured questionnaire.

Eight organizations had a final draft WPP. There were three CSOs with a first draft, one organization was in the process of development, and there were two CSOs with no WPP. Irrespective of their field of work, most organizations felt that a WPP for HIV and AIDS is important. It was very encouraging to note that the majority of the staff, regardless of job level, was familiar with the definition of a WPP and the status of such a policy in their organization. Unsurprisingly, this awareness was lower amongst staff members of the three organizations without a WPP. In some organizations respondents were not completely aware of the WPP, maybe because it was not much publicized and sensitised within the organization, and some of them saw it as similar to other policies such as life insurance or health policy.

Employees from the middle and senior level management largely attended the SAN!SIP trainings and workshops. These trainings and workshops were also the main motivation for having a WPP, followed by staff benefits – for instance, medical treatment and job security. In nine of the eleven organizations with a draft WPP, staff agreed on the consultative participatory process of the development of this draft. A vast majority of the survey respondents indicated that all levels of staff participated in the process of drafting. The importance of involvement in the drafting process was recognized by most staff members; also among those who were not aware of a WPP, the majority argued that all staff should be involved.

Awareness raising, sensitization, and education on HIV and AIDS were most reported by managers and staff as the important elements of the WPP. This was followed by confidentiality, reduction of stigma and discrimination, prevention, support and care, and the right of PLHIV to work.

As reported in the IDIs, HIV and AIDS related awareness raising amongst staff took place in almost all organizations. In six organizations, it was argued that awareness on HIV and AIDS increased as an effect of the WPP. Referral to ART information was also an important activity in many organizations.

While stigma and discrimination in India is high, survey staff reported that this is hardly a problem within their organizations. A vast majority of the survey respondents would not mind working with HIV positive staff, were of the opinion that discrimination of HIV positive staff is unacceptable, and reported that PLHIV should be employed. Respondents of the organizations with a WPP reported an improvement of the position of HIV positive staff members and a reduction of stigma as an effect of the WPP in their organization. Furthermore, openness on and discussions about HIV and AIDS were reported as an effect.

Five organizations provided condoms for staff members. Staff in the FGDs reported conflicting ideas about the provision of condoms for staff. In the survey, 32.6% of the respondents indicated that they are against the provision of condoms in their organization. However, a

majority of the survey staff indicated that they either think their organization should provide condoms or they agree with their organization providing condoms.

Main challenges identified in organizations – that are sometimes based on expectations and less on actual situations – were: 1) financial constraints; 2) stigma and discrimination of fellow HIV positive staff; 3) change in identity, for instance FBOs talking about sexuality and HIV, and organizations that, instead of working for the community, now deal with staff issues; 4) the possibility of misuse of the benefits; 5) time constraints; 6) family members to be covered by WPP; 7) a negative stance on condom promotion, especially in FBOs; and 8) lack of knowledge, especially on the process.

Promising practices identified in organizations include: 1) starting WPP activities before receiving donor funds; 2) creating awareness among staff through information sessions, trainings, and posters on the wall; 3) condom supply for staff; 4) continuing capacity building by STOP AIDS NOW! and associates; 5) gender sensitivity; and 6) planning for reviewing the WPP.

1.3.2 Recommendations of AR Phase One

To CSOs

- Take as a first step internal awareness raising of staff on HIV and AIDS issues;
- Develop the WPP in a participatory way with all staff;
- Use the STOP AIDS NOW! documents ‘Good Donorship in a Time of AIDS’ and the Budgeting Tool ‘What’s it Likely to Cost’ for the development of the WPP and budget;
- Disseminate the WPP to all staff and translate if needed;
- Provide HIV and AIDS and WPP information to staff – for instance on a notice board;
- Look at promising practices of peer CSOs – replicate if applicable and share experiences;
- Start or continue to implement activities that do not cost money;
- Write proposals for funding to bodies other than STOP AIDS NOW! donors;
- Link with other stakeholders for services, including training, VCT, and ART.

To SAN!SIP

- Assist organizations that are willing to develop a WPP, but do not have the technical know-how;
- Facilitate linking and learning – share promising practices between organizations;
- Continue training for capacity building – train organizations on STOP AIDS NOW! tools;
- Lobby STOP AIDS NOW! donors for quick release of funds;
- Link with other public and private stakeholders for services and share networks with participating CSOs.

To STOP AIDS NOW! donors

- Quick release of funds for WPP;
- Consider extension of funding;
  - Open or continue dialogue with partner organizations about managing HIV and AIDS in the workplace.

1.4 AR Phase Two and Three

The SAN!SIP project was coming to a close in December 2009. For this and other practical reasons, the second phase on WPP implementation and the third phase on effects were clubbed together. AR Phase Two and Three was initiated in June 2009 with the following objectives:

1. To describe and analyse implementation of WPP activities in CSOs and participation of staff.
2. To describe and analyse the effects of WPP implementation at staff and organization level.
3. To describe the utilization of SAN! support structures and documents in the development of a WPP.
4. To identify and document promising practices and challenges in the implementation of a WPP.
5. To provide recommendations to CSOs, SAN!SIP, and donors for sustainable and effective WPP development and implementation.

Specific themes identified for study in this phase were: 1) utilization and opinion of SAN! documents; 2) stigma and discrimination; 3) gender; 4) correlation of stigma and gender; 5) sustainability; 6) other policies – HR, gender, sexual violence – and relation with WPP; 7) relations and networking; channels of communication and nature: within the organization, CSOs with SAN!SIP and SSIPG, Technical Assistance for Policy Services (TAPS), CSOs with donors, CSO networking, public institutions.

1.5 Structure of the report

This report presents the findings of AR Phase Two and Three. In the following chapter the study methodology will be explained, as well as a profile of the organizations and staff participants involved. Chapter 3 describes the status of the workplace policies and the process of development, followed by Chapter 4 that deals with the activities related to HIV and AIDS in the workplace. The effects of these activities are presented in Chapter 5. In Chapter 6 special themes are discussed, such as the use of documents, gender, disclosure and confidentiality, stigma and discrimination, and sustainability of the workplace policies. Chapter 7 is an evaluation by organizations of challenges, good practices, and expectations. The final chapter concludes with lessons learnt in this phase, extracting the promising practices and challenges related to WPP development and implementation. It ends with recommendations to the different stakeholders of the project.

2 METHODOLOGY

2.1 Study populations and data collection methods and tools

AR Phase Two and Three studied organizations that are at three different stages of WPP development and implementation. The sample selection was based on an organization's experience with a WPP and included CSOs with a fully functional policy, CSOs with a draft, and CSOs that do not have a draft as yet, to understand how WPP development and implementation has impacted member organizations. The STOP AIDS NOW! Secretariat was involved in the selection process. They ascertained the status of WPP implementation of each organization and then selected organizations based on willingness to participate, logistics of staff availability, and timeline.

The AR sample size was increased from 15 CSOs in Phase One to 24 CSOs in Phase Two and Three. Ten CSOs from Andhra Pradesh, eight CSOs from Karnataka, and six CSOs from Tamil Nadu participated in this phase (see Appendix A for an overview of the organizations and their activities).

Information was collected at two levels, staff and CSO level. Unlike Phase One, where just the CSO heads or managers were interviewed, this phase also sought to obtain information from the FPPs. In some cases they may be more familiar with the policy and therefore better able to provide policy related information. FGDs and face-to-face interviews with staff with a semi-structured questionnaire (survey) were used to understand staff perceptions about the WPP.

AR Phase Two and Three planned to collect data from twenty-four CSO heads/managers and FPPs through IDIs. It was decided to conduct two FGDs comprising six to eight participants and fifteen surveys in each organization to obtain opinions of middle, junior, and support staff. Time and organizational constraints did not always permit data to be collected according to the initial plan. In some organizations, IDIs could only be conducted with either the CSO head or FPP. This was either because the CSO head was not available at the time of data collection or in some cases there was no FPP for the WPP. In organizations where there are less than ten staff members, the AR team could conduct only one FGD and administer less than 15 surveys. In total, 38 IDIs with managers and FPPs, 40 FGDs with 289 staff members, and 315 survey interviews with staff were conducted across 24 organizations (see Appendix B for data collection tools).

2.2 Data collection and data collection team

A team of trained ethnographers and interviewers from YRGCARE completed the data collection process. Originally this was planned for a period of three months, beginning in July 2009 and ending in September 2009. However due to logistical inconveniences expressed by CSOs, the data collection could not be completed until the beginning of November 2009. The AR team experienced minor changes in plans, often due to partner organizations' inability to spare over a day for data collection process. Despite this, the level of cooperation and hospitality was exemplary.

2.3 Data processing, analysis, and reporting

Qualitative data was collected using voice recorders. All raw data was transcribed in the local language and then translated into English. Trained YRGCARE staff handled these processes. To ensure there was no loss in translation, a quality control team checked all transcripts and compared them with the audiotapes. Once the data was approved for analysis, another team of ethnographers coded the transcripts based on key themes that were drawn in consultation with the AR consultant. All transcripts were shared with the

AR consulatant to review the quality of data collection. An outline of the report generation was also designed with guidance from Ms Koster, and the AR team developed this report, in consultation with consultants from the University of Amsterdam.

2.4 Characteristics of the samples

2.4.1 IDI respondents

In total, 38 managers and FPPs were interviewed – eighteen in Andhra Pradesh, twelve in Karnataka, and eight in Tamil Nadu. As illustrated in Table 1, six of the respondents in Andhra Pradesh were directors, the other twelve were FPPs. In Karnataka, seven directors and five FPPs were interviewed. In Tamil Nadu, three of the eight respondents were directors of their respective workplaces, while the remaining five were FPPs. IDI respondents had been active within their organizations for an average of 11.5 years. This number is highest in Tamil Nadu, followed by Andhra Pradesh and Karnataka.

***Table 1**: Background characteristics of IDI respondents, by state*

		Andhra Pradesh N=18	**Karnataka N=12**	**Tamil Nadu N=8**	**All N=38**
Designation	Director	6 (33.3%)	7 (58.3%)	3 (37.5%)	16 (42.1%)
	FPP	12 (66.6%)	5 (41.7%)	5 (62.5%)	22 (57.9%)
No. of years in organization	Mean	11.2	10.9	12.5	11.5
	Range	1.5 - 30	3.0 - 23	0.25 - 25	
Gender	Female	9 (50%)	6 (50%)	2 (25%)	17 (44.7%)
	Male	9 (50%)	6 (50%)	6 (75%)	21 (55.3%)
Age group	18-25	1 (5.6%)	0	0	1 (2,6%)
	26-35	3 (16.7%)	2 (16.7%)	1 (12.5%)	6 (15.8%)
	36-45	5 (27.8%)	4 (33.3%)	3 (37.5%)	12 (31.6%)
	46+	9 (50%)	6 (50%)	4 (50%)	19 (50%)
Marital status	Married	12 (66.6%)	10 (83.3%)	8 (100%)	30 (78.9%)
	Single	6 (33.3%)	2 (16.7%)	0	8 (21.1%)

Table 1 further shows that the distribution of gender across respondents was equal in Andhra Pradesh and Karnataka. In Tamil Nadu, six respondents were men, whereas only two were women.

Nineteen respondents (50%) were over the age of 46, comprising the largest age category. Twelve respondents (32%) were aged between 36 and 45 years old. Six respondents (16%) were between the ages of 26 and 35, and only one respondent (2%) was between the ages of 16 and 25. Age category percentages for individual states are consistent with the total percentage breakdown.

The majority of the respondents are married; twelve out of eighteen respondents in Andhra Pradesh, ten out of twelve in Karnataka, and all respondents in Tamil Nadu.

2.4.2 Staff members in FGDs

As illustrated in Table 2 below, 289 staff members participated in 40 FGDs. These respondents are from 23 organizations, since in one organization no FGD took place. Considering state of origin, 42.2% of FGD participants were from Andhra Pradesh, 34.3% from Karnataka, and 23.5% from Tamil Nadu. The majority of the participants (54.7%) were women. There were 114 men (39.4%) and seventeen (5.9%) transgender staff. In Karnataka and Tamil Nadu female staff outnumbered male staff, probably

because five organizations in these two states have more female staff. Only one CSO in this sample, based in Karnataka, has staff members who are transgender.

***Table 2**: Background characteristics of FGD participants, by state*

		Andhra Pradesh N=122	Karnataka N=99	Tamil Nadu N=68	All N=289
Gender	Female	54 (44.3%)	57 (57.6%)	47 (69.1%)	158 (54.7%)
	Male	68 (55.7%)	25 (25.2%)	21 (30.9%)	114 (39.4%)
	Transgender	0	17 (17.2%)	0	17 (5.9%)
Age group	16-25	16 (13.1%)	24 (24.2%)	11 (16.2%)	51 (17.6%)
	26-35	58 (47.5%)	43 (43.4%)	29 (42.6%)	130 (45%)
	36-45	36 (29.5%)	22 (22.2%)	22 (32.4%)	80 (27.7%)
	46+	12 (9.8%)	10 (10.1%)	6 (8.8%)	28 (9.7%)
Marital status	Married	96 (78.7%)	62 (62.6%)	53 (77.9%)	211 (73%)
	Single	26 (21.3%)	37 (37.4%)	15 (22.1%)	78 (27%)
Educational qualification	Middle	3 (2.5%)	41 (41.4%)	0	44 (15.2%)
	Higher secondary	29 (23.8%)	13 (13.1%)	33 (48.5%)	75 (26%)
	Graduation	44 (36.1%)	27 (27.3%)	22 (32.4%)	93 (32.2%)
	Post graduation	40 (32.8%)	15 (15.2%)	12 (17.6%)	67 (23.2%)
	Above PG	6 (4.9%)	3 (3%)	1 (1.5%)	10 (3.5%)
Job category	Junior level	70 (57.4%)	58 (58.6%)	31 (45.6%)	159 (55%)
	Middle level	38 (31.1%)	35 (35.4%)	31 (45.6%)	104 (36%)
	Senior level	14 (11.5%)	6 (6.1%)	6 (8.8%)	26 (9%)
No. of years in organization	0 to 1 year	23 (18.9%)	10 (10.1%)	0	33 (11.4%)
	1 to 3 years	35 (28.7%)	33 (33.3%)	26 (38.2%)	94 (32.5%)
	4 to 7 years	36 (29.5%)	27 (27.3%)	23 (33.8%)	86 (29.8%)
	7+ years	28 (22.9%)	29 (29.3%)	19 (27.9%)	76 (26.3%)

Women's peak age category was 26-35 across all three states. The second most represented age range was 36-45 in Andhra Pradesh and Tamil Nadu, and 16-25 in Karnataka. Female representations of age ranges were generally consistent across all three states. The largest age representation among males was also 26-35 in Andhra Pradesh and Karnataka, but was split between 16-25 and 36-45 in Tamil Nadu. There were no men above the age of 46 in the FGDs in Karnataka and Tamil Nadu.

Across the three states, the majority of respondents were married. Only in Karnataka did single women (25) nearly equal married women (32). Andhra Pradesh, by contrast, had the highest proportion of married women (46) compared to single women (8).

Karnataka had a higher representation of female and transgendered employees that had only completed higher secondary education compared to male employees. Half of the transgendered employees had completed only higher secondary education. All employees in Tamil Nadu had completed at least secondary education, and this comprised the largest category of workers. Though numbers decreased with higher levels of education, the gender ratio across education categories was consistent with that among the employees. By contrast, the number of employees in Andhra Pradesh that had completed bachelors' or masters' degrees far out-numbered those who had received only higher secondary or middle education. Gender was split equally across all education categories in Andhra Pradesh.

Men and women were generally equal at the senior management level in all three states. No transgendered employees occupied senior positions. Karnataka and Tamil Nadu had

about one-third more female middle level managers compared to male managers, whereas Andhra Pradesh had over twice the number of male managers as female managers. This relates to the number of male and female staff in these states. Junior level management was split equally between the genders in Andhra Pradesh, but Karnataka and Tamil Nadu showed many more female junior managers than male.

In Karnataka, there are 29 long term employees, who have worked in the organization for more than seven years, consisting of nineteen women, nine men, and one transgender. Short term employees, in the organization for one to three years, numbered mostly women (16) and transgenders (12), compared to five men. In Tamil Nadu there is a slight difference in the numbers of men and women working for organizations for one to three years (nine men to seventeen women), and four to seven years (ten men and thirteen women). However, only two male staff had worked for more than seven years, compared to twenty female staff. In Andhra Pradesh, the gender ratio was reflected across the four categories of work experience.

2.4.3 Staff members in the survey

Table 3: *Background characteristics of survey respondents, by state*

		Andhra Pradesh N=135	Karnataka N=109	Tamil Nadu N=71	All N=315
Gender	Female	62 (45.9%)	63 (57.8%)	48 (67.6%)	173 (54.9%)
	Male	73 (54.1%)	44 (40.4%)	23 (32.4%)	140 (44.4)
	Transgender	0	2 (1.8%)	0	2 (0.6%)
Age group	16-25	22 (16.3%)	30 (27.5%)	11 (15.5%)	63 (20%)
	26-35	64 (47.4%)	42 (38.5%)	23 (32.4%)	129 (41%)
	36-45	39 (28.9%)	28 (25.7%)	30 (42.3%)	97 (30.8%)
	46+	10 (7.4%)	9 (8.3%)	7 (9.9%)	26 (8.3%)
Marital status	Married	103 (76.3%)	60 (55%)	55 (77.5%)	218 (69.2%)
	Unmarried	29 (21.5%)	48 (44%)	14 (19.7%)	91 (28.9%)
	Widowed	3 (2.2%)	1 (0.9%)	2 (2.8%)	6 (1.9%)
Staff level	Senior level	12 (8.9%)	7 (6.4%)	3 (4.2%)	22 (7%)
	Middle level	58 (43%)	21 (19.3%)	11 (15.5%)	90 (28.6%)
	Junior level	29 (21.5%)	33 (30.3%)	17 (23.9%)	79 (25.1%)
	Grassroots / program	28 (20.7%)	38 (34.9%)	35 (49.3%)	101 (32.1%)
	Officer level	6 (4.4%)	6 (5.5%)	1 (1.4%)	13 (4.1%)
	Lower level	2 (1.5%)	4 (3.7%)	4 (5.6%)	10 (3.2%)
Time on the job	0 to 1 year	28 (20.7%)	14 (12.8%)	5 (7%)	47 (14.9%)
	1 to 3 years	34 (25.2%)	32 (29.4%)	24 (33.8%)	90 (28.6%)
	4 to 7 years	38 (28.1%)	31 (28.4%)	13 (18.3%)	82 (26%)
	7+ years	35 (25.9%)	32 (29.4%)	29 (40.8%)	96 (30.5%)
Type of contract	Staff	130 (96.3%)	98 (89.9%)	68 (95.7%)	296 (93.7%)
	Volunteer	3 (2.2%)	11 (10.1%)	3 (4.2%)	17 (5.4%)
	Other	2 (1.5%)	0	0	2 (0.6%)

Data was collected from 315 participants in 22 organizations: 135 respondents in Andhra Pradesh, 109 in Karnataka, and 71 in Tamil Nadu. The majority of the participants were

women (173 (54.9%), followed by 140 men (44.4%), and two transgender respondents (0.6%). Similar to the FGD sample, the number of women exceeded that of men in Karnataka and Tamil Nadu, but was lower in Andhra Pradesh. Participants' ages ranged from 16 to 69 years, with a mean age of 33.74 years. Over seventy percent of all participants were in the age range of 26-45; the most productive and sexually active age group in the Indian context. This number is highest in Andhra Pradesh and Tamil Nadu. The majority of all respondents are married. The number was especially high in Andhra Pradesh and Tamil Nadu, where about seventy-seven percent were married.

Close to sixty percent of all participants across the three states were from the junior or grassroots level employee cadre. Andhra Pradesh reported a higher percentage of participants from middle and senior level compared to the other states. Over fifty percent of the participants in this state were from senior and middle level management. This may have impacted some of the key responses. Their mean experience within the organization was six years, with experience ranging from one month to 28 years. In total, most respondents (30.5%) had been working in their organization for over seven years, followed by the category one to three years (28.6%). In all states, respondents working for less than a year represented the smallest category. The highest number of respondents from Tamil Nadu (40.8%) show a tenure of seven years and above, whereas in Karnataka this percentage is 29.4%, and in Andhra Pradesh 25.9%. While it could be expected that individuals with longer tenure in organizations are better positioned to respond with clarity on organizational issues, it could also be that they are adept at socially desirable responses. This needs further analysis.

3 WPP DEVELOPMENT AND AVAILABILITY

3.1 Status of WPPs

Eleven out of the 24 organizations have a fully functional WPP. Generally a policy is considered fully functional when the board members, the management, or the CSO head have approved it. One of the organizations with a fully functional WPP, however, implemented the policy without formal board approval. In Andhra Pradesh, six out of ten organizations have a final WPP, while two in Karnataka and two in Tamil Nadu have a fully functional WPP. Seven organizations have developed a final draft WPP and four organizations do not have a final draft as yet. Two organizations have not yet initiated the process of drafting a WPP. The boards of all organizations have endorsed the WPP, and in two organizations respondents have said that the board has played an active role in developing the WPP.

Table 4: *Status of WPP, by state*

	Andhra Pradesh N=10	Karnataka N=8	Tamil Nadu N=6	All N=24
Fully functional	6 (60%)	3 (37.5%)	2 (33.3%)	11 (45.8%)
Final draft WPP	4 (40%)	1 (12.5%)	2 (33.3%)	7 (29.2%)
Draft	0	4 (50%)	0	4 (16.7%)
Not started	0	0	2 (33.3%)	2 (8.3%)

There are several reasons why CSO managers report not having a fully implemented WPP. Three CSOs that have HIV integrated projects say they need external help to guide them through the development and implementation process. One organization first plans to refine the policy before implementing it. In three organizations, the board and management have temporarily stalled the WPP implementation because other staff welfare policies are not yet in place. The director of one such CSO, based in Karnataka, said:

> *We submitted the draft policy for approval but they* [management] *felt that since none of the 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 organizations that have not initiated the process of drafting the WPP are CSOs that 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 CSO commented, "*I have HIV positive staff and there are benefits for them. So why do I need a policy?"*

3.1.1 Funding status

CSOs are or have been funded by Cordaid (7), Hivos (5), ICCO (5), and Oxfam Novib (7). While the policy is fully functional in thirteen organizations, only two of these CSOs have availed funding from their respective Dutch donors and secured four percent of the total payroll towards WPP development and implementation. One of these organizations, based in Tamil Nadu, received the funding for 2009, while the other organization availed funding in 2007 to conduct workshops for the WPP.

Two organizations have applied for funding and are confident of receiving it. Two other CSOs are unsure of how to go about applying for funds, but support the existing

activities related to HIV and AIDS with their own resources. An HIV organization in Andhra Pradesh approached their donor and, according to the IDI respondent, *"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".* The organization is now managing without funding.

The remaining seven CSOs are also able to support WPP implementation with existing funds. According to the IDI respondent of an HIV integrated organization in Karnataka, 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".* Another Karnataka based organization does not need funding as the organization has many linkages with service providers. In a non-HIV organization in Karnataka, it was stated that *"we have not made a policy to take foreign funds. This is the decision taken by our organization. We are not dependent on any funds".*

Organizations that do not have a WPP in place were asked about their plans for funding to understand their financial systems. Out of the four organizations that do not have a draft WPP as yet, two will not be able to receive funding. The director of one of these CSOs said the project funded by the Dutch donor is in the withdrawal stage and so the donor is not going to support the policy. In the other CSO, the project came to a close in 2006, leaving them no choice but to approach other donors. In the two organizations where only the FPPs were interviewed, information on funding could not be obtained, as the respondents were not aware of the funding scenario.

3.1.2 Awareness of staff about WPP status

In five organizations, all respondents who participated in the FGDs were well aware of the WPP and its components. They explained salient features of their WPP and its benefits. A female part-time worker explained:

> *The WPP talks about treating HIV staff at par with other staff. Their status should be kept confidential. Their family should be given support. They should not be given a lot of workload. We should be easy on them when it comes to office rules and regulations etc.*

In two organizations, only the FPP turned out to be aware of the WPP. The staff members in one of these CSOs explained that they have never heard of something called the WPP. Though the CSO heads of these two organizations confirmed that the policy development was a consultative and inclusive process, the FGDs in both these organizations reflect that information about the policy has not permeated to all staff levels.

In the survey, a majority of 291 respondents (92.4%) appeared to be aware that their organization has a WPP. Awareness was highest in Tamil Nadu, followed by Karnataka and finally Andhra Pradesh. This is striking, since the IDIs revealed that Andhra Pradesh has the most organizations with a WPP in place. The majority of staff from Andhra Pradesh (nearly 87%) who were not aware of the WPP belonged to three CSOs that did not have a fully functional policy.

Table 5: *Staff awareness about WPP, by state*

	Andhra Pradesh N=135	**Karnataka N=109**	**Tamil Nadu N=71**	**All N=315**
Aware of WPP	121 (89.6%)	101 (92.7%)	69 (97.2%)	291 (92.4%)
Not aware of WPP	14 (10.4%)	8 (7.3%)	2 (2.8%)	24 (7.6%)

All 24 respondents that were not aware of a WPP in their organization were also not aware of any discussions or processes concerning the development process. There were eight respondents from Karnataka that were not aware of the WPP. These were all from the same organization. The FPP and the CSO head of this organization confirmed that the WPP draft is available but that the implementation process has not yet been initiated. The other sixteen respondents who were unaware are scattered over nine organizations, with a maximum of three respondents who are unaware per organization. This does not necessarily mean that these organizations do not have a WPP in place, but it could indicate that the respective respondents were not included in the development process of the WPP.

Table 6: *Source of awareness about WPP, by state (multiple response)*

Source of staff awareness of WPP	Andhra Pradesh N=121	Karnataka N=101	Tamil Nadu N=69	All N=291
Information disseminated in a meeting	71 (58.7%)	46 (45.5%)	28 (40.6%)	145 (49.8%)
Participated in development / discussions	23 (19.0%)	51 (50.5%)	35 (50.7%)	109 (37.5%)
Has seen a copy	13 (10.7%)	15 (14.9%)	5 (7.2%)	33 (11.3%)
Was given a copy	9 (7.4%)	7 (6.9%)	7 (10.1%)	23 (7.9%)
Other way	39 (32.2%)	12 (11.9%)	13 (18.8%)	64 (22%)

The 291 respondents who are aware of a WPP were asked how they had gained this awareness. Table 6 shows that almost half of these respondents (49.8%) obtained their information about the WPP in a meeting. Almost thirty-eight percent of the respondents participated in the development process of the WPP or discussions about it. This number was much lower in Andhra Pradesh than in the other two states. Only 7.9% of the respondents were given a copy of the WPP, a little higher number has seen a copy. Other ways of getting awareness of the WPP were primarily through attending trainings or workshops, through colleagues, or through the FPP.

Table 7*: Staff knowledge of WPP being implemented in organization, by state*

	Andhra Pradesh	Karnataka	Tamil Nadu	All
WPP implemented	98 (81%)	65 (65%)	66 (95.7%)	229 (79%)
WPP not implemented	15 (12.4%)	32 (32%)	3 (4.3%)	50 (17.2%)
Don't know	8 (6.6%)	3 (3%)	0	11 (3.8%)
All	121 (100%)	100 (100%)	69 (100%)	290 (100%)

Table 7 shows that 229 out of 290 respondents (79%) indicated that their organization has some sort of WPP on HIV and AIDS implemented. Implementation of the WPP is highest in organizations in Tamil Nadu (95.7%), followed by Andhra Pradesh (81%) and Karnataka (65%). The high number in Tamil Nadu contradicts with the status of the WPP as indicated by CSO heads. An explanation for this disparity could be that these organizations have HIV and AIDS as their core area of work, and hence also have HIV and AIDS related facilities in the workplace. A small section of the respondents (3.8%) did not know about a WPP being implemented, while 17.2% of the respondents were of the opinion that the WPP has not been implemented in their organization. These respondents are scattered over thirteen organizations, but in four organizations between 61.5% and 68.8% of the respondents reported that there is no WPP implemented.

Table 8 highlights employees' reporting of the WPP. Their responses are segregated as per staff level, their years of work experience in their organization, and type of contract. This has been done to find out whether WPP information is disseminated among all staff levels, and whether staff members and volunteers are equally involved in the processes of WPP development and implementation. The general logic was kept in mind that the longer an employee is part of a work setting the more he or she is involved in the

organizational development process – and it is assumed that information flow to this person is better due to acclimatization to the work culture.

Table 8: *Staff awareness about WPP, by job level, time on the job, and type of contract*

		N	Aware	Not aware
Staff level	Senior level	22	22 (100%)	0
	Middle level	90	86 (95.6%)	4 (4.4%)
	Junior level	79	77 (97.5%)	2 (2.5%)
	Grassroots / program	101	87 (86.1%)	14 (13.9%)
	Officer level support	13	11 (84.6%)	2 (15.4%)
	Lower level support	10	8 (80%)	2 (20%)
Time on the job	0 to 1 year	47	42 (89.4%)	5 (10.6%)
	1 to 3 years	90	84 (93.3%)	6 (6.7%)
	4 to 7 years	82	73 (89%)	9 (11%)
	7+ years	96	92 (95.8%)	4 (4.2%)
Type of contract	Staff	296	275 (92.9%)	21 (7.1%)
	Volunteer	17	14 (82.4%)	3 (17.6%)
	Other	2	2 (100%)	0
All		**315**	**291 (92.4%)**	**24 (7.6%)**

Awareness about the WPP was very high among all staff members, regardless of job level, time on the job, or type of contract. However, there were some small differences. Awareness was highest among staff belonging to senior management and lowest among junior level support staff. It seems that awareness levels are directly proportional to the job category in the organization; the higher the job category, the greater is the awareness of WPP. Analysis of WPP awareness based on time on the job indicates that respondents who have one to three years experience and respondents with seven or more years of experience in the organization have the maximum awareness. Awareness levels among staff on contract are higher than those of volunteers: around 93% of staff is aware of the WPP as compared to 82% of volunteers. Nearly fifty-four percent of the respondents who are not aware of the WPP are from CSOs that do not have a final draft, while the remaining either have a fully functional WPP (17%) or have finalized their draft (29%).

3.2 Development of policies

The project strongly recommends that the policy development and implementation is participatory and inclusive, in order to promote ownership amongst staff and therefore sustainability. The survey revealed that 92.4% of staff is aware of a WPP, and the majority of IDI respondents agreed that the policy in their CSO was developed in a participatory process. It was either developed in consultation with all staff or was communicated to all staff once the draft was finalized. The following program officer and FPP's response summarizes a CSO's efforts in making it a participatory process.

> *We* [all staff] *had a round of interaction on what should be included and what kind of concepts to be included. I had a round of interaction with senior staff also. After that I went through several corporate industries and CSO workplace policies not only for HIV/AIDS but also in general. I shared the final copy to the staff and everybody readily accepted it. After that I made a presentation in one orientation workshop, which was not on HIV but about strategic planning. I explained all the staff about what this policy was and what the guideline for this policy was and what kind of norms, provisions, and rights we have in this policy and relaxations in this policy.*

Another IDI respondent also explained how the WPP was developed by staff members themselves.

> *Initially, we had workshops with the staffs at different levels and managerial level. 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.*

A majority of twenty CSOs referred to the SAN!SIP resource package to develop the policy. Among the various documents provided by SAN!SIP, the ILO guidelines were extensively used. CSOs have also referred to policies of other member organizations to draft their own WPP. Section 6.1 of this report further elaborates on the usage of documents in the development process.

3.3 Dissemination of the policy to staff

All respondents agreed that the WPP was either developed in consultation with all staff or was communicated once the draft was finalized. Staff was oriented about the various aspects of the WPP and in most organizations a copy of the policy was made available. In three CSOs the policy has been translated into the local language to help staff understand contents. Large CSOs have not been able to involve all levels of staff in developing the WPP, but have taken efforts to communicate the WPP to all staff. In one of the organizations with a high number of staff members, WPP dissemination was decentralised; field level coordinators were informed about the WPP and they in turn were responsible for discussing it with their respective teams. Respondents from smaller organizations with less than ten employees on the payroll preferred dissemination through staff meetings. Organizations provide information and services relating to HIV, and this is an indicator that with consistent follow-up and essential guidance, organizations will implement a WPP that will suit staff's requirements.

3.3.1 Staff feedback on communication

Staff members of a majority of the organizations were happy with their organizations' efforts to include them in policy development and implementation. Staff meetings, trainings, and workshops for the WPP, and informal discussions, were the most preferred modes of disseminating information. FGD participants of three organizations acknowledged that the policy had been translated into the local language and that this ensured complete understanding. 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 organizations felt that communication about WPP issues was inadequate. They suggested other ways to improve communication about the policy, such as letters or emails to all staff and training programs. This was, among others, suggested by a female mandal convener: *"The communication method is ok but it could have been better if they had told us more about this policy vis à vis the objective, purpose, and other information before they got involved in it. I also think they should have given us the training related to HIV/AIDS earlier."*

3.4 Other organizational policies

3.4.1 Policies in place

he AR team asked respondents about organizational policies and the relation of the WPP to these policies. As illustrated in Table 9, seventeen organizations have a written human resource (HR) or provident fund (PF) policy in place. Most of these organizations are located in Andhra Pradesh. Apart from these seventeen organizations, one CSO has a document containing the organization's rules, and an organization in Karnataka has leave and termination rules, which is equivalent to an HR policy.

Table 9*: Other policies available, from IDIs, by state (multiple response)*

State	N	HR / PF	Welfare / health	Gender	Sexual harassment	Financial policy	Other
Andhra Pradesh	10	8 (80%)	3 (30%)	3 (30%)	1 (10%)	3 (30%)	6 (60%)
Karnataka	8	5 (62.5%)	5 (62.5%)	1 (12.5%)	1 (12.5%)	1 (12.5%)	5 (62.5%)
Tamil Nadu	6	4 (66.7%)	4 (66.7%)	0	0	1 (16.7%)	4 (66.7%)
All	**24**	**17 (70.8%)**	**12 (50%)**	**4 (16.7%)**	**2 (8.3%)**	**5 (20.8%)**	**15 (62.5%)**

Half of the organizations have a staff welfare or health policy. Organizations support health care for staff in different ways, for instance through health insurances, loans, and medical expenses reimbursement. The benefits and the staff members that are included vary. According to the IDIs, four organizations only support staff for health care. In one of these organizations only permanent staff members are covered, due to financial constraints. In four other CSOs, family members are also included. In one organization, only certain staff members are entitled to health care benefits. While in this CSO medical and admission expenses are covered for all staff, the medical insurance is only for permanent staff.

Around sixty-seven percent of survey respondents indicated that their organization has some sort of health insurance or medical scheme for its staff. Sixteen respondents (5%) stated that some sort of discussion among the management personnel regarding health or medical insurance for staff is currently ongoing. Generally, IDI respondents argued that there were no clear guidelines on loans for health care. Instead, decisions are made on a case by case needs basis. From the IDIs, it furthermore appeared that six organizations do not have a medical scheme. However, this does not mean that there are no provisions for staff. One organization, for instance, raises its own funds and makes sure that the staff members who need it benefit out of it. In one organization opinions differed; one respondent argued that there was never thought about the medical allowances, while another respondent said that there is insurance for many of the staffs and their families. In a Karnataka based organization, discussions are going on whether to have a medical insurance. According to the respondent, *"It was not yet finalized as the staff has an opinion that they are young and there is no need for medical insurance".* Medical expenses in this organization can, however, be claimed, depending on the work experiences. One CSO used to have a health insurance scheme, but this stopped because staff were not showing any interest in paying an annual premium. Now

the organization encourages staff to take up health insurance on a personal basis. In one organization, many staff members have their own medical insurance and therefore it was decided not to have one in the organization. Although there is no policy, loans are provided to staff in case of sudden or serious illness.

Four organizations, of which three are based in Andhra Pradesh, have a gender policy in place that addresses issues of sexual harassment. Two organizations have provisions for sexual harassment but no written guidelines, and three organizations were in the process of developing a gender policy. In addition, two organizations have a gender committee that is concerned with gender issues and sexual harassment, instead of a gender policy. There are two organizations with only female staff. These do not have a gender policy since gender is not an issue.

Almost 21% of the CSOs have a financial policy in place, and a considerable percentage (62.5%) has other policies than those mentioned above. Examples are a mobility policy, a Dalit policy, an environment policy, and a policy for transgenders.

3.4.2 Integration of WPP in other policies

In eight organizations, the WPP is integrated into the existing gender or welfare policy. Two CSOs mainstreamed it into their health policy and two other organizations integrated the WPP into other organizational policies. The director of an organization in Andhra Pradesh that mainstreamed the WPP in the gender policy explained that *"it is almost the same right. Women are more vulnerable, especially singe women."* According to the IDI respondent of a non-HIV organization in Andhra Pradesh, mainstreaming the WPP reduces 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 have a standalone workplace policy. One of these CSOs is planning to mainstream the WPP and in one of these organizations, discussions are going on regarding whether to have an integrated or a separated workplace policy. In the IDIs of five organizations, majorly based in Karnataka, no information was provided about the format of the workplace policy.

In one of the two organizations that did not yet initiate the workplace policy process, the workplace policy would be mainstreamed in the HR policy. There is no information available on the potential format of the workplace policy in the other organization.

3.5 Action plans

In the IDIs, respondents of eight CSOs said their organization has an activity plan, or at least has some activities that are going to be implemented. In an organization based in Andhra Pradesh, for instance, there are several activities planned, amongst others an audit, proposal writing, staff training, and evaluations. Both respondents of an HIV specific organization indicated that they plan to involve PLHIV more, since the policy is developed especially for them. Another organization, based in Karnataka, developed a clear action plan, containing a monthly training program with topics chosen by staff and a discussion of the WPP every Monday in the staff meeting.

Three organizations are in the process of writing out other organizational policies before they begin the process of WPP implementation. One of these three CSOs is clear about the way forward and has set a timeline for implementation. The executive officer and FPP explained:

> *We were conducting staff meetings from 2008 regarding this* [policies] *and we have decided to put down the organizational policy integrated with HIV WPP within two years. This is the commitment we have right now. It is not to fulfil the STOP AIDS NOW! objective but to have all policies in place. Probably by 2010 we will have organizational policies integrated with HIV components.*

Similarly, another organization that works for vulnerable people has plans to develop an inclusive policy which addresses the needs of those people too, as it could otherwise be misconstrued by staff as discrimination.

As mentioned in section 3.1, one CSO is planning to fine-tune the policy and another CSO that has a draft in place is looking for technical help in taking the policy forward. Two organizations have not laid out any action plans for implementation and may just lack the impetus to initiate the process. Another eight respondents indicated that their organization does not have an activity plan.

4 ACTIVITIES RELATED TO HIV AND AIDS IN THE WORKPLACE

Table 10 summarizes the HIV and AIDS related activities in organizations, according to managers and staff. These activities will be expanded upon in the paragraphs of this chapter.

***Table 10**: HIV and AIDS related activities for staff, reported in IDI, FGDs, and survey (multiple response)*

Activities	IDI (N=24)	FGD (N=24)	Survey (N=315)
Awareness raising and sensitization	24 (100%)	20 (87%)	305 (96.8%)
Prevention activities	9 (37.5%)	13 (56.5%)	299 (94.9%)
Condoms for staff	6 (25.0%)	6 (26.1%)	130 (41.3%)
VCT promotion	14 (58.3%)	4 (17.4%)	243 (77.1%)
Involvement of PLHIV	14 (58.3%)	1 (4.3%)	NA
Facilitate access to treatment	17 (70.8%)	18 (78.3%)	241 (76.5%)
Instalment of WPP committee	8 (33.3%)	2 (8.7%)	NA
Appointment of FPP	17 (70.8%)	2 (8.7%)	210 (66.7%)

4.1 Awareness raising and sensitization

Qualitative and survey data both highlight awareness building as the most common HIV and AIDS activity in organizations. All CSOs conduct training programs and workshops for staff on HIV and AIDS issues as part of the internal and external mainstreaming. From the survey, almost ninety-seven percent of the staff reported receiving information about the basic facts of HIV and AIDS through their organization. Staff receive information about HIV and AIDS through resource materials, informal discussions, updates on notice boards, and from staff who attend HIV and AIDS trainings. One organization arranged exposure visits to other CSOs that have internally mainstreamed HIV, to understand how they directly work without stigma and discrimination, and conduct training for family members. Respondents in all three states reported a positive response to information flow about HIV. This is most seen in Tamil Nadu, where one hundred percent of the respondents said they receive basic HIV and AIDS information.

The quantitative data in Table 11 show the number and percentages of different groups of staff who report HIV and AIDS related training in their organization, and the percentages participating in this training.

Table 11: *Staff participation in training, by state, gender, and staff level*

		N	Reported training (X)	Participated in training (% X)
State	Andhra Pradesh	135	120 (88.9%)	105 (87.5%)
	Karnataka	109	109 (100%)	104 (95.4%)
	Tamil Nadu	71	70 (98.6%)	69 (98.6%)
Gender	Female	173	167 (96.5%)	154 (92.2%)
	Male	140	130 (92.9%)	122 (93.8%)
	Transgender	2	2 (100%)	2 (100%)
Staff level	Senior level	22	21 (95.5%)	21 (100%)
	Middle level	90	88 (97.8%)	79 (89.8%)
	Junior level	79	73 (92.4%)	68 (93.2%)
	Grassroots / program	101	97 (96%)	92 (94.8%)
	Officer level	13	11 (84.6%)	10 (90.1%)
	Lower level	10	9 (90%)	8 (88.9%)
All		**315**	**299 (94.9%)**	**278 (93%)**

Nearly 95% of the survey respondents reported that trainings have taken place in their organization, and most of those reporting training (93%) participated in at least one. It means that a high of 88% of all survey staff have received training in HIV and AIDS.

Table 12*: Topics of training about HIV and AIDS, reported by staff in survey (multiple response)*

Training topics	N	Yes #	Yes %
HIV prevention	279	271	97.1
VCT	279	112	40.1
STI	278	84	30.2
WPP	278	82	29.5
PMTCT	278	51	18.3
Treatment of OIs	278	38	13.7

Training content differs in organizations. Understandably, CSOs with HIV and AIDS projects have higher levels of training content as compared to CSOs with smaller or no HIV and AIDS projects. The chief coordinator of a CSO where HIV is not the core area of work said: "*We gave training to our staff and family members on modes of transmission, prevention, and issues around stigma and discrimination*". From the survey, it became clear that training mostly covered HIV prevention, as was also reported by CSO managers and FPPs. Forty percent of the trainings covered VCT, followed by STI and WPP with 30%. Less than one-fifth of staff received training in prevention of mother to child transmission of HIV (PMTCT).

4.2 Prevention activities

As discussed above, information on HIV prevention is primarily disseminated to staff in the form of trainings. This is confirmed by ninety-seven percent of the survey respondents.

While all organizations promote condom usage for the community, qualitative data shows that only six organizations have made condoms available for staff within the workplace. These are all secular organizations. In four of these six organizations, condom provision has been available prior to implementation of the WPP.

***Table 13**: Accessibility of condoms in CSOs, by state, nature of organization, and core area of work*

		N	Yes	No	Don't know
State	Andhra Pradesh	133	28 (21.1%)	101 (76%)	4 (3%)
	Karnataka	109	70 (64.2%)	31 (28.4%)	8 (7.3%)
	Tamil Nadu	71	32 (45.1%)	39 (54.9%)	0
Nature of organization	Secular	286	125 (43.7%)	149 (52.1%)	12 (4.2%)
	Faith based	27	5 (18.5%)	22 (81.5%)	0
Core area of work	HIV	32	32 (100%)	0	0
	HIV integrated	173	70 (40.5%)	95 (54.9%)	8 (4.6%)
	Non-HIV	108	28 (25.9%)	76 (70.4%)	4 (3.7%)
All		**313**	**130 (41.5%)**	**171 (54.6%)**	**12 (3.8%)**

Table 13 shows that 41.5% of respondents indicate that condoms are available in their organization. This number is high in Karnataka (64.2%) and low in Andhra Pradesh (21.1%). Comparisons between faith based and secular organizations show a higher number of respondents from secular organizations (43.7%) saying that condoms are available, as compared to 18.5% belonging to faith based organizations. All organizations with HIV and AIDS as their core work provide condoms in the workplace. About forty-one percent of the respondents belonging to organizations with an HIV integrated project agreed that condoms are available in the organization. It is encouraging to note that 25.9% of the respondents working for organizations that do not have HIV and AIDS projects report that condoms are made available in their organizations.

Table 14 shows the different places where staff can access condoms, in the CSOs where condoms are available for staff.

***Table 14**: Place of condom display, from survey (N=129)*

Place of condoms for staff	Respondents
Public corridor take away box	41 (31.8%)
Storeroom	27 (20.9%)
Cupboard	17 (13.2%)
Restroom	13 (10.1%)
Vending machines	1 (0.78%)
Other	46 (35.7%)

A public corridor take away box is the most common place where condoms are accessed in the organizations, and 39 respondents belonging to secular organizations confirmed this. Respondents belonging to FBOs highlighted drop in centres, storerooms, and counsellor's rooms as places where condoms are made available. Providing condoms in restrooms is an unknown concept in India – this was mentioned by only 10.1% of respondents.

Managers of 18 organizations indicated that they do not promote condoms for their staff members. Three of these organizations even showed strong disagreement for condom promotion, as illustrated in the following two phrases:

> *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 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. (Program officer and FPP)

I know people talk about leaving condoms in the restrooms for the staff but I don't think India has reached [the] stage where we put condoms in restrooms and distribute condoms among staff. But that's my personal opinion. It's very American to ask if condoms are distributed among staff. So I think I shouldn't answer the question. (CSO head)

The other 15 CSOs 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.

Table 15 gives information of 314 respondents' opinions about the provision of condoms in the organization. It is evident 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.

Table 15: *Staff's comfort level with provision of condoms, by nature of CSO, core area of work, and job level*

		N	Very comfortable	Moderately comfortable	Less comfortable	Uncomfortabl e
Nature of organization	Secular	287	194 (67.6%)	43 (15%)	23 (8%)	27 (9.4%)
	Faith based	27	14 (51.9%)	2 (7.4%)	7 (25.9%)	4 (14.8%)
Core area of work	HIV	32	31 (96.9%)	1 (3.1%)	0	0
	HIV integrated	172	113 (65.7%)	19 (11%)	23 (13.4%)	17 (9.95%)
	Non-HIV	110	64 (58.2%)	25 (22.7%)	7 (6.4%)	14 (12.7%)
Job level	Senior level	22	13 (59.1%)	4 (18.2%)	1 (4.5%)	4 (18.2%)
	Middle level	90	59 (65.6%)	13 (14.4%)	9 (10%)	9 (10%)
	Junior level	79	50 (63.3%)	13 (16.5%)	9 (11.4%)	7 (8.9%)
	Grassroots / program	100	72 (72%)	12 (12%)	8 (8%)	8 (8%)
	Officer level support	13	8 (61.5%)	2 (15.4%)	1 (7.7%)	2 (15.4%)
	Lower level support	10	6 (60%)	1 (10%)	2 (20%)	1 (10%)
All		**214**	**208 (66.2%)**	**45 (14.3%)**	**30 (9.6%)**	**31 (9.9%)**

A majority of 80.5% of respondents is or would be very or moderately comfortable with accessing condoms at the workplace, which is a positive outcome. In both secular and faith based organizations, a majority of the respondents is comfortable with the provision of condoms at the workplace. Comfort level is, however, highest in secular organizations. All respondents working in an organization with HIV as its core business are comfortable accessing condoms. Respondents from non-HIV organizations expressed the highest discomfort in accessing condoms at the workplace. Employees belonging to the grassroots (72%) are most comfortable to access condoms from the workplace, followed by employees belonging to the middle level management (65.6%). Respondents from the senior management (59.1%) show lowest levels of comfort in accessing condoms.

4.3 VCT promotion and facilitating access

A majority of fourteen organizations promote VCT in their workplaces, for instance through training. Information on VCT centres is given to staff, and two organizations have made a directory of HIV and AIDS services and circulated it to staff. Over seventy-one percent of the 315 survey participants was aware of the VCT services offered by the organizations. It is noteworthy that in Tamil Nadu and Karnataka the response was almost one hundred percent, while in Andhra Pradesh only 56.3% of respondents confirmed that their organizations promote VCT. This seems logical, taking into consideration the very low positive responses for condom promotion, provision of HIV prevention information, and the setting up of active information flows for accessing ART in this state.

Two CSOs have organized voluntary testing for staff, and in one CSO plans are underway. Most organizations encourage staff to get themselves tested or direct them to VCT centres when the need arises. In two other CSOs, VCT was a part of the other tests that staff were recommended to go for. In one of these CSOs the management facilitated medical check-ups and blood tests for staff (not specifically for HIV). Interested staff was asked to register with the FPP and were given contact details of HIV testing centres.

4.4 Access to treatment and ART

CSOs facilitate access to treatment through 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. Over seventy-one percent of the survey respondents reported that their organizations offer them information about ART access. This is an encouraging trend that indicates comfort in discussing HIV issues. It is worth mentioning that only 60% of Andhra Pradesh respondents mentioned this as a service that their organization provides, while in Tamil Nadu and Karnataka this was mentioned by over 85% of respondents. Awareness of institutions providing ART services provided similar numbers for each state. This needs further verification, considering that Andhra Pradesh reported the highest number of FPPs (see section 4.5).

Eight CSOs bear the medical expenses of staff, either through the WPP or other schemes. The expenses (total or partial) are borne through schemes or medical reimbursements, 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.*"

The project officer of another organization does not see the necessity of bearing the medical expenses of staff.

> *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.*

Other CSOs also make use of services, such as free ART and VCT provided by the public health system, and form liaisons with service providers to facilitate care and treatment for staff living with HIV. The project director of one of these organizations 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.*

4.5 Participation and involvement of FPP, committee, and PLHIV

Having an FPP and installing a committee are regarded as essential for effective development and implementation of the policy, and are therefore strongly advocated by the project. Out of the 24 organizations, 17 (70.8%) have an FPP. Of the survey respondents, 72.2% are aware of an FPP in the organization. When analyzed across individual states, it is interesting to note that 87.8% of all respondents in Andhra Pradesh report having an FPP, while in Tamil Nadu and Karnataka this is 65.2% and 58.4% respectively.

Organizations have appointed FPPs to be key drivers of the policy. They furthermore act as an interface between the management and staff, and in some cases between the organization and the project, as explained by one FPP: *"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."*

***Table 16**: Presence of FPP according to survey respondents, by state*

	Andhra Pradesh	Karnataka	Tamil Nadu	All
FPP	106 (87.6%)	59 (58.4%)	45 (65.2%)	210 (72.2%)
No FPP	10 (8.3%)	37 (36.6%)	20 (29%)	67 (22%)
Don't know	5 (4.1%)	5 (5%)	4 (5.8%)	14 (4.8%)
All	121 (100%)	101 (100%)	69 (100%)	291 (100%)

Eight CSOs have formed a committee; either exclusively for the WPP or an existing committee to guide WPP development and implementation. The roles and responsibilities of the committee have been detailed out in two organizations, suggesting that considerable thought has gone into the committee formation. In one, the FPP articulated:

> *We have rounds of interactions with the staff on who all should be in the committee. Finally, the team decided four persons to represent all levels of staff. We have a representation each from the management committee, program team, administration, and finance. The person from administration will look into the requirements of all female staff, the FPP will facilitate HIV and AIDS related services, the person from the management will give guidelines to the team and integrate HIV and AIDS activities in all programs, and the finance person be responsible for claiming any paid services for HIV and AIDS services used by staff.*

PLHIV participation is present in the twelve CSOs which have HIV positive staff members. Two organizations, where no staff members are known to be HIV positive, invited PLHIV to sensitize the staff and to obtain information on how the WPP should be favouring HIV positive staff. Based on these experiences, the policy was designed. Similarly, another organization collected essential inputs from the Indian Network for People living with HIV/AIDS (INP+) and a member of the men having sex with men (MSM) network, before developing the WPP.

5 EFFECTS OF WPP

CSOs are at various stages of WPP implementation, but there are already noticeable effects of the policy on staff and organizations. While some are directly related to WPP implementation, others are a result of the WPP development process. This section provides only information on organizations with a WPP in place, or organizations that are in the process of drafting a WPP. Table 17 summarizes the reported effects that are elaborated on in the sections of this chapter and in Chapter 6.

***Table 17**: Effects of WPP on staff and organization, reported by managers and staff*

Effect	IDI report the effect (N=22)	Staff in survey report the effect (N=291)	FGD report the effect (N=21))
Increased knowledge and awareness of HIV issues	17 (77.3%)	265 (91.1%)	17 (81.0%)
More IEC materials / access to information about HIV and AIDS	12 (54.5%)	247 (84.9%)	12 (52.2%)
More openness to discuss HIV and AIDS	12 (54.5%)	255 (87.6%)	13 (61.9%)
More taking preventative measures	5 (22.7%)	233 (80.6%)	3 (14.3%)
More disclosure by HIV positive staff	3 (13.6%)	227 (78%)	3 (14.3%)
More access to services (VCT, ART, STI, OI)	10 (45.5%)	N/A	9 (42.9%)
Access to benefits / (trust in) support	9 (40.9%)	255 (88.2%)	10 (47.6%)
Networking for services and information	5 (22.7%)	N/A	2 (9.5%)
Job security if found HIV positive	6 (27.3%)	251 (88.4%)	5 (23.8%)
Increased confidentiality of HIV positive status	NA	214 (68%)	5 (23.8%)
Negative effects	1 (4.5%)	35 (12%)	7 (33.3%)

5.1 Raised awareness of HIV and AIDS

Organizations with a fully functional policy and CSOs with almost a draft have reported a significant increase in levels of awareness amongst staff. This is especially noticed in organizations that have small or no HIV and AIDS projects, as exemplified in the following quote by a CSO head.

> *Ever since the WPP implementation, we have been giving a lot of trainings to staff starting with the basics of what is called HIV and AIDS. They were very illiterate on HIV. They used to think talking about sex and sexuality is a very private thing and it should not be spoken openly, especially in an organization with women staff and a male being the head. And so I got external resources like Arogyagam and INSA* [training organizations, also part of the project] *to sensitize my staff. Now they know that it's like just any other ordinary thing.*

From the survey, 91.1% of the respondents feel that the WPP has increased their knowledge about HIV and AIDS. In some organizations, the WPP development in itself, i.e. the initial discussions and drafting of the policy, has led to increased awareness. The project director of one of these organizations explained: *"At the time of preparation of the WPP, our staff members had few points in their mind about HIV and AIDS. Now they have got more information."*

5.2 IEC materials availability

CSOs provide IEC materials on HIV and AIDS for staff. Over eighty percent of all respondents across the three states confirmed that they have access to resource materials. As can be seen in Table 17, almost eighty-five percent of the respondents that are aware of the WPP in their organization indicated that the availability of IEC materials increased. Access to some form of IEC is highest in Karnataka (91.7%), and slightly lower at around 78.9% in Tamil Nadu and 75% in Andhra Pradesh. HIV integrated organizations have most IEC materials in their work setting (93.1%), followed by HIV organizations where 84.7% of the respondents reported access to IEC materials. Non-HIV organizations (62.7%) have the lowest availability of IEC materials. This has to be set right by correct communication and employers' initiatives.

IEC materials are mostly displayed in the library (54.1%), followed by a notice board (16.7%). HIV and AIDS materials are furthermore available in information boots (11.3%), in an AIDS corner (8.9%), which is more common in Karnataka than in the other two states, and in a few cases via a helpline. Other places where IEC materials are available are at clinics or health centres, in a documentation or store room, in a cupboard, or at the coordinator or FPP. Over ninety-one percent of the respondents across the three states have ever accessed or looked at the information. It is interesting to note that all employees belonging to the senior management level expressed that their access to information has increased after the WPP, while only around seventy percent of the respondents belonging to other categories report greater access to information. This suggests that access to IEC materials should be further strengthened among these job categories. The overall response rate to the availability of resources, coverage of the material, availability and access to the material is encouraging.

5.3 More openness to discuss issues related to HIV and AIDS

FGDs show that there is a positive response among staff in thirteen organizations to discuss HIV, and this has greatly reduced inhibitions. Almost eighty-eight percent of the survey respondents reported an increased openness to discuss HIV and AIDS. Staff interviewed attributed this to the WPP implementation. The WPP has enabled an open environment for staff discussions, and particularly in two CSOs whose core area of work is not HIV. FGDs, however, brought out mixed opinions as some staff did and others did not perceive the WPP as a change agent. The special educator of an organization explained why he felt that the WPP led to more openness about HIV and AIDS:

> *Earlier, staff members will hesitate to talk about HIV/AIDS, but now they have undergone lot of training programs and also awareness programs so they have a clear idea about HIV/AIDS, now we have got lot of information and also opportunity to discuss about HIV/AIDS.*

Another FGD respondent stressed that the WPP gave staff members the chance to speak about HIV and AIDS.

> *Prior to WPP implementation, administration staff did not get many chances to talk about HIV/AIDS. But now they give information about HIV, STD, STI, condom demo, etc. At one of the trainings, an administrative staff member showed a demonstration of condom. We got information about how [the] HIV virus gets into our body, how it spreads, HIV positive care and support treatment, prevention methods of HIV, counselling, etc. We have also planned to document all these information.*

Respondents who did not see the WPP as a change agent generally felt that discussions about HIV were already there and therefore cannot be attributed to the WPP. In five organizations, some staff felt that the WPP enabled them to talk more and some did not. A male program officer explained that *"The WPP is new and even before that we have*

been having discussions on HIV and AIDS. And so I don't think the WPP has anything to do with this."

The quantitative data shows that staff members' openness to talk after WPP implementation is most pronounced in non-HIV organizations. Nearly eighty-eight percent of the respondents belonging to these organizations acknowledged that they are now more open to talk about HIV and AIDS. This percentage is almost equal for men and women.

5.4 Behavioural change and preventative measures

Staff reported very positive responses to queries relating to information flow on HIV and how this has resulted in increased HIV prevention approaches. Table 18 highlights these findings, analysed across state, gender, age, and staff level.

Table 18: *Staff taking preventative measures, by state, gender, age, staff level*

			More prevention	Same prevention	Less prevention
State	Andhra Pradesh	120	93 (77.5%)	27 (22.5%)	0
	Karnataka	100	75 (75.0%)	24 (24.0%)	1 (1.0%)
	Tamil Nadu	69	65 (94.2%)	4 (5.8%)	0
Gender	Female	154	133 (86.4%)	21 (13.6%)	0
	Male	133	98 (73.7%)	34 (25.6%)	1 (0.8%)
	Transgender	2	2 (100%)	0	0
Age group	18-25	57	45 (78.9%)	11 (19.3%)	1 (1.8%)
	26-35	121	93 (76.9%)	28 (23.1%)	0
	36-45	87	74 (85.1%)	13 (14.9%)	0
	46+	24	21 (87.5%)	3 (12.5%)	0
Staff level	Senior level	22	19 (86.4%)	3 (13.6%)	0
	Middle level	84	66 (78.6%)	18 (21.4%)	0
	Junior level	77	65 (84.4%)	12 (15.6%)	0
	Grassroots / program	87	68 (78.2%)	18 (20.7%)	1 (1.1%)
	Officer level	11	8 (72.7%)	3 (27.3%)	0
	Lower level	8	7 (87.5%)	1 (12.5%)	0
All		**289**	**233 (80.6%)**	**55 (19%)**	**1 (0.3%)**

There clearly is a positive impact on preventative measures due to the implementation of the WPP. The impact is high in all states, but highest in Tamil Nadu where 94.2% of the respondents stressed that preventative measures increased.

Behavioural change between male and female staff differed. More women (86.4%) than men (73.7%) reported taking preventive measures against HIV after WPP development and implementation. Staff members in the highest age category reported most behavioural change, followed by staff in the category 36-45. When it comes to staff level, the highest number of respondents who agree that they personally take preventive measures came from the lower level support staff, followed by senior level management and junior level management. Officer level support staff reported the lowest preventive measures.

5.5 Staff's increased confidence in CSOs

The survey sought to understand employees' feelings on job security if found positive, and employees' trust in their organization to support them in case of illness.

Table 19: ***Effects of WPP on staff's confidence in CSOs, by type of organization***

		HIV	HIV integrated	Non-HIV	All
Secure of job if HIV positive	Increased	22 (75.9%)	132 (86.8%)	97 (94.2%)	251 (88.4%)
	Same	7 (24.1%)	20 (13.2%)	6 (5.8%)	33 (11.6%)
All		**29 (10.2%)**	**152 (53.5%)**	**103 (36.3%)**	**284 (100%)**
Support in case of illness	Increased	21 (72.4%)	133 (85.3%)	101 (97.1%)	255 (88.2%)
	Same	8 (27.6%)	23 (14.7%)	3 (2.9%)	34 (11.8%)
All		**29 (10%)**	**156 (54%)**	**104 (36%)**	**289 (100%)**

When we look at the responses of the employees based on the type of organization they belong to, it is interesting to note that employees belonging to non-HIV organizations report the highest impact of the WPP on job security and trust in support. This could mean that employees of HIV or HIV integrated organizations may already have had trust in their organizations to support them in case they are found positive or if they suffer any illness. These findings are encouraging, as these factors are likely to promote disclosure of HIV status among staff members.

5.6 Improved access to services and benefits

As discussed in section 4.3 and 4.4, organizations have encouraged and in some cases facilitated general testing services in which VCT was dovetailed. The program officer of one of these organizations explained how in his organization staff can access services.

> *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.*

One CSO provided condoms in the workplace because of the introduction of the WPP, and another CSO is planning for condom provision.

5.7 Indirect effects of the WPP

5.7.1 External mainstreaming HIV and AIDS

Internal mainstreaming of HIV has had an effect on the overall organizational activities, i.e. external mainstreaming. This is very evident in one CSO that does not work for HIV and AIDS. The respondent told that:

> *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, trainings provided by CSOs as a part of internal mainstreaming has enhanced staff skills that could be appropriately translated to action in the communities they serve.

5.7.2 Addressing general health issues

The WPP has motivated CSOs to think of the larger health issues for staff. Organizations that did not focus on staff health before started doing so after the STOP AIDS NOW! intervention. A CSO head explained: *"It's because of SAN!SIP that the health care policy*

was developed. Earlier we had just provident fund[s] for staff. After WPP, we openly asked for health care and so it takes care of health aspects. We had never given importance to health care but now it's become a policy."

In another organization, the WPP made the project director realize the importance of addressing general health issues.

> *WPP has made us think about other problems. As an organization, we have never consciously thought about medical allowances. Ours is quite a big CSO and as a part of WPP I asked everyone to get [a] screening for diabetes and [an] HIV test voluntarily; I found that more and more people are becoming conscious about their own health and well being.*

5.7.3 Building organizational systems and structures

The WPP has in some ways helped organizations to review, reflect, and restructure their existing policies and systems. Three organizations are now engaged in developing other organizational policies before they take on the WPP on HIV and AIDS.

In another CSO the WPP has contributed to greater PLHIV involvement within the workplace. The IDI respondent listed what changed: *"Reorganization of responsibilities of PLHIV and involving all staff in information dissemination. Earlier we had only particular staff pertaining to the project for meetings, but now it has changed. But it's not that everything came after the WPP implementation."*

5.8 Negative effects

IDI and FGD respondents expected several negative effects of the WPP. Staff of eight organizations perceived misuse as a possible negative effect of the policy. In one of these organizations some staff members felt that misuse would depend on the organization and the individual. Five organizations have known HIV positive staff, suggesting that staff responses might be based on actual happenings. One staff member explained that organizations must be aware of possible misuse: *"We should keep monitoring the person whether they are misusing that or not. We need to explain to them clearly about the responsibility of the policy."* More specific negative effects of the policy as told by staff were breaches of confidentiality and conflicts among staff, as more benefits are given only to certain people.

Just more than one-tenth of staff in the survey reported a negative effect of the WPP (see Table 20). Around 14% of the respondents from Tami Nadu feel that the WPP has negative effects, compared to 11% in Karnataka and 9.6% in Andhra Pradesh. There is a slight difference between secular and faith based organizations: 10.8% of respondents of the former and 14.8% of the latter reported negative effects. Fifteen percent of the respondents from HIV integrated CSOs think the WPP has negative effects as compared to 9.4% from HIV CSOs and 5.5% from non-HIV organizations. More men (17.9%) than women (5.8%) think that the WPP has negative effects. When analysed at staff level, it appears that senior level management respondents report the most negative effects. The lower the staff level, the lower the percentage of respondents that see negative effects. All respondents of the lower level support category in fact indicated seeing no negative effects or did not know. When we look at age group as a variable, it appears that participants in the age group 16-25 perceived most negative effects.

Table 20: *Negative effects of WPP reported in survey, by state, type organization, core area of work, gender, and staff level*

		N	Negative effects	No negative effects	Don't know / No answer
State	Andhra Pradesh	135	13 (9.6%)	101 (74.8%)	21 (15.6%)
	Karnataka	109	12 (11%)	88 (80.7%)	9 (8.3%)
	Tamil Nadu	71	10 (14.1%)	57 (80.3%)	4 (5.6%)
Type	Secular	288	31 (10.8%)	234 (81.3%)	23 (8%)
	Faith based	27	4 (14.8%)	12 (44.4%)	11 (40.7%)
Core area of work	HIV	32	3 (9.4%)	25 (78.1%)	4 (12.5%)
	HIV integrated	173	26 (15%)	126 (72.8%)	21 (12.1%)
	Non-HIV	110	6 (5.5%)	95 (86.4%)	9 (8.2%)
Gender	Female	173	10 (5.8%)	145 (83.8%)	18 (10.4%)
	Male	140	25 (17.9%)	99 (70.7%)	16 (11.4%)
	Transgender	2	0	2 (100%)	0
Staff level	Senior level	22	4 (18.2%)	17 (72.3%)	1 (4.5%)
	Middle level	90	12 (13.3%)	69 (76.7%)	9 (10%)
	Junior level	79	9 (11.4%)	66 (83.5%)	4 (5.1%)
	Grassroots / program	101	9 (8.9%)	75 (74.3%)	17 (16.8%)
	Officer level	13	1 (7.7%)	11 (84.6%)	1 (7.7%)
	Lower level	10	0	8 (80%)	2 (20%)
All		**315**	**35 (11.1%)**	**246 (78.1%)**	**34 (10.8%)**

Against one-tenth of the respondents that see negative effects is a large group of 246 staff (78.1%) that neither see nor expect any negative effects. This percentage is quite similar for all variables, except for faith based organizations (FBOs) where only 44.4% thinks that the WPP is free of negative effects. In some FGDs it was also argued that there are no negative effects. A staff member of an HIV integrated organization felt that the development process of the WPP in his organization is responsible for this.

> *This policy has not been developed in a day or by a single person. To develop this policy we had lot of discussions, meetings, opinions, and suggestions were given by every staff in drafting this WPP. So every aspect has been looked into before finalizing this policy. There is no room for negative effects of the WPP.*

The above findings highlight that a large majority of the respondents are very positive about the WPP. Further investigation is needed to identify the breakdown of perceptions across variables, such as those organizations where WPP is implemented, those organizations that are in the process, and those in the discussion stage. This could help us to understand what communication processes are required. The higher percentage of men reporting negative effects might be because of the perception that enhanced gender equity could cause insecurity. This also needs further analysis.

5.9 General impact

As seen in Table 17, and as discussed in this chapter, respondents are very positive about the impacts of the WPP. The fact that organizations across the three states have experienced positive impacts due to the implementation of the WPP is a clear indicator that geographical divisions do not have much influence on perceptions, and that the WPP is a process that may be acceptable to any work setting. The data, however, also indicate that the impact of the WPP is felt most among respondents belonging to organizations in Tamil Nadu, since these rank highest on all questions relating to WPP impact. It is encouraging to note that the impact of the WPP on individuals' access to information, attitude towards PLHIV, and in personally taking preventive measures is seen the most among respondents belonging to non-HIV organizations. Staff from CSOs that work solely on HIV and AIDS report the lowest impact, and this could be attributed to prior sensitisation and exposure gained from working in their respective CSOs.

Comparisons between male and female staff indicate that a higher percentage of female staff report a greater impact of the WPP. In ten out of the twelve questions in the survey relating to the impact of WPP, positive responses from women outnumber those of men. Higher numbers of responses among men are seen on two issues – knowledge about HIV and AIDS and taking preventive measures. Using age category as a variable, it turns out that over fifty percent of all respondents aged 26-45 years – those who are both the most productive in a work environment and sexually active – have confirmed the positive impact of the WPP across all important indicators such as knowledge of HIV, confidentiality of PLHIV in a workplace, increased understanding of HIV and gender issues, and very low negative effects due to the WPP.

6 SPECIAL THEMES

Extra attention was paid to collect information on some themes which are key in WPP development and implementation. These themes are: 1) the utilization of STOP AIDS NOW! documents; 2) gender; 3) disclosure and confidentiality; 4) stigma and discrimination; 5) sustainability. In this chapter these themes will be discussed.

6.1 Utilization of STOP AIDS NOW! Documents

When the project was initiated in South India, a toolkit providing directions and guidance in developing the WPP was given to member organizations. This toolkit comprises: 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'; example WPPs of, for instance, CSOs and corporate houses; and WHO documents.

The AR component sought to understand organizations' opinions about these documents and their usefulness in guiding policy development. Overall, respondents were aware of the resource package and found it useful. IDI respondents in 19 organizations referred to these documents during the drafting of the policy. Out of the three main documents given to the CSOs, the ILO document was the most preferred. This could well be because this is a familiar document, which is quite easy to use. Fourteen organizations confirmed having used the ILO document. The FPP of one of these organizations 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 two supporting documents developed by STOP AIDS NOW!. Only one organization referred to the GDG when developing the WPP. Some IDI respondents explained why they did not use the BT and GDG. Respondents of two organizations involved in grassroots level implementation found the documents too long and complicated. Two others cited language as a barrier for usage. 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."* An administrator explained that *"the resource package is good but the only disadvantage is that it's in English. Everybody will not be able to make use of it."* The program director and FPP of another CSO also did not make use of the SAN!SIP documents, as she was already experienced in writing policies: "*I felt that the documents were not really required and so I developed the policies with my knowledge and experience. I sat and wrote the policy with the help of other staff members.*"

Some organizations have referred to corporate houses and policies from partner organizations, such as INSA India, MYRADA, and CWS, for developing the WPP. Other documents that were used were documents from the International HIV/AIDS Alliance and documents from the People's Health Assembly.

6.2 Gender

In seven organizations, female staff outnumber men and transgender staff. This may be due to the primary area of work, focussing on vulnerable groups. Few CSOs have more male staff members. Some organizations have addressed gender equity through a gender policy or have formed committees to examine gender related issues. Some organizations are in the draft stage of a gender policy.

In most organizations, there are no gender differences in the workplace with regard to fringe benefits. Men and women are treated equally. However, in two organizations women who work extra hours are compensated, as the management believes that women hold larger responsibilities at home.[11] One CSO has a policy to provide work opportunities to vulnerable women. Respondents of two organizations explained that Dalit staff get 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."*

Managers of three organizations argued that they strive to achieve a gender balance across all activities within the workplace. Gender audits are done in a Tamil Nadu based CSO, which helps the organization assess issues around gender equity across all activities in the organization. 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."* She furthermore explained: "*All women have a synergy meeting in which the recommendations have been made and carried to the management for necessary provision.*"

6.2.1 Perceptions of staff on gender in the workplace

Table 21: *Staff perceptions on equal gender opportunities, by state*

	Andhra Pradesh N=135	**Karnataka N=108**	**Tamil Nadu N=71**	**All N=314**
Equal promotion opportunities	134 (99.3%)	102 (94.4%)	71 (100%)	**307 (97.8%)**
Unequal promotion opportunities	1 (0.7%)	6 (5.6%)	0	**7 (2.2%)**
Equal training opportunities	135 (100%)	104 (96.3%)	71 (100%)	**310 (98.7%)**
Unequal training opportunities	0	4 (3.7%)	0	**4 (1.3%)**

Staff of all organizations agree that there are no gender differences in opportunities in their organizations. From the survey, 97.8% of staff felt that there are no differences in promotion opportunities for men and women, and 98.7% indicated that there are no differences when it comes to training opportunities. Opportunities for training and promotions are instead based on competencies and skills.

All respondents from Tamil Nadu had positive responses regarding gender equity in opportunities for both job promotion and training. Only one respondent in Andhra Pradesh indicated that her organization does not provide equal promotion opportunities. The other respondents are based in Karnatakaand; four of them are from the same organization. Three of these four respondents also found promotion opportunities in their organization unequal.

The small group of respondents that are of the opinion that there are unequal promotion and/or training opportunities in their organization consist of five men and three women. They are working for secular organizations in middle level management, junior level management, grassroots level, and officer level support staff. Three respondents explained that women in their organization have more benefits and one respondent

[11] In both the organizations, two respondents were interviewed but only one respondent in each made this remark about gender differences. The other respondent said there were no gender differences.

argued that staff close to the management have more opportunities. Three respondents who argued that opportunities are unequal explained that they are based on performance and skills. This, however, is more an indication of equality in opportunities than of inequality.

While there is no reported gender based discrimination in organizations, staff members of three organizations emphasized that their organization tries to achieve gender inclusion by striving for a fifty percent representation across all aspects. In one organization, a 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.*" All other staff in this organization stressed that gender equality is the norm.

In organizations where there is largely female staff, respondents say that there is no room for gender differences as all staff are treated equally. Staff belonging to these organizations do not identify higher female representation as an outcome of gender equity.

6.2.2 WPP effects on gender

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.

Table 22: *Effects of WPP on gender awareness, as perceived by staff in survey, by gender*

	Female	Male	Transgender	All
More awareness	130 (83.9%)	95 (71.4%)	2 (100%)	227 (78.3%)
Same awareness	25 (16.1%)	38 (28.6%)	0	63 (21.7%)
All	**155 (100%)**	**133 (100%)**	**2 (100%)**	**290 (100%)**

A majority of 78.3% of the respondents that is aware of a WPP in their organization thinks that there has been an effect on gender issues. The percentage of female staff (83.9%) is higher than that of male staff (71.4%). This is a key finding and needs further data collection.

6.3 Disclosure and confidentiality

6.3.1 Disclosure and benefits

IDI respondents of three organizations reported that disclosure of HIV status increased because of the WPP. In one CSO, the HIV positive staff opened up and voluntarily disclosed during the WPP discussions. The other CSO, which has HIV positive outreach workers and staff, witnessed an increase in disclosure. The program director explained: *"I don't think they* [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".*

CSO heads and managers agree that disclosure to the management, the FPP, accounts or administration, or the immediate supervisor is needed to access benefits. IDI respondents from five organizations openly acknowledged the challenges in maintaining

confidentiality. Two of them felt it would be beneficial for the organization 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 guidelines 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*". A CSO head also mentioned in the interview, *"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".*

6.3.2 Confidentiality at the CSO level

IDI respondents of three organizations confirmed having guidelines in the WPP for maintaining confidentiality. In another organization that works with sexuality minorities, the confidentiality clause is part of their employee appointment letter and this has been in vogue much ahead of the WPP initiative of SAN!SIP. Furthermore, in this organization there is a general understanding that unauthorized disclosure of another person's HIV status is considered serious misconduct. Having information of HIV positive staff in employee files was seen as an effective way of maintaining confidentiality in two organizations.

6.3.3 Staff perceptions of confidentiality

Respondents of most organizations argued that an employee's HIV positive status should and will be kept in confidence. This was reflected in the survey. Staff of only two organizations differed in their opinion, in that they thought that making the HIV status known to all would be beneficial for the staff and organization. In two other organizations, staff members shared the challenges they find in maintaining confidentiality in the organization. According to the FGDs, a guideline for maintaining confidentiality is available in ten organizations. In two organizations, there were different opinions about the availability of guidelines.

Staff of five organizations believe that the WPP has 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 organizations 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. There are furthermore around 49 individuals (16%) who felt there has been no impact and twelve (4%) who did not answer. This indicates a further need to strengthen communication among employees about the WPP and its positive effects.

Table 23: *Staff perceptions related to confidentiality of HIV status in CSO*

	N	Yes	No	Not sure
Trust in confidentiality	314	303 (96.5%)	1 (0.3%)	10 (3.2%)
Punitive measures if confidentiality is breached	315	164 (52.1%)	120 (38.1%)	31 (9.8%)
Comfortable to disclose	313	261 (83.4%)	14 (4.5%)	38 (12.1%)

The survey also reflected that a large majority of staff (96.2%) said that they trust their organization to preserve confidentiality. A slight majority of 52.1% of the respondents believe that their organization will take punitive measures if confidentiality is breached. Of the respondents that are not aware of a WPP in their organization, twelve do not believe that their organization would take punitive measures. Six indicated that they are

not sure, and another six respondents think their organization will do so. Over fifty-five percent of respondents from Andhra Pradesh and thirty percent of respondents from Karnataka expressed the opinion that there will be no punitive measures if confidentiality is broken, as compared to 18% in Tamil Nadu. This indicates that guidelines regarding confidentiality are not strongly laid down in these CSOs. The STOP AIDS NOW! Secretariat could look into this. There is also a possibility that respondents did not understand the question, so the benefit of the doubt for now could be given towards that angle. There is a need for a survey and then a proper training for all organizations if the WPP were to be implemented in a sustained manner in these workplaces.

6.3.4 Staff perceptions of disclosure

The majority of 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. Comparisons between faith based and secular organizations reveal that a higher number of respondents from secular organizations feel staff will be comfortable to disclose their positive status. The number, however, is high in both types of organizations. Over sixty percent of all survey respondents across the organizational hierarchy endorsed the view that HIV status disclosure is in a comfort zone. Among the respondents who would be comfortable to disclose are eighteen staff members (75%) who are not aware of a WPP in their organization. This could indicate that these CSOs already have good circumstances to disclose. 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 qualitative FGD data, it is evident that disclosing to someone with authority gives staff a sense of relief that they could avail benefits. This is reflected in the survey.

Table 24: *Most suitable person(s) to disclose HIV status to, according to staff in survey, by state (multiple response)*

Person to disclose to	Andhra Pradesh (N=135)	Karnataka (N=109)	Tamil Nadu (N=71)	All (N=315)
CSO head	64 (47.4%)	76 (69.7%)	59 (83.1%)	199 (63.2%)
Peer staff	36 (26.7%)	36 (33.0%)	17 (23.9%)	89 (28.3%)
Immediate supervisor	25 (18.5%)	18 (16.5%)	12 (16.9%)	55 (17.5%)
FPP	28 (20.7%)	7 (6.4%)	6 (8.5%)	41 (13.0%)
Counselor at workplace	17 (12.6%)	11 (10.1%)	11 (15.5%)	39 (12.4%)
HIV and AIDS committee	11 (8.1%)	4 (3.7%)	6 (8.5%)	21 (6.7%)
HR head	6 (4.4%)	2 (1.8%)	2 (2.8%)	10 (3.2%)
No one	5 (3.7%)	2 (1.8%)	0	7 (2.2%)
Other	42 (31.1%)	28 (25.7%)	21 (29.6%)	91 (28.9%)

By far, most survey respondents (63.2%) would prefer discussing their HIV status with their CSO head. This is highest among officer level support staff (84.6%); among the other job categories the percentage is somewhat equal. Almost twenty-nine percent of the respondents would prefer talking to other persons, for instance friends, 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 thirteen percent would prefer to talk to this person. Out of the 87% that would not prefer talking to an FPP, 36.9% indicated that their organization does not have an FPP. For the other respondents and partner organizations, it seems that there is an urgent need to explain the role of the FPP. Respondents furthermore do not see a major role for counsellors, AIDS committees, or the immediate supervisor.

Staff in FGDs in 16 organizations felt that the WPP has an effect on disclosure, whereby 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 the management and staff. The senior coordinator from a CSO that does not work for HIV and AIDS explained the effect on disclosure.

> *Earlier they would not have disclosed their status 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 organizations, where some staff felt that the WPP will have an effect and some others did not. The latter group felt that the environment in the organization was always conducive for disclosure.

6.4 HIV related stigma and discrimination

6.4.1 Stigma and discrimination in the workplace

One of the key components of the WPP is a stigma and discrimination related guideline. This is to ensure that HIV positive staff have an enabling environment for themselves and their families. The AR team collected feedback from respondents on their views about guidelines or policies relating to HIV stigma and discrimination in their work settings. Half of the organizations have HIV and AIDS as their core area of work. Ten of these confirmed employing PLHIV, while the other two have affected staff members as part of their work team. The rest of the organizations are also open to employing PLHIV, but have no known HIV positive staff at the moment. Increased awareness about HIV is the key reason for this finding.

6.4.2 Experiences of stigmatization of HIV positive people in CSOs

Staff of all organizations agreed that there is widespread stigma attached to HIV in India. Low awareness, associations of HIV with wrongful conduct, and misconceptions regarding the modes of transmission are some of the main reasons that attribute stigma to HIV and AIDS.

Although staff acknowledge stigma in society, the majority of them believe that there have been no previous instances of stigma and discrimination in the workplace, and that there will also not be any in the future. It is again because of increased awareness and acceptance – in some cases because of the WPP – that organizations do not discriminate against PLHIV. The exception is one CSO where staff reported that there have been instances of stigma. Similarly, 94.2% of the respondents in the survey never noticed any discrimination based on HIV status in their organization. Only two respondents (1.3%), both from the same CSO, indicated that HIV based discrimination happens in their organization.

The project director of another organization also reported experiences of stigma and discrimination in the workplace, both real and perceived. He told that *“Initially staff used to pass comments saying that these people* [outreach workers] *are positive and used to be very cautious when they talk to them. There was also a case of perceived stigma as one of the HIV staff felt that no one likes him because he’s positive*”. Staff of this organization did not mention this in the FGDs. Another CSO head opined that there might be perceptions in people’s minds which are not openly stated due to political incorrectness.

The survey indicated that 94.8% of the 155 respondents who have HIV positive colleagues said that they are comfortable working with these staff. Out of these 155 respondents, a majority of 146 (94.2%) never noticed any discrimination based on HIV

status in their organization. Almost ninety-four percent said that they would feel comfortable working with PLHIV if there will be any in future.

Table 25: *Staff's attitudes towards feeling comfortable to work next to an HIV positive colleague, by background variables*

		HIV+ staff in organization			No known HIV+ staff in organization		
		N	**Not comfortable***	**Comfortable***	**N**	**Not comfortable***	**Comfortable***
State	Andhra Pradesh	63	0	60 (95.2%)	72	4 (5.6%)	64 (88.9%)
	Karnataka	63	1 (1.6%)	59 (93.7%)	46	1 (2.2%)	44 (95.7%)
	Tamil Nadu	29	0	28 (96.6%)	42	0	42 (100%)
Gender	Female	78	0	73 (93.6%)	95	2 (2.1%)	91 (95.8%)
	Male	75	1	72 (96%)	65	3 (4.6%)	59 (90.8%)
	Transgender	2	0	2 (100%)	0	0	0
Age group	18 -25	29	1 (3.4%)	26 (89.7%)	34	1 (2.9%)	33 (97.1%)
	26 - 35	67	0	64 (95.5%)	62	3 (4.8%)	57 (91.9%)
	36 - 45	47	0	45 (95.7%)	50	1 (2.0%)	47 (94.0%)
	46+	12	0	12 (100%)	14	0	13 (92.9%)
Job level	Senior level	9	0	9 (100%)	13	0	13 (100%)
	Middle level	38	0	36 (94.7%)	52	1 (1.9%)	47 (90.4%)
	Junior level	31	1	30 (96.8%)	48	4 (8.3%)	44 (91.7%)
	Grassroots / program	66	0	61 (92.4%)	35	0	34 (97.1%)
	Officer level	7	0	7 (100%)	6	0	6 (100%)
	Lower level	4	0	4 (100%)	6	0	6 (100%)
All		**155**	**1 (0.6%)**	**147 (94.8%)**	**160**	**5 (3.1%)**	**150 (93.8%)**

* Remaining: no answer or don't know

Quantitative analysis clearly shows 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. Nearly all respondents said they have not noticed any stigma and discrimination in the workplace, except for two grassroots level staff members belonging to the same secular organization that, surprisingly, has HIV as its core work. All these are very important markers for mainstreaming HIV in a work setting.

Table 26: *Staff opinion about recruitment of HIV positive staff, by background variables*

		N	Organization should recruit HIV+ staff	Organization should not recruit HIV+ staff
State	Andhra Pradesh	135	128 (94.8%)	2 (1.5%)
	Karnataka	109	99 (90.8%)	2 (1.8%)
	Tamil Nadu	71	67 (94.4%)	4 (5.6%)
Gender	Female	173	160 (92.5%)	5 (2.9%)
	Male	140	132 (94.3%)	3 (2.1%)
	Transgender	2	2 (100%)	0
Age group	18 -25	63	53 (84.1%)	4 (6.3%)
	26 – 35	129	123 (95.3%)	3 (2.3%)
	36 – 45	97	93 (95.9%)	0
	46+	26	25 (96.2%)	1 (3.8%)
Job level	Senior level	22	20 (90.9%)	1 (4.5%)
	Middle level	90	85 (94.4%)	0
	Junior level	79	73 (92.4%)	2 (2.5%)
	Grassroots / program	101	97 (96%)	2 (2%)
	Officer level	13	12 (92.3%)	0
	Lower level	10	7 (70%)	3 (30%)
All		**315**	**294 (93.3%)**	**8 (2.5%)**

As seen in Table 26, 93.3% of the survey respondents felt that the organization should recruit a person who is HIV positive. This number is similar for each state and all genders. Staff members aged 18-25 were least enthusiastic about recruiting PLHIV. Dissent towards recruiting HIV positive staff was furthermore noticed among three (30%) officer level support staff, and a small two percent of the grassroots level staff and staff belonging to the junior level management. Looking at organization type, around eighty-nine percent of respondents from FBOs and ninety-four percent from secular organizations felt that HIV positive staff should be recruited.

If the WPP is implemented well and with proper consensus, all work settings could become equal opportunity employers and this is an important social development indicator.

6.4.3 Measures to reduce stigma and discrimination

IDI respondents of all organizations indicated that they do not tolerate stigma and discrimination, and they see it as a serious disciplinary offence that will lead to stringent action up to and including termination of employment. This indicates that there are guidelines and measures for stigma and discrimination. A program director explained how his organization 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 grounds. An enquiry will be set up and this is there in the draft itself.*

One CSO that works for sexuality minorities has clearly laid down guidelines for stigma and discrimination in the form of rules and regulations in the appointment letter. This, however, was in place well before the WPP initiation. Even showing additional care and concern for HIV positive staff qualifies as discrimination.

The severity of action varies between the organizations. Respondents of two organizations said that they are unsure of the measures they will take; it will depend on the nature of the case and action that is deemed appropriate will be taken. Other organizations believe in giving the individual a fair hearing by setting up an enquiry. The secretary of a CSO said she would first try and establish a good rapport with the individual and then address the root cause of discrimination instead of resorting to termination.

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

Trainings and sensitization programs have helped to create more awareness of HIV and AIDS issues. This is, according to managers, a key reason for the WPP having a positive effect on reducing stigma and discrimination. A 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*.

According to the chief coordinator and FPP of another organization, *"the WPP will definitely have an effect. Since the WPP is implemented, we will have continuous trainings and staff will become more aware about HIV. Secondly, they will be punished by the committee if they stigmatize PLHIV."*

In addition to enhanced awareness, respondents feel 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.

In two CSOs, where the WPP is in the draft stage, stigma and discrimination was never really a problem and therefore the WPP is not perceived to have had any effect. The supervisor and FPP of one of these organizations argued: *"We have always been having rules and regulations regarding this. It is certainly not because of the WPP."*

6.4.5 Staff perceptions of the effect of WPP on stigma and discrimination

In FGDs in 13 organizations, staff members said that that the policy has had a positive effect on stigma and discrimination because it helps increase awareness about HIV and AIDS issues. A male coordinator of one of these organizations explained this effect.

> *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 finance officer of another CSO explained: *"The WPP will definitely have an effect. This is the policy of the organization and everybody needs to abide by that."* In two organizations, there is no consensus amongst staff on the effect of the WPP on stigma. While some respondents feel that there is increased awareness because the WPP leads to stigma alleviation, others feel that since there has never been stigma and discrimination there is also no effect.

6.5 Cases: correlation of stigma, discrimination, and gender

All respondents agreed that there is a strong correlation between gender and stigma in society. Women are often accused of acquiring HIV infection, even though this may not be the case. Deep-rooted patriarchy and cultural biases that place a man higher than a

woman, as well as the association of women to sex work, are some of the reasons attributed to this. With regard to gender and stigma in the workplace, the director of only one CSO said that there might be differences within the workplace as well, however not as much as in the community. In almost all organizations, 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 CSO, 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.

To understand staff perceptions on gender and stigma, a scenario was presented to them. It was believed that participants would be able to relate to the individuals mentioned in the scenario and therefore offer their opinions easily. The scenario is as follows.

Figure 2: *Scenario correlation of stigma, discrimination, and gender*

Scenario 1
Sheila is an HIV positive person working in our organization. She is 35 years and has two children. She is living with her two children, and has requested different work timings, preferably half a day, since she is unable to manage her work and her home single handedly. Sheila has been working for the last 4 years with the organization with a team of five people and has been promoted twice. Sheila works in a livelihood promotion project. Her job entails documenting the project related activities, maintaining records, and making occasional visits to the project areas.

Scenario 2
Ravi has been suffering from TB and falls ill often. He is HIV positive for the last 2 years. He is 28 years old. He is a migrant, leaving his wife and children back in his native place. He has three children, and has requested 5 days working pattern, since he wishes to go to his family during weekends. Ravi has been associated with the organization for the last 5 years and in the capacity of an outreach worker.

The organization policy is such that this benefit can be availed only by one person. Whom would you consider first? Why?

The responses of the FGD participants in the organizations are broadly classified into those who would prefer their organization to support either only Sheila or only Ravi; those who would prefer their organization to support both Sheila and Ravi, where the staff feel that both should equally benefit from the policy; and the mixed responses where some would like their organization to support Sheila, others would like the organization to support Ravi, and some would like both to be supported.

Absence of gender related stigma was clearly seen in five organizations, where all respondents were of the opinion that their organization should support both Sheila and Ravi, or gave preference to the individuals whose health condition needed immediate attention. In sixteen organizations there were different opinions among staff about who needed to be helped. Some felt Sheila needed to be helped because she is a single woman with a bigger responsibility of taking care of her family. As suggested by a female FGD respondent: *"Men and women are different. Sheila has to take care of her children. Her children are dependent on her. […] Sheila is the only person for her children."* Some others found Ravi's health condition more pressing.

Another interesting result of the scenarios is based on the question of how Sheila and Ravi got HIV. The case described Ravi as being an outreach worker. Almost all staff members saw the fact that he has to travel a lot as the cause of the HIV infection. For

Sheila this was different. Many respondents indicated that she might have got it through blood transfusion or from her husband. One respondent argued that *"People may also think that Sheila got this through unprotected sex, but this is less".* Respondents thought Sheila got HIV through an external situation, while this was not the case with Ravi. However, in the same FGD, a respondent argued that women are always thought to be guilty for their infection: *"General people's scenario, people will think that the woman has done something wrong. If they come across any HIV positive woman, they will think that she's done something wrong."*

6.6 Relations and networking, linking and learning

CSOs network with a host of public institutions, such as State AIDS Prevention and Control Society (SACS), ART centers, VCT centers, and other CSOs for project related work. Organizations with HIV and AIDS projects have wider and stronger liaisons with institutions that provide HIV and AIDS services. Commonly, CSOs network to make referrals for care, testing, and nutritional support for their staff members.

Six organizations have networked with SAN!SIP CSOs specifically for developing and implementing the WPP. Sharing of information and cross learning, though largely limited between CSOs of a particular state, has been taking place. They have used the policy documents of other CSOs as reference to develop their own policies.

The networking among the SAN!SIP CSOs for issues not related to the WPP is good. Respondents of seven organizations said that they network for other project related activities.

6.7 Sustainability

CSOs are clearly interested in making the WPP an institutional policy, which will be continued irrespective of fund availability. Repondents of all but one CSO are 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 CSOs 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 thought of.

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(i) Lobbying with other donors

Once their project funding comes to a close, CSO heads and FPPs feel they can convince other donors who are funding them to include the WPP in the project budget. Some believe having a WPP only increases the credibility of the CSO 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."*

(ii) Earmarking a part of organizational general funds for WPP

Some CSO 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 funding raising strategy not only for this* [but] *for many other things.*"

(iii) Raising money from the 'for profit' sector

IDI respondents of three organizations plan to explore corporate houses and industries as an alternative avenue for funding. The director of one organization explains: *"We are seriously thinking about raising money from the industries in our area. We have the 80G provision and this will help us to collect money."*

While most CSOs are planning onward strategies to continue with the WPP, some others are of the opinion that WPP implementation does not have financial implications. CSOs believe that awareness programs and facilitating services do not need any specific funding. Furthermore HIV positive staff can be tied up with public institutions that offer care and support services.

The reported effects of the WPP indicate that the WPP is a successful model for organizations to enhance awareness of HIV, acceptability of PLHIV, positive modification towards preventing HIV acquiring behaviour, gender issues, and to reduce negative perceptions about the WPP. If these positive effects are further strengthened through continued communication, training, mentoring, and essential technical assistance, the response will be very promising and the WPP highly sustainable. Further analysis of the effects against background variables may guide the SAN! Secretariat to plan the next steps in this project more effectively.

6.8 Review plans

The majority of the organizations are planning to review their policy, though in only one organization did the director state that review mechanisms are inbuilt in the policy and that their policy is nearing review. Another CSO with a fully functional WPP had not thought of review until the AR team asked for it.

> *Having heard about what you said, we are encouraged to incorporate review plans into the policy. We see the WPP as a separate department and that is why we don't incorporate this into the main appraisal program. Second appraisal will take place at the end of this year, maybe in November. In that we can include a few questions relating to the WPP and this will help us know how much the staff have understood about the WPP, the idea, and the concept.*

7 REFLECTION AND EVALUATION BY ORGANIZATIONS

7.1 CSOs self reported challenges

Organizations did not report any grave challenges impeding the development of the policy. Managers and staff, however, did experience or expect some challenges. Financial constraints were the most common expected challenges reported by organizations; though the CSO head of only one organization feels he actually cannot move forward without sufficient funds to back this policy. Five organizations did not experience challenges so far, but expected to experience some challenges when staff would turn out to be HIV positive. This had to do with lack of funds to support many HIV positive staff members, but also with possible conflicts among staff.

Two CSOs foresee dissent from staff because of the seemingly disproportionate benefits given to HIV positive staff. In a CSO that works for HIV and AIDS, the FPP commented that similar policies should be developed for MSM and sex workers who are also part of the staff. Having only a WPP for HIV positive staff may exclude other vulnerable sections. Two respondents expected challenges in maintaining confidentiality if staff members turn out to be HIV positive. The manager of an FBO foresees some difficulties with the community if they would promote condom use.

More technically, two CSOs reported a lack of time to devote towards WPP as a constraint. Finally, one manager has had difficulties in developing a WPP that is approved by all staff, since he experienced many different opinions from staff. There were also some organizations that reported facing no challenges and that are sure not to face any in the future.

7.2 CSOs self reported good practices

Most organizations felt that the policy is beneficial for staff and there are no negative impacts to this policy. In the quantitative survey there was a very specific question on perceptions about a negative impact of the WPP. An overwhelming 246 respondents (over 75%) did not see any negative impact due to implementation of the WPP. This is an important indicator and a very positive outcome that needs to be highlighted. Self reported good practices were, among others, the involvement of staff, awareness raising strategies, the reduction of HIV related stigma and discrimination, and linkages with other institutions.

Managers and staff of several organizations reported good practices in WPP development and implementation. Most of these promising practices relate to staff involvement in drafting the policy. The SAN!SIP project lays emphasis on adopting a participatory approach to the development and implementation of the policy, in order to create a better sense of ownership and commitment. All organizations have either developed the WPP in consultation with all staff members or have shared the policy with all staff once it was developed. Staff inputs were taken into consideration and incorporated into the policy. Four organizations have involved their support staff to provide orientations about the WPP. Managers of two CSOs particularly mentioned the involvement of PLHIV as a good practice. In one organization, HIV positive speakers were invited to sensitize staff members. In another organization, 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 PLHIV. 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."*

In two organizations, the supportive environment for PLHIV was mentioned as a good practice. One organization had good experiences with maintaining confidentiality. In three CSOs, finally, the linkages with other organizations were a reported good practice, making it possible to refer staff to services if necessary.

7.3 Role of SAN!SIP, SSIPG, and donors

In all but one organization the role of SAN!SIP, SSIPG, and donors was discussed. It seemed that the role of SAN!SIP was most clear, since this was by far the most addressed.

7.3.1 Support provided

IDI respondents from 20 of the 22 CSOs with a draft or a fully functional WPP mentioned support provided by SAN!SIP or SSIPG as important. This support was mainly technical.

In twelve organizations, the role of SAN!SIP in providing technical assistance during workshops, trainings, or meetings was mentioned. The FPP of a CSO in Tamil Nadu explained how SAN!SIP helped them in the process of 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”.* The FPP of an organization in Andhra Pradesh also explained how SAN!SIP provided technical support.

> *Working with SAN!SIP is a different experience. Once we started WPP we got lot of inputs from them and then we got lot of trainings also from them and I have attended a lot of workshops. We received a lot of materials from them on HIV/AIDS.* [...] *I am very happy with the SAN!SIP’s technical support.*

In addition, three CSO managers acknowledged the role of SAN!SIP in providing technical assistance through the availability of information materials.

IDI respondents of only two organizations argued that SAN!SIP provided some sort of financial support, by explaining the 4% funding.

In three IDIs, the role of SSIPG in providing technical support was acknowledged. One of these respondents, from a Karnataka based organization, argued: *“SSIPG were very supportive and friendly; even though there are different levels of people in it everybody were mutually supportive and treated respectfully. There were help in reporting, giving feedback and sharing things. So it is like a give and take policy.”*

In some organizations, the respondent stressed that SAN!SIP and SSIPG gave support but did not elaborate on how this support was provided.

7.3.2 Visits by SAN!SIP

In five organizations, the visits made by SAN!SIP were seen as part of its role. Explanation of the WPP and interaction with staff members were most important in these visits. One respondent from a Tamil Nadu based organization explained why the visits are important: “*When they* [SAN!SIP] *come for visits, and question our staffs about HIV/AIDS knowledge, even our administrator staffs will get a feel to train all the staffs.”*

7.3.3 Facilitating linkages with partner CSOs

IDI respondents of four CSOs experienced how SAN!SIP facilitated linkages with partner organizations. This was mainly useful in getting to know how other organizations are implementing the WPP and what their experiences and challenges are. The FPP of a Tamil Nadu based organization explained that he did not have the chance so far to network, but *"if SAN!SIP asks me to network with them* [partner CSOs], *I will."*

The director of one organization was very enthusiastic about the role of SAN!SIP in linking SSIPG members with each other: *"The approach of SAN!SIP in getting all SSIPG members together, asking them to make a vision, and the partners owned the project; everything was nice*

7.3.4 Other support

In one organization, the role of SAN!SIP in facilitating linkages with public institutions was mentioned. One CSO manager explicitly described the role of the donors in starting the WPP process, and she added that she expects further assistance in sustaining the policy.

> *When they* [Dutch donors] *came forward and asked us to do it, it is their responsibility also to see how it is sustained. It is like they ask us to get married and have a baby and I got a baby [but] now what to do with the baby, what will be its future?* [...] *Now how to bring up the baby is the question. If they hadn't interfered I wouldn't have got married, I wouldn't have got the child. Now they made me get married, they made me get a child, now what to do? So, this is something that they have to do something about.*

One respondent explicitly argued that SSIPG was not of much support, and another CSO manager did not find SAN!SIP of much help. Respondents of the two organizations that had not initiated the WPP process also did not see a clear role of SAN!SIP or the SSIPG. These respondents, however, both did not attend any workshops or trainings.

7.4 Expectations for support

7.4.1 Technical support

Thirteen out of 23[12] organizations said they would like technical support in the form of trainings, workshops, assistance for drafting the policy, and feedback on their implementation processes. Three organizations said they need assistance in drafting the policy and two expected inputs for their drafts and also during the course of implementation. Three out of the 24 organizations said they would like to know more on how the other member organizations are proceeding. The secretary of a CSO gave an example: *"They can start a newsletter and can circulate it. They can give information on how organizations are implementing the WPP*".

While all organizations appreciated the efforts of SAN!SIP and SSIPG, two CSO heads were not very happy with the support rendered to this project. One of them worried about the continuation of the support after the end of the project: *"I would like to know what kind of support the partner NGOs will get once the project comes to an end and I would also like the SAN! Secretariat to be close to member organizations."* The other director expected more clarity in communication.

> *They are still giving us a lot of training and I personally don't know what their vision and mission is. Suddenly we get a letter saying that there is a*

[12] The IDI with the director of one CSO was stopped midway as the respondent had to attend to some urgent issues. The section on experiences, expectations from SAN!SIP, and sustainability could therefore not be discussed.

vernacular training and we get another letter saying training in Madras [Chennai] *and we send people. We don't send the same people every time as they may not be around always. A short mail to all of us and tell us where we are and what we are doing will be of great help. It's not possible to go for all meetings. Priorities are different.*

It is important to add that both these CSO heads only attended the first STOP AIDS NOW! workshop and did not actively participate in the meetings.

7.4.2 Financial support

Since financial constraints were among the most expected challenges for organizations, many CSOs had certain expectations from SAN!SIP and donors concerning this topic. Six organizations were able to manage WPP implementation leveraging their own resources, either from existing project funds or from general funds. Since HIV and AIDS testing and treatment services are provided by the public health system, organizations are not constrained to meet treatment related expenses. Most organizations refer staff to government run centres for testing and treatment. The executive officer and FPP of one of the organizations explained that the organization does not need financial support to facilitate care and treatment for HIV positive staff: *"We have a good rapport with many ART, PPTCT, and other care centres and so it's not really a problem for us* [to provide care and treatment for HIV positive staff]*."*

One organization is clear in its policy to not take foreign funds. Once the WPP is functional this CSO plans to leverage support from other organizations and other infrastructure and connect it with their staff. The CSO head added, however, that, *"Moreover we have not committed financial support in our policy. We don't give assurance that the whole expenditure will be borne by the organization. It is impossible but we will help them."*

Thirteen organizations indicated that they expected financial support to either develop or implement the policy. Three of these organizations cited financial constraints as their major challenge. The CSO head of one of these organizations explained:

Tomorrow I have 20 positives and 30 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.

Another respondent had a different view: *"Implementation does need funds always unless there is financial crisis for the infected staff or any care and support needed. In such situations we may ask help with other donors".*

Information on funding as a constraint could not be obtained from five organizations. In four of these organizations, only the FPPs were interviewed and they were not aware of the funding scenario. The interview with the secretary of the other organization was discontinued, so this topic could not be discussed.

8 CONCLUSIONS AND RECOMMENDATIONS

The impact of the WPP, as expressed by all the respondents, is very promising and impressive. Gender equality, stigma reduction, provision of HIV prevention information and supplies, and referrals for VCT and ART are certainly very promising steps towards HIV mainstreaming. There are significant developments such as WPP committees, health policies, staff guidelines in some organizations addressing gender issues, and providing training and resource materials for HIV awareness.

There are several promising developments and successes identified in this report. Respondents are willing to accommodate PLHIV in their work settings; express confidence in their organization to take care of those with HIV; are aware of the need for maintaining confidentiality; express confidence that their organization will effect punitive measures if there are any violations; and express confidence that there is no or very low stigma and discrimination against those with HIV.

Support staff, such as helpers, drivers, and clerks, usually do not benefit from organizational policies, unless they are in the payroll of the organization. CSOs have taken deliberate efforts to involve them in training programs to ensure that basic HIV and AIDS issues such as modes of transmission, prevention, care, and treatment are also disseminated to them. WPP committees in some organizations are involving support staff in different discussions and are training them. AIDS committees are formed where measures are taken to involve staff in different levels and with a primary objective of mainstreaming HIV and AIDS.

CSOs that are involved in grassroots level implementation have translated their policies to the local languages. This ensures that their policy is fully understood by staff, so that all can avail the benefits when they need it.

Not all CSOs have progressed evenly. There are constraints related to time availability, building a support structure, and ambiguity about benefits. The following paragraphs summarize the promising practices that CSOs can learn from, and the challenges that they may face and that are addressed in the recommendations of this report in section

8.1 Summary of promising practices

- Making the policy available and known to all staff;
- Implementing WPP activities before donor funding is received or without need of external funds;
- Making condoms available for staff;
- Involving all levels of staff in development and implementation of WPP;
- Involving PLHIV;
- External mainstreaming;
- Providing to staff a directory of HIV and AIDS related services;
- Translating the WPP into the local language;
- Organizing VCT in the workplace;
- Having guidelines for maintaining confidentiality and a conducive environment for disclosure;
- Putting regulations against stigma and discrimination in appointment letters;
- Linking and learning with public and private organizations for information sharing, access to free IEC, condoms, training, and referral services;
- Putting in place sustainability measures, for instance by writing proposals for funding, mainstreaming HIV and AIDS in other organizational budgets, and internal fundraising mechanisms.

8.2 Summary of challenges

- Unknown financial implications when more staff need support and benefits;
- Foreseen conflicts between staff when HIV positive staff access benefits;
- Negative stance on condoms by religious organizations;
- Time constraints for staff to participate in activities;
- Low understanding by management and staff of the role of the FPP;
- Not installing a committee for WPP activities;
- Little deliberate involvement of PLHIV;
- Striking a balance between confidentiality and HIV positive staff accessing benefits;
- Low level of linking and learning between SAN!SIP partner CSOs.

8.3 Recommendations

To CSOs

- Use the STOP AIDS NOW! documents 'Good donorship in a time of AIDS' (Good Donorship Guidelines) and the Budgeting Tool 'What's it likely to cost' in developing a WPP and budget;
- Establish a committee and appoint an FPP to augment HIV and AIDS activities and services within the organization. Roles and responsibilities of committees can be better defined or can be added to their job descriptions to effectively develop and implement a WPP;
- Discuss with staff the preferred method of WPP dissemination and disseminate the WPP to all staff. Translate the document if needed;
- Provide information on HIV and AIDS and the WPP to staff, for instance on a notice board;
- Share experiences and promising practices with other partner CSOs, for instance on issues such as maintaining confidentiality;
- Start or continue implementing WPP activities that do not cost money;
- Link with other stakeholders for services, including for training, condoms, VCT, and ART;
- Open or continue dialogue with donors about managing HIV and AIDS in the WPP;
- Write proposals for funding to bodies other than STOP AIDS NOW! donor organizations.

To SAN!SIP Secretariat and SSIPG

- Enhance awareness about the FPP and his or her roles, since there seems to be a low understanding of this important factor;
- Advocate usage of the STOP AIDS NOW! tools 'Good donorship in a time of AIDS' and 'What's it likely to cost' to member organizations that are yet to finalize their draft WPP, and recommend CSOs that have a fully functional WPP to review their policies against the backdrop of these documents;
- Organize smaller regional meetings to understand issues around why some organizations are not interested in developing a WPP, and involve those organizations with positive impacts. This could greatly help in encouraging other organizations to explore the possibilities of implementing a WPP;
- Facilitate forming meaningful linkages and channels for cross learning among member CSOs, and help CSOs to network with service providers within their respective geographical area to enable them to use HIV and AIDS services optimally;
- Give further training on gender equity and the WPP as a change agent;
- Encourage employers to offer free condoms as both family planning and as an HIV prevention tool, to enhance uptake and to lessen inhibition. Advise CSOs to understand from employees which places are most suitable for condom placement.

To donors

- Consider extension of funding;
- Open or continue dialogue with CSOs about managing HIV and AIDS in the workplace.

8.4 Conclusion – end of AR

AR has highlighted the good practices, successes, challenges, recommendations, and suggestions of partner organizations in developing and implementing a WPP. Most importantly, it has clearly shown the impact and effects of implementing a WPP. It proved to be a very useful tool for understanding how the project has been implemented, what objectives and aimed themes have been achieved, and how well this has been done.

ANNEX A: SAN!SIP PARTNERS IN AR PHASE Two/Three

Andhra Pradesh

1. Aashray
Aashray is a development agency working among Dalits, vulnerable communities such as women, *joginis*, children, and differently abled people in Andhra Pradesh. The main aim of Aashray is to promote socio-economic literacy (formal and informal), health, cultural, agricultural environment, and educational development in the vulnerable communities. Working since 1992, Aashray was formally registered in February 1994.

2. Catholic Health Association of India (CHAI)
CHAI is a non-governmental organization in existence since 1943. It has more than 3,200 health institutions as its members: large, medium, and small hospitals, health centres, and diocesan social service societies. The members are spread all over the country, operating specifically in remote areas, catering to the health needs of the poor and the marginalized.

3. Centre for People's Forestry (CPF)
Extensively working on environmental issues, CPF has diversified to HIV and AIDS and has mainstreamed the pandemic in the other fields for an effective response.

4. Centre for World Solidarity (CWS)
One of the leading organizations in addressing HIV and AIDS, CWS was also one of the first in devising a workplace HIV program and mainstream HIV internally.

5. Confederation of Voluntary Associations (COVA)
COVA is actively involved in communal harmony programs. The organization is furthermore involved in human rights issues.

6. Hyderabad Council for Human Welfare (HCHW)
HCHW is working for street based children and runs a shelter home. The organization, through linking and networking with different agencies, is trying to give these children a better life of their own.

7. Lodi Multipurpose Social Service Society (LMSSS)
LMSSS is extensively involved in addressing HIV and AIDS and runs a care and support centre. The organization has joined hands with different partners for an effective response.

8. MV Foundation
Putting education for the marginalized and un-reached children at the forefront, the MV Foundation is bringing positive change in the lives of many.

9. Social Education and Development Society – Andhra Pradesh (SEDS-AP)
Based in Anantpur district of Andhra Pradesh, SEDS-AP is one of the leading institutions in forest conservation, environmental issues, and RCH.

10. Society for Integrated Development in Urban and Rural Areas (SIDUR)
SIDUR is the brainchild of like-minded individuals who have an understanding of rural–urban linkages and also acknowledge the imperative for a comprehensive integrated developmental approach to tackle complex human problems. SIDUR came into

existence in the year 1990 to address the problems plaguing street children, urban and rural poor, and Dalits.

Karnataka

11. Belgaum Integrated Rural Development Society (BIRDS)
Starting as a village level organization in 1980, today BIRDS has its programs all over Karnataka, Maharashtra, and part of northern Kerala. BIRDS aims for the all round development of weaker sections through an integrated approach for development.

12. Grameena Mahila Okkuta (GMO)
GMO is a community based organization of rural women formed in 1997. It is the apex federation of Self Help Groups (SHG) in four *taluks* of Kolar District of Karnataka. GMO was created with the purpose of facilitating SHGs in self help, to develop the groups as grassroots community level institutions, and to foster leadership and skills among SHG members. Over a decade of its existence, GMO has grown beyond micro finance to emerge as an institution for women's empowerment.

13. INSA India
Established in 1982 with support from Global Health Action, USA, INSA India pioneered community based HIV prevention care and support mainstreaming in the late 1980s. INSA is committed to the vision of *"A just society living with health and development"*. INSA India is a credible trainer organization that offers training opportunities for all levels of staff working in registered community based organizations addressing health and development issues. INSA India houses the Secretariat of STOP AIDS NOW! South India.

14. Mahatma Gandhi Rural Development and Social Change Trust (MGRDSCT)
MGRDSCT is working on women's empowerment, RCH, and HIV and AIDS issues.

15. MYRADA
MYRADA started in 1968, and is now directly managing 16 projects in 12 backward districts of Karnataka, Andhra Pradesh, and Tamil Nadu. The principle which guides MYRADA is *"Building poor people's institutions"*, using three key elements of community participation, cost effectiveness, and sustainability beyond the intervention period.

16. Nagarika Seva Trust (NST)
NST, which began in 1976 as a modest not-for-profit service organization, has now evolved into a unique mass based organization. NST today addresses the livelihood issues of the poor and marginalized as well as environmental issues with a rights based approach. Besides its multi-pronged approach at the micro-level field activity, NST takes up policy change issues at the macro levels – both state and national – to create an enabling policy environment for sustainable development.

17. Sangama
Sangama is actively involved in and vocal for the equal rights and status of sexuality minorities. The organization has developed models where PLHIV within this sub-population can discuss their issues, without any fear of breach of confidentiality.

18. Women Health and Development (WHAD)
WHAD is involved in building the capacities of women, and empowers them for sustainable development. The organization is furthermore involved in women's rights and seeks social sanctions in dealing with sensitive issues.

Tamil Nadu

19. Arogya Agam/NESA
Primarily human rights organizations, both Arogya Agam and NESA focus on Dalits, Adivasis, women, and children. Both organizations have mainstreamed HIV and AIDS in their work. Arogya Agam/NESA provide care and support services to PLHIV, and are serving in other areas like education, Dalit rights, land rights, and gender.

20. CATER Trust
CATER Trust is rendering its services in the Thiruchirapalli (Trichy) district of Tamil Nadu for empowerment of differently abled people.

21. Don Bosco Anbu Illam
Don Bosco is working with street and railway children.

22. Indian Network for People living with HIV and AIDS (INP+)
INP+ is the voice of PLHIV in India. With its networks in almost all the states in India and at several district and *Taluk* (sub-district) levels, INP+ is determined to bring a positive change in the lives of PLHIV and the mindsets of non-PLHIV. Following GIPA, INP+ is the permanent member of SSIPG.

23. Rucode India
Rucode is involved in disability prevention, RCH, environment, and Tsunami programs.

24. SIAAP
The premier organization works on several issues revolving around HIV and AIDS, and works closely with sub-populations.

25. Society for Serving Humanity (SSH)
SSH was established in 1988, rendering to 150 villages in ten blocks/unions of Dindigul District. SSH envisions the promotion of a hunger free community and eco-environment at all levels of the community. Currently, SSH is working for HIV and AIDS infected and affected children, providing monthly assistance regarding education, nutrition environment, health, etc. SSH's activities go with the saying of *"It is better to teach a man how to fish rather giving him a fish"*.

ANNEX B: DATA COLLECTION TOOLS

Guide for IDIWith senior manager and HIV FPP for WPP

Good morning / afternoon, I am ________________________ from YRG Care Chennai. YRG Care is a non profit organization, working among people with HIV and attempting best to prevent newer infection. We are here for the AR part of the SAN! South India project and it is important to listen to the experiences of people involved – like you – and to get ideas about the project progress and what are things you are proud of and what are the challenges. That's why we are here with you and thanks for giving this opportunity.
Today I would like to discuss with you about your ideas and opinions of HIV and AIDS WPP implementation process and its effects. This interview approximately is for an hour since very important information will be shared today, I seek your permission to voice records this interview – this again to go back and transcribe data. So that we do not misinterpret your responses. If you agree I can switch on the tape recorder and begin the interview. Can we begin now?

1. Personal information

Person 1
- job/designation
- experience in the organization
- age
- marital status
- previous work experience
- training in HIV and AIDS WPP, specify

Person 2
- job/designation
- experience in the organization
- age
- marital status
- previous work experience
- training in HIV and AIDS WPP, specify

2. Status of organization WPP
What is the status of your organization's WPP?
- Implemented already or going to implement
- Action plan? Approved by the board?
  - Have you received funding for your WPP? (4% allocation). Specify, when received, when asked, who is the donor,
- If going to implement, ask for timeline and process details

3. Communication about WPP with staff
How have you shared the WPP with your staff? Probe for ways

4. Other policies and relation with WPP
Which organization policies are available?
- Types of policies – probe for HR policy, welfare policy, gender, sexual harassment
- Is the WPP integrated in other policies – explain

5. Documents used for developing WPP

What were the documents you have used for developing your WPP and how do you view theusefulness of the resource materials provided by SAN! and SAN!SIP? (ask in-depth)

- Probe for: Good donorship guidelines (Good donorship in a time of AIDS) and Budget tool (What's it likely to cost)
- Probe for: SAN!SIP materials (ask them to specify)
- Probe for: Other resource materials (ILO, government?)

6. Medical scheme

Do you have a health insurance or medical scheme for staff to cover medical expenses?

- Or are discussions ongoing to provide?
- Specify, how arranged, who pays
- Who is covered, which staff, volunteers, also family?

7. Activities related to HIV and AIDS for staff (whether WPP or not)

Have any activities related to HIV and AIDS taken place for staff / are they ongoing in the workplace?

Start with an open question, and then probe on the activities listed below

NOTE: With all answers, get details and probe whether these are part of WPP or happening anyway?

- Raising awareness / training on HIV and AIDS - specify
- Prevention activities
- Condom provision and access for staff
- Involvement of PLHIV
- Promotion of VCT
- Securing access to treatment
- Instalment of WPP committee - specify
- Appointment of FPP – specify, who, time available
- If activities were part of WPP – how were you able to fund these (donor fund received, own fund?)

8. HIV stigma and discrimination at workplace

Did you / do you have experience with stigmatisation and discrimination of HIV+ staff in the workplace?

- Specify what happened and when (important to find out when this took place)
- Guidelines and punitive measures against stigma and discrimination of HIV+ staff?
- Negative and positive effects of WPP on stigma and discrimination

9. Gender and HIV+ stigma (Need elaborative response)

- Is there any gender difference in stigma of HIV? (MAYBE PRESENT CASE)
- Is there gender bias in career growth within the organization and differential fringe benefits?

10. Confidentiality / disclosure

- Is disclosure needed to access benefits?
- Do you have guidelines to ensure confidentiality?
- Do you have guidelines about disclosure? Where, to whom in the organization should a HIV+ go for welfare?
- How is peer acceptance of PLHIV within their organization?

11. General thoughts on development and implementation of WPP

- Staff involvement, participatory approach, committee formation
- PLHIV representation
- Monitoring, periodical review, whether content is sufficient

12. Effects

How has the development process and implementation of WPP impacted HIV related information and services in the organization (ask first as open question/ then probe)

- Access to services: VCT, ART, STI, OI
- IEC / materials
- Peer discussion about HIV
- Enhanced awareness of gender equity
- Awareness of HIV issues
- Internal communication among employees, hierarchical
- Disclosure of HIV+
- Access to benefits

13. Networking

With whom do you network and for what purposes? (Collect elaborative response)

- With SAN!SIP CSOs, public institutions, CSOs
- For training, IEC, condoms, services etc.

14. Role of SAN!SIP, SSIPG and donor organization

What are your experiences with the roles of SAN! SIP, SSIPG and the donor organization in the implementation process?

- Support provided (technical and financial - elaborate)
- Visits by SAN!SIP
- Facilitating/establishing linkages with partner CSOs/TAPS
- Facilitating/establishing linkages with public institutions

15. Expectations from SAN!SIP and donors

What are your expectations and wishes from SAN!SIP, SSIPG and donors for the implementation of the WPP?

- Funding
- Technical support
- Other support

16. Sustainability

What are your thoughts on continuing the WPP beyond the project period?

- Any measures taken?
- Allotment of internal resources
- Employees / management feedback
- Leveraging resources – local and donors
- Review

17. Internal-self evaluation

What do you think are the key lessons learnt from implementation of the HIV and AIDS WPP in the organization?

- Challenges
- Success and promising development
- Positive and negative impacts
- Over all final opinion

Thank you so much for your time and co-operation

Guide for focus group discussion (Second/Third Phase)

Good morning / afternoon, we are……………… and ………… (facilitator and note taker) from YRG CARE, Chennai. We are here for the AR part of the SAN! South India project about HIV and AIDS workplace policies that your organization is also part of. Today, I would like to discuss with you your ideas and opinions about the HIV and AIDS WPP in your organization, which you are developing/have developed/are implementing.
This group discussion will approximately be for one hour and I hope you will all contribute and express your ideas. There are no right or wrong answers, so please feel free to air your view and add to or comment on answers of others because you may have different views. All what you say is valuable to us.
Since very important information will be shared today, I seek your permission to voice record this interview - this again is to go back and transcribe data, so that we do not misinterpret what you said. If you all agree, I can switch on the tape recorder and begin the interview. Can we begin now? Kindly tell me that you all have agreed to participate in an interview that is being voice recorded? This is to assure ourselves that the process of informed consent is understood by you all and that you have agreed to participate without any compulsion.

Background of respondents
We would like you to introduce yourself: Your name / position / designation / job in this organization and how long you have been working here already.

1. Policies for staff

- Does you organizations have any policies for staff?
- Probe: WPP, HR policies, medical policy, gender, sexual violence/harassment
- Probe: policy that addresses gender based violence/sexual harassment? Explain. If yes: content, target, since when.
- Awareness of status of WPP, draft, final, implemented
- If WPP is being implemented: what have been activities?
- Benefits for staff /for family within the WPP?

2. Channels and nature of participation and communication about WPP

- Have staff been participating in development of the policy?
- Specify: how, in what way, which staff
- Has the management communicated the WPP to staff?
- Probe: In-house discussions, meetings, committee, notice boards, online correspondence etc.
- Probe: To all staff, only some
- What is your opinion about this way of communication? Explain either way.

3. Openness to talk about HIV (generally) in the workplace

- Did the WPP have any effect on openness to talk about HIV in the workplace? If yes what has changed, how?
- What made you be more open to talk about HIV and AIDS? Participatory development, training? If training, what was the content.

4. Stigma and discrimination

(FACILITATOR, ALWAYS NOTE WHEN EXPERIENCES TOOK PLACE)

- Do HIV+ people experience stigma?
- Probe: How does it show? Examples of stigma? Why do people stigmatise? Why do people feel stigmatized? What happens? How can one prevent stigma?
- Any stigmatization of HIV+ staff in the workplace - Past or current?
- Is stigma on AIDS different from stigma on other diseases? Why – if so?
- Are regulations in place against discrimination of HIV+ people? If yes, what regulations are in place? Is it the same for other illnesses?

- ˜Did the WPP have any effect on stigma and discrimination in the workplace? If yes what has changed? And how?

5. Confidentiality

- Are measures taken to ensure confidentiality of HIV positive status? What measures, do they work or not work, why, situations, levels of confidentiality.
- Are these measures similar for other illnesses? All illnesses?
- Did the WPP have any effect on issues related to confidentiality in the workplace? If yes what has changed? (Staff asking for allowance/benefits) What challenges did you face in maintaining confidentiality?

6. Disclosure

- Would someone feel comfortable to disclose HIV positive status in the workplace? Why, why not, to whom?
- Is the workplace different or the same from the community related to disclosure? How?
- Is HIV different/same from other diseases concerning disclosure? Why?
- Does your organization counsel staff for disclosure? What processes and support mechanisms are used for this?
- Did the WPP have any effect on disclosure in the workplace? If yes, what has changed? Did any staff disclose HIV positive status? To whom, all?

7. Gender

- Was there any exposure of staff to understand gender issues, maybe through training? Explain
- Is there any difference for female, male and sexual minority staff in your workplace related to: positions, promotions, training opportunities? If yes, how? What is your opinion about it? Can you give experiences?
- Does the WPP address gender relations? If yes, in what ways? Elaborate, explain? If not, do you think it is necessary? Why do you think it should be addressed/or not?
- Have women, men and sexuality minorities equally participated in the WPP development / WPP committee?
- Did the WPP have any effect on gender in the workplace? If yes what has changed, and why?

8. Correlation of stigma and discrimination and gender

THINK OF SECENARIOS TO PRESENT TO FGD PARTICIPANTS TO COMMENT ON CONCERNING DISCRIMINATION AND STIGMA AND GENDER

- Open scenario: HIV+ women and HIV+ men, sexual minority, also married and not married
- Is there/would there be a difference between men and women and sexual minorities related to access to benefits, stigmatization and discrimination in work opportunities? If yes how, explain? If no, has this always been the case or has this change been recent?
- Did the WPP have any effect on the relation between stigma, discrimination and gender in the workplace? If yes what has changed? How?

9. Evaluation, Conclusion

- Any negative effects? (misuse, financial problems for CSOs)
- Sustainability measures – what are your thoughts and measures about continuing the WPP?

Thank you so much for your time and co-operation

Form number ……………………….

SAN!SIP second phase of AR
Survey for staff

Introduction

- Interviewer shortly to introduce 1) yourself – and which organization you work for; 2) YRG Care; 3) SAN!SIP; 4) AR.
- The aim of this interview: understand the experiences of staff in implementing the policy and to learn the outcome and impact of the WPP for the staff and the organization.
- Interview will last about 25 minutes.
- Confidentiality - Please mention that the name of the respondent need not be noted and that no other persons than the researchers will see the filled questionnaire
- Ask for permission to proceed – and thank them for time.

SECTION I: BACKGROUND OF ORGANIZATION
(INTERVIEWER TO FILL – NOT ASK)

1. Name of the state
2. State code
3. Name of the organization
4. Organization code

5. Core area of work of the organization
a. HIV
b. HIV integrated
c. Non-HIV

6. Nature of the Organization
a. Faith based
b. Secular

7. Type of organization
a. CBO
b. CSO
c. Co-operative
d. Others

8. SSIPG member
a. Yes
b. No

SECTION II: BACKGROUND OF RESPONDENT

9. Gender (INTERVIEWER TO TICK, ONLY ASK IF ANY DOUBT)
a. Female
b. Male
c. Transgender
d. Others, specify …

10. Marital status
a. Married
b. Unmarried

c. Living with partner
d. Separated/divorced
e. Widowed

11. Age in years: …………………. (IN NUMBERS)
Age category
a. 16-25;
b. 26-35;
c. 36-45;
d. 46 & above

12. Number of years in the organization: …………. (IN NUMBERS)
a. Less than a year
b. 1-3
c. 4-7
d. 7 & above

13. Job title ………………………………………………(NOTE IF PERSON IS ALSO FPP)
Staff category (probe)
a. Senior level management
b. Middle level management
c. Junior level management
d. Grassroots level – program staff
e. Officer level support staff
f. Lower level support staff

14. Type of contract
a. Staff
b. Volunteer
c. Others, specify…

SECTION III: AWARENESS ABOUT STATUS OF HIV AND AIDS WPP
15. Are you aware that your organization has a WPP on HIV and AIDS?
a. Yes (SKIP TO QUESTION 17)
b. No
►INTERVIEWER: IF 'NO' OR DON'T KNOW SHORTLY EXPLAIN WHAT A WPP IS

16. Are you aware of any discussions / talks / processes / development of a WPP on HIV and AIDS?
a. Yes
b. No (SKIP TO QUESTION 20
Please note: If the respondent answers 'No' skip section VIII of the questionnaire

17. How did you get to know about the WPP / the discussions? (TICK ALL THAT APPLY)
a. Participated in development / discussions
b. Was given a copy
c. Have seen a copy
d. Information disseminated in a meeting
e. Other way, specify …

18. Is the WPP in your organization being implemented?
a. Yes
b. No
c. Don't know
d. No answer

19. Is there a focal person for HIV and AIDS WPP in your organization?

a. Yes
b. No
c. Don't know
d. No answer

SECTION IV: ACTIVITIES RELATED TO HIV AND AIDS

20. Do you get information about basic facts of HIV and AIDS through the organization?
a. Yes
b. No
c. Don't know
d. Refused to answer

21. Do you get information from your organization about prevention of HIV?
a. Yes
b. No
c. Don't know
d. Refused to answer

22. Does your organization make condoms accessible for staff in the workplace?
a. Yes
b. No (SKIP TO QUESTION 24)
c. Don't know (SKIP TO QUESTION 24)
d. Refused to answer (SKIP TO QUESTION 24)

23. Where are condoms accessed in the workplace? (TICK ALL THAT APPLY)
a. Vending machines
b. Public corridor take away box
c. Restrooms
d. Others, Specify_____________

24. (INTERVIEWER TO ADJUST ACCORDING TO WHETHER CONDOMS ARE AVAILABLE OR NOT)
How comfortable are you / would you be in accessing condoms in your work place?
a. Very comfortable
b. Moderately comfortable
c. Less comfortable
d. Very uncomfortable

25. Do you get information from your organization about where to access ART if needed? (INTERVIEWER TO EXPLAIN WHAT ART IS – IF NEEDED)
a. Yes
b. No
c. Don't know
d. Refused to answer

26. Are you aware of institutions providing ART services?
a. Yes
b. No
c. Refused to answer

27. Does you organization promote VCT?
a. Yes
b. No
c. Don't know
d. Refused to answer

28. Has training about HIV and AIDS taken place through your workplace?

a. Yes
b. No (SKIP TO QUESTION 31)
c. Don't know (SKIP TO QUESTION 31)
d. Refused to answer (SKIP TO QUESTION 31)

29. Have you participated in some?
a. Yes
b. No (SKIP TO QUESTION 31)
c. Refused to answer

30. What were the contents of the training you participated in? (OPEN QUESTION, DO NOT READ OUT, TICK ALL THAT APPLY)
a. HIV transmission
b. HIV prevention
c. VCT
d. Care and treatment
e. WPP
f. PMTCT
g. OI
h. STI
i. Other, specify…
j. Other, specify…
k. Other, specify…

31. Do you know if some resource materials (for instance pamphlets, posters, video) on HIV and AIDS are available for staff in your organization?
a. Yes
b. No – not available (SKIP TO QUESTION 34)
c. Don't know if they are available (SKIP TO QUESTION 34)
d. Refused to answer (SKIP TO QUESTION 34)

32. Where are these materials on HIV and AIDS available? (OPEN QUESTON, TICK ALL THAT APPLY)
a. Information booth
b. AIDS corner
c. Helpline
d. Part of the library
e. Notice board
f. Other place, specify …

33. Have you ever accessed / looked at the information?
a. Yes
b. No
c. Refused to answer

34. Does your organization have a health insurance or medical scheme for staff – or are discussions onging?
a. Yes, have
b. Yes, discussions oCSOing
c. No (SKIP TO QUESTION 37)
d. Don't know (SKIP TO QUESTION 37)
e. Refused to answer (SKIP TO QUESTION 37)

35. Other than regular staff, who benefit from the above health welfare measures? (PLEASE TICK ALL THAT APPLY)
a. Staff on contract
b. Volunteers
c. Family members

d. Others, specify …
e. No other person

36. Do you benefit from the health insurance or medical scheme of your organization?
a. Yes
b. No
c. Don't know
d. Refused to answer

SECTION V: GENDER

37. Do you believe opportunities for job promotion in your organization are equal or unequal for men, women and sexuality minorities,?
a. Equal
b. Unequal, specify …
c. Don't know
d. Refused to answer

38. Do you believe opportunities for training in your organization are equal or unequal for men, women and sexuality minorities?
a. Equal
b. Unequal, specify …
c. Don't know
d. Refused to answer

SECTION VI: STIGMA AND DISCRIMINATION OF HIV POSITIVE STAFF (ONLY IF THERE IS HIV+ POSITIVE STAFF IN THE WORKPLACE)

39. Do you feel comfortable or not comfortable working together with a fellow staff who is HIV positive?
a. Comfortable, specify …
b. Not comfortable, specify …
c. Not applicable (no HIV+ staff in the organization)
d. Don't know
e. Refused to answer

ONLY IF THERE IS NO HIV+ STAFF IN THE WORKPLACE, ASK QUESTION 40

40. Would you feel comfortable or not comfortable working together with a fellow staff with HIV?
a. Comfortable, specify …
b. Not comfortable, specify …
c. Don't know
d. Refused to answer

41. Have you noticed any discrimination happening in your organization based on HIV Status?
a. Yes, specify …
b. No
c. Not applicable because no known HIV+ staff
d. Don't know
e. Refused to answer

42. Do you think your organization should recruit a person of who is HIV positive?
a. Yes (should recruit), explain …
b. No (should not recruit), explain …
c. Don't know
d. Refused to answer

SECTION VII: CONFIDENTIALITY AND DISCLOSURE

43. Do you trust your organization preserves confidentiality of staff living with HIV?
a. Yes, explain …
b. No, explain …
c. Not sure, explain …
d. Refused to answer

44. Do you think your organization will take punitive measures if you break confidentiality?
a. Yes, specify …
b. No
c. Don't know
d. Refused to answer

45. Do you think staff in your organization will feel comfortable or not comfortable disclosing his/her status in the workplace?
a. Comfortable, explain …
b. Not comfortable, explain …
c. Not sure, explain …
d. Refused to answer

46. According to you, who would be the best person(s) in the workplace to disclose HIV positive status to (tick all mentioned persons)
a. CSO head
b. Immediate supervisor
c. HR head
d. HIV and AIDS FPP
e. HIV and AIDS workplace committee
f. Counsellor at the workplace
g. Peer staff
h. Other, specify …
i. No one

Please explain your answer(s): ……………………………………………………………………….

SECTION VIII: EFFECTS

(This section is not applicable if the respondent has answered 'No' to question 16)
Now I want to ask you whether you noticed any effects or change for you personally related to the development or the implementation of the WPP.
I am reading out some issues and you could tell me whether it has remained the same, or was increased, or became less for you personally.

Interviewer to circle the appropriate answer

ISSUE	a.	b.	c.	d.
47. Your knowledge about HIV and AIDS	increased	same	decreased	no answer
48. Your openness to talk about HIV and AIDS with colleagues	increased	same	decreased	no answer
49. Your access to information about HIV and AIDS	increased	same	decreased	no answer
50. Personally taking preventive measures against HIV infection	more	same	less	no answer
51. Your attitude towards persons with HIV	improved	same	poorer	no answer
52. Your intention to disclose in the workplace	increased	same	decreased	no answer
53. You being secure of job if found HIV positive	increased	same	decreased	no answer
54. Your trust in organization for support in case of illness	increased	same	decreased	no answer
55. Your awareness of gender issues	increased	same	decreased	no answer

56. Do you think implementing the WPP on HIV and AIDS workplace policies will lead to/ has led to more or less confidentiality for HIV positive staff?

a. More
b. Less, explain …
c. Same, no change
d. Don't know
e. Refused to answer

57. Do you feel the HIV and AIDS WPP also has /may have negative effects?

a. Yes, specify …
b. No negative effects
c. Don't know
d. Refused to answer

Thank you for your cooperation