

Implementation and Effects of HIV and AIDS Workplace Policies

**In Ugandan non-governmental
organisations involved in the SAN!
project 'Managing HIV and AIDS in the
Workplace'**

Third Phase Applied Research Report

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ABBREVIATIONS

ABC	Abstinence, Being faithful, Condom use
AIDS	Acquired Immunodeficiency Syndrome
AR	Applied Research
ART	Anti-Retroviral Therapy
BT	Budget Tool ('What's it likely to cost')
FBO	Faith Based Organisation
FGD	Focus Group Discussion(s)
FPP	HIV and AIDS Focal Point Person
GDG	Good Donorship Guidelines ('Good donorship in a time of AIDS')
HCT	HIV Counselling and Testing
HE	Health Education
HIV	Human Immunodeficiency Virus
HRM	Human Resources Manual
IDB	Information Database
IDI	In-Depth Interview(s)
IEC	Information, Education, and Communication
JCRC	Joint Christian Research Council
LO	Lead Organisation
LPG	Local Project Group
M&E	Monitoring and Evaluation
MOU	Memorandum Of Understanding
NGO	Non-Governmental Organisation
PC	Project Coordinator
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission (of HIV)
RTI	Research Triangle Institute
SAN!	STOP AIDS NOW!
UAC	Uganda AIDS Commission
VCT	Voluntary Counselling and Testing
WPP	HIV and AIDS Workplace Policy/Policies (and other ways of addressing HIV and AIDS in the workplace)

EXECUTIVE SUMMARY

This Phase Three report is the result of a study conducted in a total of 35 organisations. The objectives of Phase Three was to describe, analyze, and measure the effect of the implementation of workplace policy activities in SAN! project partner organisations. Moreover, organisations' experiences with SAN! project support structures were studied. Data were collected at organisational and staff level, through in-depth interviews with 33 heads and senior staff of 29 organisations, and interviews using a semi-structured questionnaire with 236 staff of different levels in 31 organisations respectively. Data collection commenced in March and ended in August 2008.

Main findings

Status of policies

Twenty-four organisations (82.8%) had a final policy in place, and 5 (17.2%) a draft policy. The majority (27) of the organisations developed their policies under SAN! arrangement. Ten organisations have incorporated their policies into their human resource policy and 3 into their health policy, while 16 have their policies standing alone. All but one NGO have workplace policy activities, although only 9 workplace policies have been funded by the SAN! donor. Nearly all staff (n=212, 89.7%) are aware their organisation has a (draft) workplace policy. All but one of the 29 organisations have an HIV focal point person (FPP): 12 are male, 16 female. All FPPs work part-time; their other responsibilities are administration, finance, human resources, communication, and programme or logistic officers. 85.7% attended one or more SAN! training workshops in workplace policy. Staff is generally aware of the presence of an FPP in their organisation, with 209 (88.6%) of the 236 respondents knowing who the FPP is, and 188 (79.7%) claiming to know the FPP's activities.

Staff perceptions and behaviour

Personal risk perceptions: About one-fifth (18.2%) of respondents said they have at least once felt at risk of HIV infection in the workplace or during duty travel. Relatively more risk was felt by males (20.0%), the younger age group 20-29 (21.2%), singles (20.5%), management (22.5%), technical staff (20.2%), and staff going for fieldwork where they have to stay overnight (21.2%), compared with other groups.

Reported prevention behaviour: Almost all staff (96.6%) reported taking measures to prevent HIV infection, the majority reporting faithfulness (65.3%). About one third (33.9%) use condoms for HIV prevention and 25.4% practice abstinence. Abstinence is relatively more practiced in the younger age groups (37.5%) and by single staff (46.2%), compared with faithfulness among age groups over 30 and married staff (82.0%). Condoms are used relatively more by men (40.0%), by those in the age group 20-39 (40.0%), singles (50.0%), administration (41.0%), technical staff (37.2%), and by staff going for fieldwork (37.0%).

Reported Voluntary Counselling and Testing (VCT): Almost all staff (96.0%) think that everyone should know their HIV status, but not all have gone for VCT themselves (n=154, 65.3%). For those who have been at least once, the average number of VCT visits was 2.9.

Attitude towards PLHIV in the organisation: Only 3.4% of respondents felt it is always the fault of the person with HIV for having contracted the infection, while about half (50.4%) felt it is never the person's fault. 45.8% believe infection may *sometimes* be due to the person her- or himself. The majority (92.0%) of staff feel comfortable working beside someone who is HIV positive. Only 15 believe that an HIV positive staff member is or would be treated differently, and just 9 said that they themselves would treat HIV positive staff in a different way. Only two staff members reported that others stigmatize HIV positive co-workers (though they themselves do not).

Intended disclosure of HIV status in the workplace: More than four-fifths of staff (84.3%) said they would disclose their HIV positive status to someone in the organisation, The most popular person cited was the HIV FPP (36.2%); followed by the immediate supervisor with 31.2%; 25.6% would tell the head of the organisation; 15.6% their peers. Only 10.6% of those intending to disclose would do so to everyone.

Preference for place of ART: Almost half of the respondents (47.5%) said they would prefer free treatment by a service organisation; 34.7% had a preference for government services; only 15.3% opted for private clinics.

Workplace policy activities

All but one NGO had started implementing workplace policy activities at the time of the study.

Awareness raising: In 28 NGOs awareness raising has been going on, either in the form of routine discussions (19), internal training for staff (11), or training by externals (6). IEC materials are displayed on notice boards in 17 organisations, or in AIDS corners (12). 73.7% of staff report knowing about awareness raising activities, and the majority (83.9%) of those who knew about it also participated. Routine discussions in the workplace were reported by 66.0% of staff, and special training for staff by 50.0%. Concerning IEC materials, 75.8% of staff reported such materials being provided in the office, which they also looked at.

Prevention: 18 NGOs provide condoms for staff. 66.1% of staff reported having condoms available in the workplace, with 50.6% of those who know about them also reporting taking them, at least sometimes. Of all staff, 33.4% get condoms from the workplace.

VCT promotion: In 19 organisations VCT promotion takes place; 69.6% of staff worked in organisations which reportedly promote VCT.

Guidelines for disclosure and confidentiality: 10 NGOs have specific guidelines regarding to whom you should disclose in order to access support, and 8 have guidelines on how confidentiality is maintained. Concerning the views of the 236 staff, 62.3% thought the organisation promotes disclosure of HIV status, and in some organisations to a specific person. According to 64.4% of staff, their organisation ensures confidentiality of HIV positive status.

Measures to reduce stigma and discrimination: Fifteen NGOs take measures to reduce stigma and discrimination, by making staff aware that they will be punished or suspended if they stigmatize PLHIV. According to 54.7% of staff, anti-stigma and anti-discrimination measures are taken.

Addressing gender concerns: In 15 NGOs measures are taken for gender equality. 47.9% of staff thought the organisation pays attention to gender concerns.

Access to ART: Ten NGOs facilitate access to ART for staff, 6 by arrangements with a private facility, 3 have ART included in their health insurance, and in one organisation it is included in the health insurance but staff have to contribute some money towards it. Concerning staff knowing about the provision of ART through their employer, 22.9% of staff said their organisation facilitates access, 39.0% said their organisation does not have such provision, and a considerable number (38.6%) did not know whether their organisation provides access to ART or not.

Care and support: Seven NGOs have measures to support HIV positive staff. Not many organisations reported having affected staff, however those that reported it indicated they referred their staff to service organisations such as TASO, which provide care and support, including provision of food. The majority of staff (76.7%) trusted that their organisations will support HIV positive staff.

Counselling: Nine organisations reported the implementation of (one-to-one) peer counselling.

Effects of workplace policy

Level of awareness raised regarding HIV and AIDS: 75.9% of NGOs and 67.4% of staff report increased knowledge of HIV and AIDS.

Changed attitude towards PLHIV: 55.1% of staff reported changed attitudes towards PLHIV.

More openness about HIV and AIDS: In 72.4% of NGOs and by 63.6% of staff, more openness was reported regarding discussion about HIV and AIDS as a result of the workplace policy.

Stigma reduction: In 62.1% of organisations stigma was reduced because of the workplace policy, although it was acknowledged that stigma remains a challenge. 55.1% of staff reported a changed attitude towards PLHIV (not necessarily in the workplace) because of the workplace policy.

Intention to disclose: Among staff, 46.6% said the workplace policy made them likely to disclose their HIV status if they found themselves to be positive, whereas 15.3% said they would have disclosed even before the workplace policy.

Staff disclosed HIV positive status: Six organisations report that disclosure has increased because of the workplace policy; 10.6% of staff know an HIV positive person in the organisation, and 64.0% of these were told personally by the HIV positive person.

VCT uptake increased: In 37.9% of NGOs increased VCT was reported; while 19.9% of staff said that the workplace policy had motivated them to go for VCT, others had already gone on their own initiative, had been tested when preparing for marriage, or had received routine testing when in hospital or during pregnancy.

Behavioural change: 39.0% of staff said their behaviour had changed because of the workplace policy; change related mainly to safer sexual behaviour, including being more faithful to one partner and using condoms outside marriage or with casual partners.

Increased use of condoms: About one-third (34.5%) of NGOs report increasing numbers of staff taking condoms provided by the organisation.

Workplace more gender sensitive: Nine NGOs report a more gender friendly workplace. Only 6.8% of staff felt gender relationships have changed; this may mean that many workplaces were already gender friendly.

Increased involvement of family members and friends: In 34.5% of organisations family is reported to be more involved because of the workplace policy. Almost half of the staff (46.2%) reported discussing workplace policy and AIDS issues with family and friends outside the workplace – which can be considered a spill over effect of the workplace policy.

Increased linking and learning: 69.0% of organisations reported increased linking with and learning from other organisations; 62.1% linked with other SAN! partners, 55.2% with various service organisations generally, 65.5% with organisations for IEC, 44.8% for condoms, and 37.9% for training.

Utilization of SAN! support structures

Good Donorship Guidelines (GDG) and Budget Tool (BT): 82.8% of organisations know about the GDG document. However, only 29.2% of them have read the whole document, while 70.8% read part of it. Less than half of the respondents (40.7%) had seen the document 'What's it likely to cost'. Most organisations (20) reported having received the GDG through the SAN! project coordinator when they started developing their workplace policy. Evaluating the usefulness of these documents, 62.5% of the organisations who know about the GDG

consider them very useful, 37.5% somewhat useful. Concerning the BT, of the 11 who had seen it, 8 found it very useful, while the other 3 only somewhat useful. The commitment of donors to contribute an amount of up to 4.0% of staff salaries towards the workplace policy was remembered by most, but was also what most organisations had problems with. They argued that if staff salary is low, then 4.0% is a very small amount and inadequate to cover many activities. Most respondents were not satisfied with how donors live up to their principles and commitments; only 9.1% out of 22 respondents said they did live up to their commitments, 59.1% said partly, and 31.8% considered that they did not.

SAN! database: 92.6% of organisations access the SAN! database. All respondents indicated it was the FPP who filled in the database as he/she was mandated to do so. Most think it is user friendly.

Support from within the SAN! structure: 93.1% of NGOs have received support from within the SAN! structure; 96.3% of them from the SAN! project coordinator, 58.6% from the lead organisation, 17.2% from the local project group, 20.7% from other SAN! partner organisations, and 10.3% from the Dutch programme officers.

Need for more support: Support needs mentioned included: support visits by the project coordinator and lead organisation, especially for implementation of workplace policy; more training; financial support; workshops at organisational level; and assistance with self assessment at the organisational level.

Applied Research (AR) reports: 79.3% of NGOs have seen and read AR reports. However, only 30.0% out of 20 reported having used the AR reports.

Internal evaluation

Sustainability approaches/strategies: 92.9% of NGOs have measures in place to sustain their workplace policy when SAN! donor support will stop. Sustainability strategies include training their own peer educators, writing proposals for funding, mainstreaming HIV/AIDS in other organisational budgets, and internal fundraising mechanisms.

Self reported good practices by organisations: Good practices highlighted by managers included having an FPP with a clear job description, openness to discuss HIV/AIDS issues, the participatory nature of workplace policy development, reduction of stigma and discrimination, and recognition that HIV/AIDS is a workplace issue.

Strong points reported by staff: Most often mentioned was job security by 36 (23.5%) out of 153 staff reporting, followed closely by care and support for staff with HIV, by 34 (22.2%). Increased awareness about HIV and AIDS was mentioned by 29 (19.0%), less stigma and discrimination by 24 (15.7%), openness in the workplace to talk about HIV and AIDS related issues by 22 (14.4%). Seven staff (4.6%) mentioned they liked that family members were also cared for in their workplace policy.

Self reported challenges: 86.2% of NGOs reportedly encountered challenges in the implementation of their workplace policy. The main reported challenges were related to poor funding, lack of time, and high turnover of staff.

Conclusions

Promising practices: Promising practises that other organisations can learn from include making the workplace policy available and known to all staff; starting workplace policy activities before donor funding is received; making condoms freely available for staff; reaching beyond the workplace boundaries; linking and learning for information sharing; access to free IEC; training and referral services; having a job description with time allocation for FPP; and putting in place sustainability measures.

Challenges: Challenges relate to late or absent funding from the donor; to the risk of losing momentum; time constraints, especially for the FFP; and high staff turnover causing loss of institutional memory of the workplace policy.

Recommendations to organisations:

- Continue with internal awareness raising on the workplace policy and IEC on HIV and AIDS – also for the benefit of new staff
- Start/continue implementing workplace policy activities that do not require much funds
- Reduce work related risks of HIV infection (maintain office cars, provide cars with first aid box and condoms, provide protective gear)
- Share with and learn from other partner organisations, for instance by organising exchange visits
- Link with services, IEC, and training institutions; and be keen to identify free services
- Specify the job description of the FPP with attached time allocation
- Internally share what has been gained through training individual staff; for instance internally train more peer educators.

Recommendations to project coordinator and lead organisations:

- Involve stakeholders in activities, especially governments, donors, and HIV/AIDS related organisations – promote the SAN! project with them
- Better disseminate GDG and BT to NGOs, and continue sensitizing them
- More support supervisions to motivate and support those NGOs lagging behind – possibly involve neighbouring peer NGOs which have performed well with workplace policy
- Better disseminate the AR reports – give the applied research team a role in AR report dissemination through workshops

Recommendations to SAN! donors:

- Screen budgets regularly and release funds quickly
- Initiate new programme managers in workplace policy at the start of their job
- Share good practices and lessons learnt with other agencies/countries – lobby for funding

1 INTRODUCTION

This introductory chapter will set forth the objectives of the Third Phase applied research, the progress in the SAN! project in this phase, the study methodology, and will introduce the background of the study populations. The last paragraph will explain the structure of this report.

1.1 Applied Research Phase Three

This report presents the findings of Phase Three of the applied research component of the Ugandan branch of the STOP AIDS NOW! (SAN!) project 'Managing HIV and AIDS in the Workplace'. It is the fourth in a series of study reports on the experiences of the SAN! project in Uganda. The two reports of the First Phase described 1) the process of development of HIV and AIDS workplace policies at organisation level, and 2) staff knowledge and perceptions related to HIV and AIDS and workplace policy. The Second Phase report recorded the start of policy implementation in organisations.¹

The study objectives of this phase were to describe, analyze, and measure the implementation *and* effects of HIV and AIDS workplace policies at organisational and staff levels. In addition, promising practices were to be documented and challenges identified. The aim was to arrive at feasible recommendations.

As in the previous reports, when referring to workplace policy we mean all policies, guidelines, and other ways of addressing HIV and AIDS in the place of work. This may, for instance, also be through human resources or health policies.

1.2 Progress of the SAN! project in Uganda in the Third Phase

Supervision visits by the project coordinator and lead organisations have been ongoing, and training programmes have been conducted. Three day peer education training workshops at regional level were conducted, during which 55 peer educators were trained from the north east, central, and western regions. The training objective was to enhance their management of HIV and AIDS in their workplaces. Organisational follow-up plans have been formulated.

One day refresher training, for 29 organisations that had not developed workplace policy, was conducted. The training aim was to enhance skills for workplace policy, work plans, and budgets, and to motivate the trainees to develop a workplace policy; 60.0% of the 29 NGOs have taken up the idea of addressing HIV and AIDS in the workplace.

The M&E consultant made follow-up and skills building visits to individual NGOs. Partner NGO staff were encouraged to document all activities being implemented and disaggregate data where necessary. The consultant also carried out an internal database (IDB) system performance assessment (audit) survey in partner NGOs of the eastern region, and a few of the central region, which enabled coordination between the office and developers to identify actual and potential failures within the system.

In 2008, 16 partner organisations arranged the active promotion of HIV counselling and testing (HCT) as family day events, and conducted 11 HCT campaigns (4 in central, 5 in western, and 2 in the north east regions). HCT events involved 32 CSOs and reached 1,872 staff and dependants. Such events have stimulated discussions within organisations on how best to address HIV/AIDS, and encourage staff together with their dependants to undertake testing. It has also resulted in opportunities for referrals for post-test support services.

¹ For the other AR reports see the STOP AIDS NOW! website.

The network with strategic partners was extended. The coordination office has been working with the National Community of Women Living with AIDS (NACWOLA), lobbying for greater involvement of PLHIV in advocating increased access to treatment, HCT services, and ensuring that workplaces become more responsive to HIV and AIDS. NACWOLA is helping the SAN! project to come up with a "Code of practice to fight stigma and discrimination at the workplace". RTI International accepted to extend counselling and testing services to the SAN! project partners at no cost, as long as it is done through the already existing sites. RTI is more than willing to provide testing kits and register participants during the HCT campaigns organised by the SAN! project in the western region.

1.3 Methods of data collection and study populations

Data collection for the third phase commenced in March and ended in August 2008. Two data collection methods were used: 1) interview of staff using a semi-structured questionnaire (the 'survey'); and 2) in-depth interviews (IDI) with managers using a question guide. The data collection instruments are provided in Annex 1.

Staff reported on their personal perceptions and behaviour. Themes in the staff survey were, among others, their knowledge of the workplace policy and participation in activities, risk perceptions, attitudes towards PLHIV, practices of prevention and VCT, and their perception of the effects of workplace policy.

Managers in the IDIs reported on the organisational level. Themes in the IDIs were, among others, the HIV and AIDS focal point person, funding, activities, effects, their perception of SAN! support structures and documents, and their evaluation of the project (this being the final phase).

In total 35 organisations were involved. Organisations were selected with the help of the project coordinator, sampling organisations that had a draft or final workplace policy and that had workplace policy activities implemented. In 29 organisations 33 IDIs were conducted. Those targeted for the IDIs were the head of the organisation or other senior manager, and the workplace policy focal point persons. In 31 organisations, 236 staff were interviewed. Staff for the survey were selected by convenience sampling: those who were present at the time of data collection and had time to be interviewed.

1.4 Data processing, analysis, and reporting

Survey data were entered in EPI DATA statistical software package and later exported to SPSS statistical software package for cleaning and analysis. Open ended questions in the survey instrument were later categorized and coded, and entered and analysed in SPSS. Frequencies distributions were prepared for all variables, and cross tabulations were run on key background variables including sex, age, staff level, and marital status as required.

Data from in-depth interviews were tape recorded, transcribed, and typed in WORD ready for content analysis. Answers to open questions were grouped into themes and categorized after the AR team had read through the transcripts. All data were later logged and displayed in master sheets for analysis and write up. Content analysis was employed to make meaning of the data. Some information from the IDIs was entered in a summary database in EPI DATA for easy quantification, for instance on background variables and specific activities and effects of workplace policy.

In the presentation of data, the report combines information from the surveys and IDIs, more or less representing staff and organisational level respectively.

1.5 Research team

The research team was composed of the principal investigator who provided oversight to the study and data collection. Three research assistants collected the field data and worked on analysis and report writing. Three secretarial staff were involved in transcribing IDIs and entering the transcripts in WORD. Quantitative data management and analysis was done by a statistician. The consultant from the Netherlands gave advice during the stage of tools development and data analysis.

1.6 Study limitations

Due to management personnel and/or other staff not being available for interviews on the day the research team went to collect data, there are a few organisations where either only staff (n=4) or only managers (n=4) were interviewed.

No representative sampling of staff was possible because the team had to rely on availability of staff on the day of data collection. Staff members' busy schedules further delayed the process of data collection, especially in Kampala where the team visited most organisations several times to interview staff.

This report of the Third Phase of the SAN! Uganda project is biased towards a positive impression of the SAN! Uganda project, because out of the 76 participating organisations it only included organisations that have a final or draft workplace policy. Of the 41 remaining organisations, 26 have no policy. However, considering this limitation, the report provides a wealth of information on positive developments and promising practices because of workplace policy implementation.

1.7 Background of the samples

Organisations

Twenty-nine organisations were involved in in-depth interviews, and in 4 organisations 2 people were interviewed, totalling 33 respondents – 20 males and 13 females. The respondents were mainly the HIV focal point person (n=14), managers or directors (both 5), or financial officers (4). Fourteen NGOs were from the central region, 12 from the north east, and 3 from the west region. 21 are secular and 8 are faith based organisations (FBO). Their core field of operations is varied, from fisheries to adult education to psycho-social support, with 19 (also) having HIV/AIDS projects and 12 paying attention to gender. Annex 2 provides background information for the participating NGOs.

Staff members

In 31 NGOs, 236 staff members were interviewed. There were slightly more male (53.0%) than female (47.0%) respondents. Their socio demographic and work related background variables are provided in Tables 1 and 2 respectively.

Table 1: Socio demographic background of the 236 respondents, by sex

<i>Background variable</i>	<i>Male</i>	<i>Female</i>	<i>All</i>
Age group			
20-29	39 (31.2%)	46 (41.4%)	85 (36.0%)
30-39	57 (45.6%)	43 (38.7%)	100 (42.3%)
40-49	23 (18.4%)	19 (17.1%)	42 (17.8%)
50 over	6 (4.8%)	3 (2.7%)	9 (3.8%)
Marital status			
Married	89 (71.2%)	59 (53.2%)	148 (62.7%)
Single	36 (28.8%)	47 (42.3%)	83 (35.2%)
Widow/divorced	0	5 (4.5%)	5 (2.1%)
ALL	125 (100%)	111 (100%)	236 (100%)

Most respondents (42.3%) were aged between 30-39 years, and only 3.8% were over 50 years. The majority (62.7%) were married. Females are relatively more represented among the younger age groups and single staff.

Table 2: Work related background of the 236 respondents, by sex

<i>Background variable</i>	<i>Male</i>	<i>Female</i>	<i>All</i>
Level of job (N=232)			
Management	28 (22.4%)	12 (11.1%)	40 (16.9%)
Support	38 (30.4%)	36 (33.3%)	74 (31.4%)
Technical	47 (37.6%)	42 (38.9%)	89 (36.9%)
Administrative	11 (8.8%)	18 (16.7%)	29 (12.3%)
Year on the job			
1-3	69 (55.2%)	63 (56.8%)	132 (55.9%)
4-6	34 (27.2%)	29 (26.1%)	63 (26.7%)
7-9	11 (8.8%)	11 (9.9%)	22 (9.3%)
10 and above	11 (8.8%)	8 (7.2%)	19 (8.1%)
Type of contract			
Fixed	64 (51.2%)	51 (45.9%)	115 (48.7%)
Temporary	57 (45.6%)	52 (46.8%)	109 (46.2%)
Volunteer	4 (3.2%)	8 (7.2%)	12 (5.1%)
Going for fieldwork			
Yes	81 (64.8%)	65 (58.6%)	146 (61.7%)
No	44 (35.2%)	46 (41.4%)	90 (38.3%)
ALL	125 (100%)	111 (100%)	236 (100%)

The largest group (36.9%) were technical staff, followed by 31.4% of support staff. Over half (55.9%) had been on the job for 1-3 years, 27.0% for 4-6 years, and 17.4% had been on the job for 7 years and above. About 48.7% were employed on fixed terms and 46.2% on temporary terms. A significant proportion of staff (61.7%) frequently work in the field. Men were relatively more represented among management level staff, while women relatively more in administration. Men go for field work relatively more often. Women were relatively more on voluntary contracts and men on fixed contracts.

1.8 Structure of the report

After this introduction, Chapter 2 examines the workplace policy status, content, and dissemination, and the HIV focal point persons. Chapter 3 highlights the staff's perception and behaviour: risk perceptions, preventive behaviour, VCT, ART, and attitudes towards PLHIV. Chapter 4 examines the various activities being implemented under the workplace policy. Chapter 5 highlights the effects of workplace policy. Utilization and use of support structures are dealt with in Chapter 6. Chapter 7 provides reflection and evaluation by organisations:

sustainability approaches, and practices they are proud of. Finally, Chapter 8 provides conclusions, highlighting promising practices, challenges, and recommendations.

2 WORKPLACE POLICIES AVAILABILITY

This chapter explains the status, format, policy development arrangement, and content of the workplace policies of the NGOs. It further highlights the policy dissemination methods and role of the HIV focal point person within the partner organisation. In general, the sub-sections begin with information drawn from the IDIs, after which the views of staff are given.

2.1 Status of policies

Twenty-four organisations (82.8%) had a final policy in place, and 5 (17.2%) a draft policy. Only 16 reported having their policy fully operational, however all but one had ongoing activities related to HIV and AIDS.

Of the 29 organisations, 11 (37.9%) are funded by OXFAM/NOVIB, 10 (34.5%) by Cordaid, 6 (20.7%) by Icco, and 2 (6.9%) by HIVOS. Nine have received funding for their workplace policy budget (31.0%), while the others did not at the time of the study. Four also received funds from another donor (see Annex 2). As of December 2008, 4 more organisations have been funded.²

Regarding policy development arrangements, the majority (27) of the organisations developed their policies under SAN! arrangement. However, some 8 organisations reported having started development under other arrangements. For instance, JIDECO, WOUGNET, NUWODU, SSD, and VEDCO developed their policies with assistance from the Community Development and Resource Network (CDRN), while KADP was guided by CONCERN. CDRN and ACORD reported having developed their policies independently. However, all organisations attributed the final development of their policies to SAN!.

“At first we were supported by CDRN. I think some time last year when we started working closely with SAN!, we submitted the draft we had to SAN!. They also advised and put in their comments which we incorporated in the draft. (JIDECO)

“No, they started before. SAN! came just to scale it up and they were drawing on our experiences. I think when the SAN! project came in we were just at polishing level.” (ACORD)

Sixteen organisations (53.0%) have a stand alone HIV/AIDS workplace policy; in 10 (33.0%) organisations it is incorporated into their human resources (HR) policy; and in 3 (10.3%) into their health policy. The tendency now is to mainstream the HIV and AIDS policy by incorporating it into other policies, such as the HR or health policy. In fact, the OXFAM team gives training guiding this process.

Reasons given for the various arrangements were explored, and answers varied between organisations. Some argued that making their HIV workplace policy a stand alone policy might create stigma amongst staff, while others argued that a stand alone policy is not sustainable compared to when incorporated into the human resource policy.

“We prefer to call it a health policy instead of HIV policy because HIV is part of health including other diseases. It may stigmatize if we called it HIV/AIDS policy. (CDRN)

² The SAN! Report ‘WPP status for SAN! partners’ gives the following figures as of December 2008: 13 of the 76 organisations involved had their WPP funded; 16 had forwarded their policies to funders; 21 had their policies reviewed by the SAN! Uganda review committee; 26 had no WPP.

“We sat and discussed after SAN! had started. We feel maybe in the future they may not continue funding it separately. We needed to incorporate it in all aspects of the organisation.” (Health Need)

“The general human resource policy talks about things to do with sickness, sick leave, but it is not very specific on HIV like the workplace policy. So being a stand alone brings out those special issues because we are treating this pandemic as a special issue.” (AMFIU).

2.2 Contents of workplace policy

All organisations' workplace policy contained similar elements, which is not surprising because most were involved in SAN! training and their draft policies were reviewed and commented on by the SAN! workplace policy review committee. workplace policies included: awareness raising and education, promotion of non-discriminating environment, disclosure and confidentiality, prevention, care and support, access to treatment, and a focus on gender equality.

In this Third Phase the focus was on implementation and effects of workplace policies, not on content. However, some questions related to content were posed, including: 1) what was left out that may be later included; and 2) were there were any issues or arguments raised by the contents?

Concerning absent content, most said they would know this better after having implemented the policy for some time. Some already had foreseen issues they still had to tackle, mainly related to medical care for dependants:

“Okay. When we developed that policy, of course we catered for the staff. As in maybe health insurance, but no dependants were catered for in the policy.” (COU Education)

In 20 organisations (69.0%) there were points of discussion on the contents of the workplace policy. In 14 NGOs (48.3%) this related to the scope of the policy, in terms of who should benefit from it; in 9 (31.0%) there were discussions on condoms in the organisation, including whether to also provide female condoms; in 3 (10.3%) whether it should be a stand alone policy or incorporated in other policies; and in 2 (6.9%) there were discussions about access to ART.

“I think up to now, at the moment the question has remained unresolved. It was a question of how many members, how many relatives of the staff should access treatment. So it was like when we were asked to make a budget, it was limited, whereas for us we thought three members. And eventually we just left out all family members and mentioned something about the staff only.” (CEFORD)

“On the issue of condoms, we do have different faiths in this organisation. And those who don't believe in condoms – the divisions that are strongly opposed to use of condoms – definitely have representatives in the organisation, and they were like “Hey! What are we promoting? We are promoting immorality!” And we here are saying that this is a problem which is with us. And I think we have to try to sensitize people – we are not saying that when we put them there, everybody should go and get one and try it on and make use of it and so on and so forth. For us we are just saying, “Just in case you need it, at least you have it”. So that is one area that raised a lot of debate.” (FHRI)

“Yeah, because you know under normal work you don't usually discuss such things. You know – I mean if somebody has two families, that has nothing to do with his work. But when we started developing this, we needed people to tell us exactly the cross – their family. Now you find somebody listing six kids and when

you go to his normal place you see only two kids. And now what is this – “Well you know I have two in Kawempe, three in Mengo and now this one”. So that was – and well you find the staff also who may not even have a kid but lost a relative, and that particular staff is now looking after three or so kids; do we count this as part of this person’s family, or as you assume that eventually he will get married and produce his own offspring, then how do you call the first lot? Do you continue with the first lot or cut them off and replace with the others? So those were really big challenges.” (BUSO)

2.3 Dissemination of the policy to staff

Most organisations reported that their staff members are aware of the workplace policy because they participated in the process of developing it. Copies of the draft and final workplace policy were disseminated through meetings and consultations, local area networks, notice boards, group discussions, and resource files. According to the IDI informants, in 24 NGOs (82.8%) all staff were given a hard copy of the policy, and 11 (37.9%) indicated that each staff member has a soft copy. Some NGOs circulated soft copies of drafts to all staff for them to comment on. In FIDA, the content was discussed in a staff meeting, but staff were not given individual copies; and in TAP staff are able to read the workplace policy in a resource file that is open to all.

“[It was] a small committee within here which spearheaded the development. Then after that the draft was circulated among the staff through our local area network and they gave comments. Then from there we decided to do the final draft which we put to management, and then we eventually sent it to the board.” (AMFIU)

“Everybody got a copy, we discussed it together, we revised it, and everybody got a copy [of the final workplace policy] as well. So that is in everybody’s heart.” (FHRI)

“We have not had like maybe a big function where we have disseminated it, but we use the opportunities where we have come together – you know – for like meetings, workshops, to give information about it. It is not translated. We have soft copies on computers which all the staff read through, and we have hard copies also.”

Some organisations realised that simply distributing (English) copies is not enough. In JIDECO they felt more discussion on the content was needed for staff to really understand, in EASSI there was an official launch, and ACORD and KARUDEC translated the workplace policy into the local language. EA specified that all new staff should be given a copy during induction for them to know

*“the issues that protect them”.
“Already they have copies of the policy, but to keep them informed, in this quarter we shall have certain activities so that we allocate time to discuss issues related to HIV/AIDS as staff. It can be maybe a two hour session in two weeks’ time, so that the staff keep informed.” (JIDECO)*

“It was a launch. First of all the development of the policy was a participatory process, staff were presented by a committee that was formed comprised of junior and senior staff. And when the draft was presented to the committee the final draft was presented to the Board members’ committee. They approved of it and it was adopted as health policy. So we were informed during a staff meeting that the policy had been discussed in the board meeting and had been approved. So I call that launch of the policy, because staff members were always updated at the several stages during the development.” (EASSI)

Staff awareness of workplace policiess

Nearly all staff (n=212, 89.7%) were aware their organisation has a (draft) workplace policy. Asking how they came to know about it, they could give multiple answers. Of all 236 staff, 82.0% (n=173) reported having been involved in the development of the policy, 69 (29.2%) said they had received a copy, while 56 (23.7%) said they had been made aware by an official presentation of the policy to all staff. The last contradicts the information provided at organisational level through the IDIs, where only EASSI said they had an official launch. However, staff may have interpreted a presentation in a routine staff meeting as an official launch. Table 3 shows that there were differences between levels of staff in terms of their awareness of the workplace policy, and also in how they became aware.

Table 3: Knowledge of and involvement with workplace policy, by job category (multiple response)

<i>Job level</i>	<i>N</i>	<i>n Know about WPP (% of N)</i>	<i>Involved in Development (% of N)</i>	<i>Have a copy (% of N)</i>	<i>Official dissemination (% of N)</i>
Management	40	40 (100%)	35 (87.5%)	10 (25.0%)	11 (27.5%)
Support	74	59 (79.7%)	46 (78.0%)	22 (37.3%)	13 (22.0%)
Technical	89	81 (91.0%)	65 (80.2%)	26 (32.5%)	27 (33.8%)
Administration	29	28 (96.6%)	24 (85.7%)	10 (35.7%)	4 (14.3%)
TOTAL	232	208 (89.7%)	170 (81.7%)	69 (32.5%)	56 (26.4%)

All management and almost all technical and administration staff were aware that their organisation has a workplace policy, but support staff knew relatively less. However, still nearly four-fifths of support staff were aware, which is high. Of those who were aware of the policy, again support staff were relatively less involved in the development of workplace policy, and were less involved in dissemination sessions. However, relatively high numbers of support staff have a copy of the workplace policy. The claim in IDIs that all staff have a copy of the workplace policy is not confirmed by findings from the survey, where overall less than one-third of staff who know about their organisation's workplace policy have one.

There were no differences found between staff regarding involvement in the workplace policy in terms of type of contract, sex, or age group (table not shown).

2.4 HIV focal point person

The HIV and AIDS focal point person is a staff member, appointed by management, who coordinates workplace policy activities, usually on a part-time basis. To appoint such a person was a recommendation by the SAN! project. focal point persons are mandated to execute the workplace policy programme, which normally includes:

- Information dissemination
- Establishing and maintaining the HIV/AIDS corner and the First Aid Kit
- Organising HIV talks for staff
- Provision of condoms
- Guiding staff where to access HIV related services: HCT, ART
- Representing organisations in meetings regarding HIV/AIDS at the workplace
- Visiting sick staff

All but one of the 29 organisations have an focal point person; 12 are male, 16 female. focal point persons all hold other positions, and thus the role is an added responsibility. Only one focal point person is also the HIV/AIDS programme officer; their other positions range from administration, finance, human resources, communication, and programme and logistics officers. Concerning the time they have available for their work as focal point person, of those 19 who answered, 2 said they were able to work almost full-time (in COU-ED and KALI), 10

about half-time, 6 about one day a week, and 1 less than one day a week. Of those 19 who answered, 7 have been on the job less than one year, while 6 had been there for 1 to 2 years, and 6 for more than 2 years. The majority of focal point persons are the first ones assigned to the task.³ Twenty-four (85.7%) focal point persons had received SAN! training in workplace policy, while 4 (14.3%) had not. The focal point person of TOCINET reportedly also received training on HIV mainstreaming by OXFAM, and the focal point person of JIDECO by CDRN. Most of the focal point persons had attended more than one SAN! training: Table 4 shows the specific training which the focal point persons attended, and in addition, includes all other members of the organisation who had attended the specific SAN! training.

Table 4: Reported attendance at SAN! training by focal point persons and other members of the organisation (multiple response)

Content of training	FPPs		Organisation members	
	Number	% (N=28)	Number	% (N=29)
Database	14	50.0	17	58.6
WPP development	13	46.4	17	58.6
12 Box model	9	32.1	12	41.4
Capacity building lead organisations	6	21.4	3	10.3
Peer education	3	10.7	6	20.7
Director's workshop	0	0	3	3.4

It appears that focal point persons are well represented in the SAN! training received by organisations (as they should, according to the target groups for the training). However, most likely there is underreporting of attended training, because respondents may not always have known who had been to what training.

focal point persons reported several limitations in executing their work. The main problem is that it is difficult to find a balance between their work for the organisation and their workplace policy work, so as a result they often feel overworked. Another problem mentioned was that because of staff turnover, focal point persons become lost when they join other agencies, leaving a big gap which is difficult to fill by a new focal point person who may not be trained.

Staff awareness of focal point person

Staff is generally aware of the presence of an focal point person in their organisation, with 209 of all 236 staff (88.6%) knowing who is the focal point person and 188 (79.7%) claiming to know the focal point person's activities. Table 5 shows there is a difference in awareness levels by type of staff.

Table 5: Knowledge of presence and activities of focal point person, by job category

Job category	N	n Know about FPP (% of N)	Knows activities of FPP (% of N)
Management	40	39 (97.5%)	35 (89.7%)
Support	74	62 (83.8%)	55 (88.7%)
Technical	89	79 (88.8%)	73 (92.4%)
Administration	29	27 (93.1%)	24 (88.9%)
TOTAL	232	207 (87.7%)	187 (90.3%)

Most management, technical, and administration staff know who the focal point person is in their organisation, but support staff know relatively less – although still more than four-fifths of them do know. Of those who know the HIV focal point person, in all categories of staff close to nine-tenths know what their activities are (as outlined in the beginning of this section).

³ The reason why there is no information on all 28 FPPs is that the respondent in the IDI could not always answer the questions related to the FPP, who was not present at the time of the AR team visit for data collection.

The most-mentioned focal point person activities by the 176 staff answering were: 1) giving information on HIV (34.7%); 2) coordination of the workplace policy in the organisation (33.0%); 3) training (11.9%); and 4) distributing condoms (10.2%). Less-mentioned activities were: counselling (5.7%); and organising meetings (4.5%).

3 STAFF PERCEPTIONS AND BEHAVIOUR

In the staff survey we asked questions related to their risk perception, personal prevention measures, utilization of VCT services, preference for ART service providers, and their intentions about disclosure should they test HIV positive. Their attitudes towards HIV positive people in general, and fellow staff in particular, were also studied. Differences in answers between groups of staff by sex, marital status, and job level were explored for many variables, in order to propose possible target groups for interventions.

3.1 Risk perceptions

Staff were asked whether they ever felt at risk of contracting HIV at the workplace or when on duty travel, and if so why. About one-fifth (18.2%) of respondents said they had at some point felt at risk. Table 6 shows risk perceptions by socio-demographic and work-related background variables.

Table 6: Respondents feeling at risk of HIV, by socio-demographic and work-related background

<i>Background variable</i>	<i>Felt at risk</i>	<i>Felt not at risk</i>	<i>All (100%)</i>
Sex			
Male	25 (20.0%)	100 (80.0%)	125
Female	18 (16.2%)	93 (83.8%)	111
Age group			
20-29	18 (21.2%)	67 (78.8%)	85
30-39	17 (17.0%)	83 (83.0%)	100
40-49	6 (14.3%)	36 (85.7%)	42
50 over	2 (22.2%)	7 (77.8%)	9
Marital status			
Married	27 (17.6%)	122 (82.4%)	148
Single	17 (20.5%)	66 (79.5%)	83
Widowed/divorced	0	5 (100%)	5
Job category (N=232)			
Management	9 (22.5%)	31 (77.5%)	40
Support	11 (14.9%)	63 (85.1%)	74
Technical	18 (20.2%)	71 (79.8%)	89
Administration	5 (17.2%)	24 (82.8%)	29
Going for fieldwork			
Yes	31 (21.2%)	115 (78.8%)	146
No	12 (13.3%)	78 (86.7%)	90
	43 (18.2%)	193 (81.8%)	236

Relatively more risk was felt by males (20.0%), the younger age group 20-29 (21.2%), singles (20.5%), management (22.5%), technical staff (20.2%), and staff going for fieldwork where they have to stay overnight (21.2%), than by other groups.

The reasons, given by 33 respondents for why they felt at risk were mainly related to: 1) being attracted to and having sex with someone else in workshops, or in the accommodation where they were staying during fieldwork (n=12, 36.4%); 2) being exposed to possibly contaminated blood during pricking accidents or delivery (n=9, 27.3%); or 3) having had a road accident (n=9, 27.3%).

3.2 Prevention behaviour

Almost all staff (96.6%) reported taking (sometimes multiple) measures to prevent HIV infection, with the majority reporting being faithful (65.3%). About one-third (33.9%) use condoms for HIV prevention, and 25.4% practise abstinence. Two used other prevention methods: one married man of 29 said he prevented HIV by testing before marriage and by now being faithful, and another man working in a health setting used protective gear when working in the lab. As would be expected, there are differences in the use of prevention methods between groups, by socio-demographic and work-related background – all, however, had roughly equally high general HIV prevention behaviour (see Table 7).

Table 7: Prevention measures by background variables (multiple response)

<i>Background variable</i>	<i>N</i>	<i>Any measure</i>	<i>Abstinence (% any)</i>	<i>Being faithful (% any)</i>	<i>Condom (% any)</i>
Sex					
Male	125	120 (96.0%)	31 (25.8%)	81 (67.5%)	48 (40.0%)
Female	111	108 (97.3%)	29 (26.8%)	73 (67.6%)	32 (29.6%)
Age group					
20-29	85	80 (94.1%)	30 (37.5%)	42 (52.5%)	32 (40.0%)
30-39	100	97 (97.0%)	15 (15.5%)	72 (74.2%)	40 (41.2%)
40-49	42	42 (100%)	13 (31.0%)	31 (73.8%)	8 (19.0%)
50 over	9	9 (100%)	2 (22.2%)	9 (100.0%)	0
Marital status					
Married/divorced	153	150 (98.0%)	24 (16.0%)	123 (82.0%)	41 (27.3%)
Single	83	78 (94.0%)	36 (46.2%)	31 (39.7%)	39 (50.0%)
Job category (N=232)					
Management	74	72 (97.3%)	13 (18.1%)	47 (63.5%)	24 (33.3%)
Support	89	88 (98.9%)	28 (32.2%)	59 (66.3%)	32 (37.2%)
Technical	29	27 (93.1%)	9 (33.3%)	15 (51.7%)	11 (40.7%)
Administration					
Going for fieldwork					
Yes	146	141 (96.6%)	39 (27.7%)	96 (68.0%)	54 (37.0%)
No	90	87 (96.7%)	21 (24.1%)	58 (66.7%)	26 (28.9%)
ALL	236	228 (96.6%)	60 (25.4%)	154(65.3%)	80 (33.9%)

As would be expected, abstinence is relatively more practised in the younger age group of 20-29 (37.5%) and by single staff (46.2%), whereas faithfulness is practised more among age groups over 30 and married staff (82.0%). Condoms are relatively more used by men (40.0%), by the younger age groups 20-39 (about 40.0%), by singles (50.0%), by administration staff (41.0%), by technical staff (37.2%), and by staff going for fieldwork (37.0%).

3.3 Voluntary Counselling and Testing (VCT)

Almost all staff (n=227, 96.0%), are of the opinion that everyone should know their HIV status, but not all have gone for VCT themselves (n=154, 65.3%). The majority of staff (93.0%) knew where to access VCT; women (90.0%) and support level staff (91.0%) knew relatively the least (table not shown).

Of the 154 staff who had gone for VCT, 13.6% had been once, 33.1% twice, 27.3% three times, and 26.0% had been 4 times or more. The average number of visits for VCT for those who went at least once was 2.9. There were variations between groups regarding who went more often, as Table 8 shows.

Table 8: Staff who have gone for VCT, and number of times, by background variables

<i>Background</i>	<i>N</i>	<i>Gone VCT</i>	<i>1 time VCT</i>	<i>2 time VCT</i>	<i>3 time VCT</i>	<i>>4 VCT</i>	<i>Mean</i>
Sex							
Male	125	82 (65.6%)	12(14.6%)	32 (39.0%)	21 (25.6%)	17 (20.7%)	2.8
Female	111	72 (64.9%)	9 (12.5%)	19 (26.4%)	21 (29.2%)	23 (31.9%)	3.1
Age group							
20-29	85	55 (64.7%)	7 (12.6%)	18 (32.9%)	16 (29.1%)	14 (25.5%)	3.1
30-39	100	67 (67.0%)	7 (10.4%)	22 (32.8%)	16 (23.9%)	22 (32.8%)	3.1
40-49	42	25 (59.5%)	4 (16.0%)	10 (40.0%)	9 (36.0%)	2 (8.0%)	2.4
50 over	9	7 (77.8%)	3 (42.9%)	1 (14.3%)	1 (14.3%)	2 (28.6%)	2.3
Marital status							
Married/div	153	103 (67.3%)	12 11.7%)	35 (34.0%)	28 (27.2%)	28 (27.2%)	3.0
Single	83	51 (61.4%)	9 (17.6%)	16 (31.4%)	14 (27.5%)	12 (23.5%)	2.9
Job category							
Management	40	31 (77.5%)	5 (16.1%)	9 (29.0%)	8 (25.8%)	9 (29.0%)	2.9
Support	74	40 (54.1%)	2 (5.0%)	21 (52.5%)	10 (25.0%)	7 (17.5%)	2.8
Technical	89	61 (70.1%)	10 (16.4%)	11 (18.0%)	19 (31.1%)	21 (3.5%)	2.8
Administration	29	18 (62.1%)	4 (22.2%)	8 (44.4%)	3 (16.7%)	3 (16.7%)	2.5
Fieldwork							
Yes	146	103 (70.5%)	15 (14.6%)	35 (34.0%)	27 (26.2%)	26 (25.2%)	2.9
No	90	51 (56.7%)	6 (11.8%)	16 (31.4%)	15 (29.4%)	14 (27.5%)	2.9
Feel at risk							
Yes	43	28 (65.1%)	3 (10.7%)	9 (32.1%)	4 (14.3%)	12 (42.9%)	3.2
No	193	126 (65.3%)	18 (14.3%)	42 (33.3%)	38 (30.2%)	25 (19.8%)	2.9
ALL	236	154 (65.3%)	21 (13.6%)	51 (33.1%)	42 (27.3%)	40 (26.0%)	2.9

The age group 30-39 (67.0%), the married staff (67.3%), management (77.5%), technical staff (70.1%), and staff who go for fieldwork (70.5%) went for VCT relatively more often than other groups. However, of those who went, it was the women, younger age groups of 20-39, and those who had felt at risk, who had the highest mean number of times going for VCT. Women are probably offered routine HIV testing during pregnancy, and obviously staff who have felt at risk want to get tested.

3.4 Attitude towards PLHIV

In order to gauge stigma in the workplace, respondents were asked various questions about their attitudes towards PLHIV. The first was a general question about blame: whether they thought it was always, sometimes, or never the fault of the person for becoming infected; if answering 'sometimes', respondents were asked to explain this view. Only 3.4% of respondents felt it is always the fault of the person, while about half (50.4%) felt it is never their fault. However, there was a considerable proportion, 45.8%, who said infection may sometimes be the responsibility of the person her- or himself.

The respondents who reported that HIV positive persons were sometimes to blame for their infection can be divided into two groups. The largest group, of the 105 staff⁴ who reported on it, referred to the fact that while HIV is normally *not* one's own fault, it can be by exception. Reasons for this are: 1) having unprotected sex by not using condoms if needed (n=70, 66.7%); 2) being unfaithful (n=11, 10.5%); or 3) a combination of unfaithfulness and not using condoms (n=7, 6.7%). Reasons mentioned just once each were: having multiple partners, or by not taking measures against getting infection from unsterilized instruments. Two respondents thought it is your own fault for contracting AIDS if you agree to inherit a widow, knowing or suspecting that her husband died of the infection.

⁴ 3 of the 108 staff who opined that sometimes PLHIV are to blame did not give a reason for their opinion.

The smallest group assumed that HIV infection *usually* is the fault of the person, and only by exception not; 13 respondents mentioned that HIV is not your own fault when you become infected in an accident, through contact with infected blood (12.4%). Table 9 shows the findings when exploring the differences between groups of staff in assigning blame.

Table 9: Perceptions on blame for being HIV positive, by background variables

<i>Background variables</i>	<i>N</i>	<i>Fault</i>	<i>Sometimes</i>	<i>Never</i>
Sex				
Male	124	7 (5.6%)	55 (44.4%)	62 (50.0%)
Female	111	1 (0.9%)	53 (47.8%)	57 (51.4%)
Marital status				
Married/divorced	153	5 (3.3%)	62 (40.5%)	86 (56.2%)
Single	82	3 (3.7%)	46 (56.1%)	33 (40.2%)
Job category (N=232)				
Management	40	2 (5.0%)	22 (55.0%)	16 (40.0%)
Support	74	2 (2.7%)	27 (36.5%)	45 (60.8%)
Technical	89	2 (2.2%)	45 (50.6%)	42 (47.2%)
Administration	28	1 (3.6%)	12 (42.9%)	15 (53.6%)
ALL	235	8 (3.4%)	108 (46.0%)	119 (50.6%)

Males (5.6%) and management (5.0%) were relatively more often of the opinion that HIV infection is one's own fault. Married (56.2%) and support staff (60.8%) relatively more often considered HIV infection never to be the fault of the person.

When asking about working with HIV positive people in the workplace, the majority (92%) of staff said they felt comfortable working beside someone who is HIV positive. Relatively more women (9%), married (11%), and technical staff (10%) did *not* feel comfortable working with someone who is HIV positive, as were staff who feel at risk of HIV infection at the workplace (12%) (table not shown). The main reason for not feeling comfortable is due to travelling together and being involved in a possible car accident.

Only 15 respondents answered that an HIV positive staff member is or would be treated differently in the organisation, while even fewer, just 9, said that they themselves would treat HIV positive staff in a different way. Surprisingly, however, the main reasons for this were not negative, but that they would be treated differently in a positive way, by receiving treatment, counselling, or being assigned other tasks. Only two staff members reported that others stigmatize HIV positive co-workers (though they themselves do not).

It seems that the reported attitude of workers towards HIV positive people in general, and more specifically co-workers, is positive in the sense that they are treated in the same way as anybody else and are not blamed for their infection.

3.5 Disclosure of HIV positive status

More than four-fifths of staff (84.3%) said they would disclose their HIV positive status to someone in the organisation, while the others (15.7%) would not disclose their status in the workplace. The main reasons given by 21 for not disclosing were that: 1) they were afraid of rumours and stigma (n=16, 76.2%); or 2) did not expect any benefit from disclosing, some adding that one would be better off telling people in the hospital who could help (n=9, 23.8%).

When asked about to whom they would disclose, and why to that particular person, the most popular person was the HIV focal point person, with 36.2% of those with an intention to disclose. Fifty-eight staff, giving reasons why they would disclose to the focal point person, said they would expect: 1) understanding and support (n=35, 60.3%); or 2) advice on how to benefit from the workplace policy (n=23, 39.7%). The second most popular person to disclose

one's status to is the immediate supervisor, with 31.2%. The 44 staff giving reasons why said that the supervisor: 1) could assign duties according to their health status (n=25, 56.8%); or 2) would show understanding and be supportive (n=19, 43.2%). The reasons why 25.6% would tell the head of the organisation, given by 49 staff, is because: 1) (s)he can provide care and support (n=37, 75.5%); or 2) they are sure of confidentiality (n=12, 24.5%). The 15.6% (n=19) who would disclose their status to their peers would do so because: 1) they can be trusted (n=15, 78.9%); or 2) they can help with advice or with taking over some of the workload (n=4, 21.1%). Only 10.6% of those intending to disclose would do this openly to everyone. The 20 staff who gave reasons why said that: 1) there is no reason to hide your status (n=10, 50.0%); 2) to receive encouragement and support (n=9, 36.0%); and 3) one woman hoped she would be a good example to others for knowing their status and for positive living. There were differences between groups of staff in intention to disclose, and to which person, as Table 10 shows.

Table 10: Disclosure of HIV status to certain persons, by background (multiple response)

Background	N	Disclose = X	Disclosure to a certain person (% of X)*				
			Head	Supervisor	HIV FPP	Peers	Everyone
Sex							
Male	125	111 (88.9%)	34 (30.6%)	40 (36.0%)	38 (34.2%)	16 (14.4%)	13 (11.7%)
Female	111	88 (79.3%)	17 (19.3%)	22 (25.0%)	34 (38.6%)	15 (17.0%)	8 (14.5%)
Age group							
20-29	85	65 (76.5%)	14 (21.5%)	26 (40.0%)	28 (43.1%)	12 (18.5%)	6 (9.2%)
30-39	100	92 (92.0%)	26 (28.3%)	25 (27.2%)	25 (27.2%)	14 (15.2%)	11 (12.0%)
40-49	42	36 (85.7%)	10 (27.8%)	9 (25.0%)	16 (44.4%)	4 (11.1%)	3 (8.3%)
50 over	9	6 (66.7%)	1 (16.7%)	2 (33.3%)	3 (50.0%)	1 (16.7%)	1 (16.7%)
Marital status							
Married/div	153	132 (86.3%)	39 (29.5%)	38 (28.8%)	40 (30.3%)	16 (12.1%)	13 (9.8%)
Single	83	67 (80.7%)	12 (17.9%)	24 (25.8%)	32 (47.8%)	15 (22.4%)	8 (11.9%)
Job category							
Management	40	32 (80.0%)	9 (28.1%)	13 (40.6%)	13 (40.6%)	0	4 (12.5%)
Support	74	65 (87.8%)	15 (23.1%)	16 (24.6%)	18 (27.7%)	12 (18.5%)	8 (12.3%)
Technical	89	73 (82.0%)	21 (28.8%)	25 (34.2%)	30 (41.1%)	15 (20.5%)	6 (8.2%)
Admini- stration	29	26 (89.7%)	6 (23.1%)	7 (26.9%)	9 (34.6%)	4 (15.4%)	3 (11.5%)
ALL	236	199 (84.3%)	51 (25.6%)	62 (31.2%)	72 (36.2%)	31 (15.6%)	21 (10.6%)

* There were only two others to disclose to: the human resource manager and the counsellor.

Table 10 indicates that relatively fewer women (79.0%), those among the younger age group 20-29 (77.0%), single staff (81.0%), and management (80.0%) would disclose compared to the other groups. Women and singles are generally more vulnerable in the community to negative repercussions of being known to be HIV positive. Women are often blamed by husbands and in-laws for HIV infection, and for single staff being known to be HIV positive may mean it is more difficult to find a marriage partner. To what extent these motivations against disclosure also count for the workplace can only be guessed, because it was not further investigated. Relatively more women and singles who do intend to disclose would do so to the focal point person – which may indicate trust in his/her confidentiality and ability to handle the situation.

3.6 Preference for place of ART

Nearly all respondents (n=211, 89.4%) know where to access ART. When asked where they would prefer to receive ARV treatment, of the different options it was in a way surprising that only 15.3% opted for private clinics. The main reasons for this preference, given by 28 staff,

were: 1) confidentiality and privacy (n=10, 35.7%); 2) easy to access (n=9, 32.1%); 3) less time spent accessing the services (n=6, 21.4%); and 4) follow-up is easy (n=3, 10.7%). Almost half of the respondents (47.5%) said they would prefer free treatment by a service organisation. The reasons given by 114 staff were that: 1) the quality of care is good, with a passionate attitude of service providers, and professional services (n=78, 68.4%); 2) medicines are always available (n=18, 15.8%); and 3) it is more convenient, with less stigmatization by clinic staff (n=16, 14.0%). Two respondents said that their organisation made arrangements with a service organisation for staff to access treatment. The main reason why 34.7% said they would prefer government services, given by 82 respondents, was that they are cheap (n=75, 91.5%). Seven respondents said that seeing many other people attending government clinics gives a person courage, and may provide support and guidance from others (8.5%). There were differences between groups of staff in their preferences for where to access ART, as can be seen in Table 11.

Table 11: Preference for place of ART, by background variables

<i>Background variables</i>	<i>N</i>	<i>Private for fee</i>	<i>Free by govt</i>	<i>Free by service org</i>	<i>Other*</i>
Sex					
Male	125	19 (15.2%)	51 (40.8%)	53 (42.4%)	2 (1.6%)
Female	111	17 (15.3%)	31 (27.9%)	59 (53.2%)	4 (3.6%)
Age group					
20-29	85	13 (15.3%)	41 (48.2%)	31 (36.5%)	0
30-39	100	19 (19.0%)	32 (32.0%)	47 (47.0%)	2 (2.0%)
40-49	42	4 (9.5%)	8 (19.0%)	27 (64.3%)	3 (7.1%)
50 over	9	0	1 (11.1%)	7 (77.8%)	1 (11.1%)
Marital status					
Married/divorced	153	20 (13.1%)	49 (32.0%)	80 (52.2%)	4 (2.6%)
Single	83	16 (19.3%)	33 (39.8%)	32 (38.6%)	2 (2.4%)
Job category					
Management	40	5 (12.5%)	7 (17.5%)	27 (67.5%)	1 (2.5%)
Support	74	8 (10.8%)	35 (47.3%)	30 (40.5%)	1 (1.4%)
Technical	89	15 (16.9%)	34 (38.2%)	36 (40.4%)	4 (4.6%)
Administration	29	8 (27.6%)	4 (13.8%)	17 (58.6%)	0
ALL	236	36 (15.3%)	82 (34.7%)	112 (47.5%)	6 (2.5%)

* Others mainly did not have a preference for one or another service provider

The age group 30-39, singles, and especially administrative staff, preferred relatively more often to go to private services for ART, while males, those in the age group 20-29, and support staff relatively more often preferred free government services. Women, the age groups over 40 years, and management relatively more often preferred to get ART from service organisations, which are also free.

4 IMPLEMENTATION OF WORKPLACE POLICY ACTIVITIES

All but one NGO has started implementing workplace policy activities. The sections in this chapter give information about the specific activities being implemented; information from the IDIs is compared with the information from the staff survey. This will indicate whether in general staff members know that the activity is taking place and whether they participate. Table 12 first provides an overview of the workplace policy activities, and the number and percentage of organisations implementing such activities, as well as the percentage of staff who reported the activity. (Table 3 of the Annex provides the names of the 29 NGOs, specifying the activities that had taken place at the time of data collection, as reported in the IDIs.)

Table 12: Summary of implemented workplace policy activities, reported in IDI and survey

<i>Activities</i>	<i>NGOs</i>	<i>% NGOs</i>	<i>% staff reported</i>
Awareness raising and sensitization	26	96.6	73.7
Internal routine discussions	19	65.5	47.0
Internal training for all staff	11	37.9	}52.2
Training for all staff by external trainers	6	20.7	}
First aid box	3	10.3	
HIV/AIDS notice board	17	58.6	}75.8
AIDS corner	12	41.4	}
Condoms for staff	18	62.1	66.1
VCT promotion	19	65.5	69.6
Guidelines for disclosure (to certain person)	10	34.5	62.3
Guidelines for confidentiality	8	27.6	64.4
Stigma reduction measures	15	51.7	}54.7
Non discrimination measures	16	55.2	}
Attention to gender	11	37.9	47.9
Facilitate access to ART	10	31.0	22.9
Arrangement with private facility for ART	6	20.7	
Insurance including ART	3	10.3	
Staff pay part of salary for health/insurance	1	3.4	
Measures for care and support	7	24.1	76.7
Counselling	9	31.0	
ANY ACTIVITY	28	96.6	

4.1 Awareness raising, IEC, and training

In all but one of the 29 organisations, according to respondents in the IDIs awareness raising has been going on. This takes the form of staff sensitization meetings where an AIDS related topic is discussed, especially where staff feel less knowledgeable, for example in KADP; or during routine meetings where HIV/AIDS is discussed, such as in VEDCO. Awareness raising is also done through training, having an HIV/AIDS notice board in a strategic place, or having an AIDS corner with information about HIV and AIDS.

NGOs may solicit Information from other agencies, such as from the AIDS Information Centre, and this is then distributed to the staff, as is done in SSD and NUWODU; or it is displayed on the notice board. Newspaper clippings are also placed on the notice board or in the AIDS

corner as is the case with FHRI, COU Education Department, TEDDO, and FURA. Environmental Alert brings resource persons, especially from the AIDS Information Centre, to talk about HIV/AIDS to its staff. WOUGNET have a digital information sharing network where HIV information is collected and disseminated.

"I get information from AIDS Information Centre which I give to staff, then sometimes I just hang it like on the notice board and – you know – places where staff can sit. Then there was a time when I used to receive Straight Talk – these papers of Straight Talk – I would get them, give them to staff, and even though they were not interested I would say, "At least if you don't want to read it please take it to your teenage daughter at home". (AMFIU)

"We had actually put them to sensitize our staff about that – the board about HIV/AIDS and also collecting HIV information from various sources to disseminate to our members. But right now what we did was actually to...like collecting HIV information. We are doing it jointly with – we have a programme called Information Sharing and Network. So it is done like any other information sharing activity. But we have a special place like the notice board where we put information if there is any key information that has come in that kind of thing. We have even a corner for HIV materials in the lab". (WOUGNET)

Staff awareness

When asking staff whether any awareness raising activities take place within their organisation, they reported less about it than the organisational heads. 73.7% of staff reported knowing about such activities, and the majority (83.9%) of those who knew about it participated. There could be multiple activities, such as routine discussions in the workplace, reported by 66.1%, or more organised training for staff (50.0%). Concerning IEC materials, 76.0% of staff reported that such materials were provided in the office, either on the notice board or in the AIDS corner, or in another place; nearly all of those who reported the presence of IEC materials said they looked at them (96.0%). Table 13 shows the differences between groups of staff in terms of knowing about awareness raising activities and participating in them.

Table 13: Methods of awareness raising and participation according to staff, by background

<i>Background</i>	<i>N</i>	<i>Aware = X</i>	<i>Participated (% X)</i>	<i>Routine discussions (% X)</i>	<i>Training for awareness (% X)</i>	<i>IEC materials (% N)</i>
Sex						
Male	125	94 (75.2%)	83 (88.3%)	70 (74.5%)	49 (52.1%)	91 (72.8%)
Female	111	80 (72.1%)	63 (78.8%)	45 (56.3%)	38 (47.5%)	88 (79.3%)
Marital status						
Married/divorced	153	114 (74.5%)	96 (84.2%)	72 (63.2%)	60 (52.6%)	117 (76.5%)
Single	83	60 (72.3%)	50 (83.3%)	43 (71.7%)	27 (45.0%)	62 (75.0%)
Job category						
Management	40	35 (87.5%)	33 (94.3%)	27 (77.1%)	21 (60.0%)	35 (87.5%)
Support	74	47 (63.5%)	39 (83.0%)	28 (59.6%)	25 (53.2%)	49 (66.2%)
Technical	89	66 (74.2%)	54 (81.8%)	46 (69.7%)	28 (42.4%)	68 (78.2%)
Administration	29	24 (82.8%)	19 (79.2%)	14 (58.3%)	11 (45.8%)	24 (82.8%)
ALL	236	174 (73.7%)	146 (83.9%)	115 (66.1%)	87 (50.0%)	179 (75.8%)

Figures show that especially support staff members know relatively less about awareness raising in their organisation, although those who were aware did participate in them at a same level as other categories of staff. However, of all support staff, only 52.7% participated in activities, compared with other staff levels: 82.5% of the management, 60.7% of technical, and 65.5% of administrative staff. Support staff is also the category least aware of IEC materials in the office (66.2%), compared to managers, of whom 88.0% know about such materials.

Aside from general awareness raising, specific training was provided by the organisations. In 11 (37.5%) organisations training has been internally organised for staff, while in 6 (20.7%) external trainers have been invited to train staff (these 6 are also among those who organised internal training). From the staff survey we see that 123 (52.2%) participated in training on HIV and AIDS organised by the organisation, but Table 14 shows that there are considerable differences between groups in levels of participation. It was striking that males (56.0%), management (67.5%), and staff on temporary contracts (57.5%) had training relatively more often, while females (47.7%), support staff (41.9%), and volunteers (33.3%) had less.

Table 14: Staff receiving training by the organisation, by background variables

<i>Background variable</i>	<i>Had training</i>	<i>Had no training</i>	<i>All (100%)</i>
Sex			
Male	70 (56.0%)	55 (44.0%)	125
Female	53 (47.7%)	58 (52.3%)	111
Staff level (N=232)			
Management	27 (67.5%)	13 (32.5%)	40
Support	31 (41.9%)	43 (58.1%)	74
Technical	46 (51.7%)	43 (48.3%)	89
Administrative	17 (58.6%)	12 (41.4%)	29
Type of staff			
Fixed contract	56 (48.7%)	59 (51.3%)	115
Temporary contract	63 (57.8%)	46 (42.2%)	109
Volunteer	4 (33.3%)	8 (66.7%)	12
	123 (52.2%)	113 (47.9%)	236

The training subjects that were dealt with most were, according to 118 respondents participating in the training: 1) signs, symptoms, and transmission of HIV/AIDS (n=31, 26.3%); 2) developing a workplace policy (n=20, 16.9%); 3) peer education (n=16, 13.6%); 4) the effect of HIV and AIDS on beneficiaries of programmes, such as for adult literacy and fishermen (n=10, 8.5%); and 5) the '12 Box Assessment' (n=7, 5.9%). Training also covered positive

living and rights of PLHIV (n=6, 5.1%); the SAN! database (n=6, 5.1%); counselling (n=5, 4.2%); and stigma and discrimination (n=4, 3.4%).

It is a promising development that the majority of the 123 staff who had training said they shared what they had learned with others (n=111, 90.2%). The 91 who reported on specifically with whom they shared the information mostly mentioned family (n=35, 31.5%), friends and peers (n=34, 30.6%), their spouse (n=12, 10.8%), and community members and neighbours (n=7, 6.3%). One person said he shared the information in his church (thus reaching a large audience).

4.2 Prevention activities

Aside from giving information on HIV prevention in awareness raising activities and IEC, 18 organisations (62.0%) also provide condoms in the workplace intended for HIV prevention; only one is a Faith Based Organisation (Vision Terudo). Condoms are mainly placed in bathrooms and toilets, but also in first aid kits and in the office of the HIV focal point person.

"We have condom dispensers in our bathrooms and we consistently replenish them. We get new stock from SAN! on a timely basis. Aside from replenishing condom dispensers, I also distribute to staff in periods like the weekend. I just pick and give to individual staff". (EASSI)

Staff about condoms

About two-thirds (66.1%) of staff reported having condoms available in the workplace. Staff (n=117) reported on the different places where they can access condoms, and in some organisations they are provided in more than one place. The most common places to put condoms are the toilet or bathroom (n=86, 73.5%), and the AIDS corner (n=14, 12.0%). In some organisations the condoms are available in closed offices like the storeroom (n=8, 6.8%), the office of the focal point person (n=7, 6.0%), boardroom (n=6, 5.1%), and administration (n=2, 1.7%). Staff report, however, that condoms are not always available: 117 (75.0%) out of the 156 respondents who reported condoms in the workplace said that condoms are always available, while 39 (25.0%) said they are not always available (not in table). Thus almost half (49.6%) of all 236 staff have condoms always available in the workplace, and about half of those who are aware of them (50.6%) do actually take them, at least sometimes. Calculated over all staff, about one-third (33.4%) get condoms from the workplace. Table 15 shows the availability and use of condoms from the workplace according to staff by background characteristics.

Table 15: Availability and use of condoms from workplace according to staff, by background

<i>Background variables</i>	<i>Total</i>	<i>Know of condoms = X (%N)</i>	<i>Number get condoms (% of X)</i>	<i>Get condoms from workplace (% N)</i>
Sex				
Male	125	83 (66.4%)	49 (59.0%)	39.2
Female	111	73 (65.8%)	30 (41.1%)	27.0
Age group				
20-29	85	60 (70.6%)	32 (53.3%)	37.6
30-39	100	64 (64.0%)	36 (56.3%)	36.0
40-49	42	30 (71.4%)	11 (36.7%)	26.2
50 over	9	2 (22.2%)	0	0
Marital status				
Married/divorced	153	105 (68.6%)	47 (44.8%)	30.7
Single	83	51 (61.4%)	32 (62.7%)	38.6
Job category				
Management	40	24 (60.0%)	14 (58.3%)	35.0
Support	74	46 (62.2%)	24 (52.2%)	32.4
Technical	89	62 (69.7%)	30 (48.4%)	33.7
Administration	29	23 (79.3%)	11 (47.8%)	37.9
Go for fieldwork				
Yes	146	98 (67.1%)	56 (57.1%)	38.4
No	90	58 (64.4%)	23 (39.6%)	25.6
ALL	236	156 (66.1%)	79 (50.6%)	33.4

The differences between groups in terms of knowing about condoms in the workplace are not very big, although married and administration staff know more than others. As would be expected, among those who know about condoms, relatively more are taken by males (59.0%), singles (63.0%), and people going for fieldwork (57.0%). Surprisingly, management take them relatively more than other levels of staff.

That staff take condoms from the workplace does not mean they use them (only) for themselves. Managers in the IDIs said they suspected – and this was confirmed by findings from the survey – that staff also take condoms for others. Of the 82 staff who reported, 37 (45.1%) used the condoms for themselves only, 33 (40.2%) used them for themselves *and* for others, while 12 (14.6%) took condoms only for others. If others were specified, these were mainly friends, brothers, youth (*‘who may not have money to buy them’*, or *‘to safeguard them’*), neighbours, or others who cannot access them easily. One woman said: *‘I get them from the office for others, because myself, I don’t. I am faithful to my husband who doesn’t even need them.’*

4.3 VCT promotion and facilitating access

In 19 organisations promotion of VCT takes place. KADP, KARUDEC, and TOCINET have organised a workshop on VCT, and 16 organisations, such as CDRN and EASSI have organised special VCT days where staff, family members, and neighbouring community members can get themselves tested.

“We did something with SAN! and Mildmay and we invited other friends in the neighbourhood and other organisation staff were excited last December 2007 we included the project coordinator of SAN! Some staff tested apart from one volunteer and one staff”. (CDRN)

“We held a VCT day here which we also invited our neighbourhood, family members, dependants, our partner organisations, and the turn up was very good. We had 125 people who went for HIV test”.(EASSI)

From the staff survey we learn that 156 staff (66.1%) work in organisations which reportedly promote VCT. The way in which these organisations promote VCT is, according to these staff, by: 1) providing information (n=123, 78.8%); 2) staff sessions (n=56, 35.9%); and 3) organising a VCT family day (n=13, 8.3%).

4.4 Disclosure and confidentiality

Through their workplace policy, all organisations said they guaranteed confidentiality for staff who disclosed their HIV positive status. However, only 10 have specific guidelines about whom to disclose to in order to access support, and only 8 have guidelines for how confidentiality is maintained. KADP pointed out that when someone finds out that he/she is infected, she/he is free to talk to anyone of their choice. When paying for treatment, the money for the bills passes through the organisation manager, but the focal point person signs for the money so that others do not know for whom it is intended. In NUWODU, guidelines for disclosure are in place and staff should report to the Executive Secretary who also serves in human resources. If there is a financial implication of their positive status, then the accountant and two signatories must know. However, a person's status is kept confidential from other staff. In VEDCO it was mentioned that to ensure confidentiality only the human resource manager knows, as illustrated by the quote below:

“Even when we are receiving reports from AAR [insurance company], they are coded – we don't put people's names. Because if the report is submitted here, maybe to go to the ED's office, to the accountant for accountability purposes, we use codes. So nobody knows who is who; but it is only the HRM and in future we are even thinking that it is not even necessary. For example, if we have a comprehensive health cover, people don't need to come and say we need this or that. However, for psycho-social support, I feel it is still necessary that the Human Resource and the Administration Manager or any assigned person has to know because it is not only about treatment it is also about support.” (VEDCO)

Staff about disclosure and confidentiality

Concerning the views of the 236 staff, 147 (62.3%) think their organisation promotes disclosure of HIV status, and in some organisations also to a specific person. However, 54.0% (n=67) of the 124 who answered the question about to whom an HIV positive person is advised to disclose said that one can disclose to anyone convenient and that there are no guidelines for a specific person. Fifteen staff (12.1%) reported that their organisations advise disclosure to a specific person, including the director, HIV focal point person, HR manager, or supervisor. Only five staff (4.0%) reported that they are advised to disclose to everyone. It was striking that a considerable number, 33 (26.6%), said that they are advised to disclose to someone outside the workplace, either to spouses, family, or friends.

According to 152 staff (64.4%), their organisations ensure confidentiality of HIV positive status. The main ways in which the organisations do this, according to 115 staff reporting, were: 1) keeping test results secret (n=55, 47.8%); 2) giving results privately and counselling in a private room (n=44, 38.3%); 3) using numbers on files and not names (n=10, 8.7%); and 4) keeping the files in a locked room or cabinet (n=6, 5.2%).

4.5 Measures to reduce stigma and discrimination

Fifteen NGOs take measures to reduce stigma and discrimination by making staff aware they will be punished or even suspended if they should stigmatize PLHIV. However, most organisations indicated they have not yet had a PLHIV who has disclosed, therefore they were not able to measure whether he/she faced stigma or not. This was, for instance, reflected by KALI.

“Okay, like for stigma reduction, just like I had told you, we have not had any case that has disclosed the status such that I may not express the real experience of how stigma will affect an employee at the workplace. However, I have the theories but practically we have not expressed it. So that is why I cannot talk much on that because we have not had any trouble”. (KALI)

“It is well explained in both the HIV/AIDS policy and even the human resource policy. So as a disciplinary issue it fetches punitive action and staff members are well aware of it. So, and I haven’t heard any serious problem with that. Because I have heard staff members who are affected and they are working well with their colleagues”. (VEDCO)

Staff about stigma

According to 129 staff (54.7%) measures are taken against stigmatisation and discrimination of HIV positive persons in their organisation. The most common ways organisations do this, as reported by 117 staff, is to counsel and sensitize staff about the reality of living with HIV, and the rights of PLHIV (n=54, 46.2%). Twenty-three staff (19.7%) reported there are procedures for equal treatment and equal work for PLHIV. Sixteen staff (13.7%) reported disciplinary action being taken against someone stigmatizing a PLHIV, and they are warned about this. Organisations also have IEC messages and posters to fight stigma (n=11, 9.4%). Two contradictory measures staff reported for fighting stigma were, one the one hand, keeping test results secret (n=11, 9.4%), and on the other hand encouraging disclosure (n=2, 1.7%).

4.6 Addressing gender concerns

In 15 NGOs measures are taken for gender equality. Not many organisations talk much about it, though they are aware of gender concerns and HIV/AIDS, and are doing something about it. They are aware that women are more vulnerable to HIV/AIDS; KADP, for instance, mentioned that women can be raped whereas men cannot. VEDCO highlights:

“We shared the same view that women are much more vulnerable and they need much more support and care than any other. So in all our intervention mechanisms the gender issue is well embedded and we are aware that it is something that should not be ignored if we are to push this fight to its logical direction”. (VEDCO)

Almost half of the staff (n=113, 47.9%) think their organisation pays attention to gender concerns. Measures taken, according to 97 respondents, include: 1) same treatment, equal access, same benefits (n=55, 56.7%); 2) having separate services for women and men, for instance for counselling (n=19, 19.6%); and 3) awareness raising on gender issues (n=10, 10.3%). In some organisations women are especially encouraged to claim their rights – 9 staff say so (9.3%) – while 4 (4.1%) say their organisation is involved in gender mainstreaming in all project activities.

4.7 Access to ART

Ten NGOs have measures for staff to access ART, 6 by arrangements with a private facility, 3 have ART included in the health insurance, and in one organisation it is included in the health insurance but staff have to contribute some money towards it. AMFIU and EASSI mentioned that they have a medical insurance scheme including access to ART. At AMFIU, ARVs are paid by contingency money, as illustrated by the quote below:

“So we provide a contingency; like there is a regular package we pay where malaria, everything falls. But in case you want ARVs or if there is anything that is beyond, like what they provide under that package, we have our contingency which someone can use and they don’t have to seek permission from AMFIU to use it”. (AMFIU)

“Then of course we have a medical scheme, our staffs have been insured. They are free or they have a provision to access any treatment in regard to HIV/AIDS – they can access ARVs, you know – although I don’t have statistics on that – to know how many people, but the organisation already paid for the medical fee and micro-care insurance cover. So for illness, at least they are guaranteed of getting treatment”t. (EASSI)

“The workplace policy has done a lot to those who embraced it. In LABE, the workplace policy has enabled us to have a general health insurance scheme in place which caters for each staff and two dependants (spouse and child)”. (LABE)

Concerning staff knowing of the provision of ART through their NGO, 54 (22.9%) said their organisations facilitate access, 92 (39.0%) said their organisations do not have such provision, and a considerable number of staff, 91 (38.6%), do not know whether their organisations provide access to ART or not.

Of the 54 staff who said they have access to ART services through their NGO, almost half (n=26, 48.1%) said this is by referral to free services, 14 (25.9%) thought their organisation pays for ART, while 12 (22.2%) reported they have access through insurance cover.

4.8 Care and support for HIV positive persons

Seven NGOs have measures to support HIV positive staff. Not many organisations reported having sick staff, however those that did report it indicated they refer their staff to service organisations such as TASO, which provide care and support including provision of food.

The majority of staff (n=181, 76.7%) trust that their organisations will support HIV positive staff. The 162 staff who reported on the ways in which they believed their organisation (would) support HIV positive persons gave multiple responses, as explained in Table 16.

Table 16: Organisations’ support, as reported by 162 staff (multiple response)

<i>Way of support</i>	<i>Number</i>	<i>% (N=162)</i>	<i>% Total (N=236)</i>
Treatment, ensuring linking to treatment, paying for medical costs or insurance	86	53.1	36.4
Counselling, giving information on positive living, social, emotional, and moral support	51	31.5	21.6
Ensuring income, salary support, financial support, pay for sick leave, income generation,	37	22.8	15.7
Redeployment, rescheduling workload, provide good working conditions	24	14.8	10.2
Treatment of opportunistic infections	11	7.0	4.7
Eliminate stigma	2	1.2	0.9
Visit in hospital	2	1.2	0.8
<i>Any support</i>			<i>76.7</i>
<i>No support</i>			<i>23.3</i>

Staff mainly believed their organisation would support them by arranging access to ART and other medical services, facilitating positive living, and providing financial support. Organisations were also believed to support the sick with a good working environment, such as reduced workload and redeployment.

4.9 Counselling

Nine organisations reported peer (one-to-one) counselling being implemented. FIDA, for instance, has trained peer educators and counsellors. Two focal point persons have been

trained in counselling, which they do regularly with members of staff if the need arises (BUSO Foundation and CDRN). In 4 other NGOs, other staff received SAN! training on peer education. Those organisations with no counsellors reported that they usually send staff to service organisations such as TASO, AIDS Information Centre, and Ministry of Health units for counselling.

“Well you know because someone – a staff has not come out openly as in to disclose although we have of course in this kind of discussions/meetings we try to tell them that okay – it is something one should really feel for himself or herself. You don’t force people to begin talking about their status but if you feel like you can share it maybe with our coordinator or with our focal person, we encourage. Or even just if you know that at the district health unit there is someone you can freely go and discuss with it is fine. We encourage them to do that but we haven’t brought in really someone to come and conduct counselling here”. (MADEFO)

5 EFFECTS OF WORKPLACE POLICIES

This chapter analyses the effects of the implementation of workplace policy activities. It provides information on actual changes that have taken place in staff's attitudes and (intended) behaviour as a result of the workplace policy activities, according to information by managers in the IDIs and by staff in the survey. A large majority (26, 89.7%) of the 29 organisations reported effects of the workplace policy activities. Table 17 provides a summary of these reported effects, which will be elaborated on in this chapter.

Table 17: Summary of workplace policy effects, according to IDI respondents and staff

<i>Effect</i>	<i>% NGOs report effects (N=29)</i>	<i>% Staff reported effects (N=236)</i>
Increased knowledge	75.9	67.4
Changed attitude towards PLHIV	-	55.1
More openness to discuss HIV/AIDS	72.4	63.6
Stigma reduction	62.1	
More (intended) disclosure	20.7	46.8
Motivation to go for VCT / increased VCT uptake	37.9	19.9
Increased demand for condoms	34.5	
Now feel supported by the organisation	-	50.4
Confident of job security	-	88.1
More gender friendly workplace	31.0	6.8
Behavioural change	-	39.0
Now discuss with family and friends	-	46.2
More staff on ART	13.8	-
Raised staff performance	6.9	-
Increased linking & learning (any)	69.0	-
With other SAN! partners	62.1	
With service organisation	55.2	
For IEC	65.5	
For condoms	44.8	
For training	37.9	
More family members involved	34.5	46.2
Negative effect	0	14.0
No effect	6.9	-

5.1 Level of awareness raised on HIV and AIDS

Managers feel that a lot of awareness about HIV and AIDS among staff has been created through the workplace policy related activities (as explained in the previous chapter), such as openly discussing the issues, and having posters about HIV on public display. Awareness is related to knowledge of HIV and AIDS 'basics', but also of the workplace policy, the importance of VCT and disclosure, and of the proper attitude towards PLHIV by not stigmatizing and discriminating them.

"On awareness, it has gone up. And then there is a lot of openness among staff. Right now there are those who are willing to test. That is very good. Some might even lie that they have done it and yet they have not. There is more awareness".
(Health Need)

More than one-third of staff (67.4%) reported increased knowledge about HIV and AIDS because of the workplace policy activities. The most important issues which the 159 staff members reporting this have learned are: 1) how HIV can spread and how to prevent it (49.4%); 2) that they should not stigmatize and discriminate against people with HIV/AIDS (28.2%); and 3) the importance of and how to develop a workplace policy (19.4%).

Almost half of the staff (46.2%) felt they now have enough knowledge about HIV and AIDS, but the figures varied by level of staff, as Table 18 explains.

Table 18: Perception on having enough knowledge of AIDS, by level of staff

<i>Level of staff</i>	<i>Knows enough</i>	<i>Does not know enough</i>	<i>All</i>
Managers	22 (55.0%)	18 (45.0%)	40
Support	32 (43.2%)	42 (56.8%)	74
Technical	39 (43.8%)	50 (56.1%)	89
Administrative	13 (44.8%)	16 (55.2%)	29
TOTAL	109 (46.2%)	127 (53.8%)	232

In all levels of staff, except managers, more than half reported not having sufficient knowledge about HIV and AIDS. Those not knowing enough were asked open questions about what they would like more information on; 112 staff reported sometimes multiple information needs: 29.5% wanted to know more about treatment with ARVs, including the side effects; 18.8% still needed more general information on HIV and AIDS; 14.3% wanted to know about mother-to-child HIV transmission; 12.5% about protection from HIV infection; and another 12.5% about discordant couples. Less mentioned were issues of stigma and discrimination (7.1%); care and support (7.1%); and positive living (4.0%). Three staff said they would like to have information on the female condom.

5.2 More openness to discuss HIV and AIDS and (intention) to disclose

About two-thirds of the staff (63.6%) said their openness to discuss HIV and AIDS has increased because of the workplace policy activities. Staff reported they can now sit down and discuss issues related to AIDS with fellow staff, for instance during lunch breaks or during duty travel, and that AIDS is no longer a taboo subject. They said they can also now talk freely with their fellow staff about how HIV and AIDS affects their families. Many expressed it as, *'I now have no fear to talk about HIV and AIDS.'* Staff reported also that their openness to talk about HIV and AIDS outside the workplace has increased: *'When I am out with my friends and see them over-drinking and being at risk of HIV, I talk to them friendly'*, and *'I can now openly talk about HIV and AIDS even among the young, elderly people, and even to the positive affected and infected people.'*

In almost three-quarters of the NGOs (72.4%), according to the managers, the workplace policy activities have created more openness to discuss HIV and AIDS.

"One, now people are no long shy to talk about HIV/AIDS. People can ask me for condoms – right away say Eric I want condoms and I do give them as it never used to be. They used to know condoms are taken by either prostitutes or they are kept to death – you know, there are is no – there is kind of a bit of openness in terms of talking or discussing about HIV/AIDS issues and concerns. People are free to ask". (EASSI)

Openness also shows itself in the intention to disclose one's possible HIV positive status to other staff. Six organisations reported that disclosure has increased because of the workplace policy. Concerning staff's increased intention to disclose, some staff said they would already have disclosed anyway (15.3%), but almost half (46.6%) said the workplace policy made them likely to disclose their status if found to be HIV positive; 89 staff (37.7%), however, said they would not disclose in the workplace.

There were very few people who had openly disclosed their status in the workplace; the managers of only four organisations knew of an HIV positive staff member. Of the staff, 25 (10.6%) *knew* someone who was HIV positive in the organisation: 16 (64.0%) of them were personally told by the HIV positive person, while others heard it from third persons. Only 18 staff members (7.6%) said there is *no* person with HIV in the organisation, while the majority, 193 (81.8%), said they *do not know* whether there is someone. Obviously, people do not disclose their status to all – considering that so many people do not know.

5.3 Stigma reduction

Stigma reduction as an effect of the workplace policy was reported for 18 organisations (61.2%). In some of the other NGOs there already was reportedly no stigmatization. Although stigma remains a challenge, it has reduced as people now do not feel so shy talking about HIV/AIDS.

“Yah. I think it [stigma] has reduced – if people tested now and found out that they are positive they would be able to come out very openly. Because we had a staff who tested positive and was really a very good advocate and encouraged people to test and let others know about their HIV status. Because – unfortunately the staff died two months ago, but – you know – he was like, you know – encouraging people and telling people that – you know – you people you are here, you think you are okay, you are healthy and what have you, but you might not know that you could die – you may die in a week’s time. So it is better for you to know your status and he would talk about himself – you know...” (CEFORD)

“Staff members are actually taking it as a major concern that HIV/AIDS is not to be taken as, you know, previously it was taken as a disease for people who are – I don’t know which term I would use – you know, people were taking it to be a disease of people who go reckless; but now people consider it to be just like any other disease. So this kind of stigma, of saying that maybe you got it from wherever I don’t know, I think that thing has now gone out of people’s minds”. (KALI)

In organisations such as VEDCO and Health Need the policy stipulates punitive measures against people stigmatizing PLHIV; and according to them, staff members are well aware of this. They indicated that as a result the organisation had not experienced someone being stigmatized, and they have staff that are affected and work well with their colleagues. However, only four organisations have staff who disclosed their HIV positive status, and so in the other NGOs where they do not have that experience the reduction of stigmatisation in the workplace is theoretical:

“Like for stigma reduction, just like I had told you, we have not had any case that has disclosed their status such that I may not express the real experience of how stigma will affect an employee at the workplace. However, I have the theories but practically we have not expressed it. So that is why I cannot talk much on that because we have not had any trouble”. (KALI)

Of the staff, 130 (55.1%) reported a changed attitude towards PLHIV because of the workplace policy; 117 staff elaborated on how their attitudes had changed. Most of them (83.8%) said that they now treat PLHIV as equals and do not discriminate them anymore, as they used to. Because they are more knowledgeable now, 15.4% said they now care more for PLHIV. One staff said that because of the workplace policy he can now freely discuss the issues with PLHIV. The staff reporting on the changes in attitude were not necessarily referring to a person with HIV in their workplace, but in general.

5.4 Behavioural change

Behaviour change is difficult to measure, and with this study methodology we have to rely on the reports of managers about staff and staff about themselves. According to managers there has been some behavioural change after the sensitization and awareness programmes. For instance, it was indicated that with increased knowledge on HIV/AIDS, people now fear they may sometimes be at risk of infection and therefore may take precautions, such as the use of condoms.

“Yah, actually on awareness, you know when people are using condoms at high rates it means there are some things they are fearing. So to me my assumption is behaviour change: feeling conscious of what you are doing that if I don’t use this thing I will get the other thing”. (LABE)

“There is internalization of the workplace policy by staff, increased knowledge about HIV/AIDS by staff who have even accepted to use condoms”. (TTP)

Further, it was indicated that by management accepting the idea of having a workplace policy, this also constitutes a form of behaviour change at organisational management level. Table 19 shows what different groups of staff have to say about whether their behaviour has changed or not because of the workplace policy, with overall 39.0% of staff reporting personal behaviour change.

Table 19: Reported behavioural change by background variables

<i>Background variable</i>	<i>Total</i>	<i>Changed behaviour</i>
Sex		
Male	125	61 (48.8%)
Female	111	31 (27.9%)
Age group		
20-29	85	30 (35.3%)
30-39	100	40 (40.0%)
40-49	42	18 (42.9%)
50 over	9	4 (44.4%)
Marital status		
Married/divorced	153	56 (36.6%)
Single	83	36 (43.4%)
Job category (N=232)		
Management	40	22 (55.0%)
Support	74	23 (31.1%)
Technical	89	34 (38.2%)
Administration	29	10 (34.5%)
ALL	236	92 (39.0%)

Men, older age groups, singles, and management staff most often reported their behaviour to have changed. Open ended questions in the survey showed that most behavioural change relates to now practicing safe(r) sex, either by being faithful to one partner, having fewer girlfriends, abstaining, or using condoms; 43 staff reported this. Some expressed that they are now more conscious about HIV risk and their own sexuality, and are more careful: they said now they more often stick to one girlfriend; are/try to be faithful to their wife; and now use condoms for safety when they have extra marital sex, sex with multiple partners, or are on fieldwork.

“I used to have many girlfriends. I have left all and stuck to one. I feel I have changed and will continue to change”. (Single male, 24)

"I have chosen to abstain, not that I am a virgin, but my commitment to abstain has grown stronger". (Single male, 27)

"I emphasize on using the condom with my boyfriend who works in another district. You never know what he does". (Single female, age 28)

"Become more responsible in dealing with my sexual life". (Married male, 30)

"Be more cautious about HIV/AIDS and be more faithful". (Married male, 42)

Six staff said they now have changed their behaviour towards PLHIV by not stigmatising them anymore, realizing it can happen to anyone. Four reported that now they regularly go for HIV testing and test before a new relationship, and also require this from their new girl-/boyfriend. Three referred to their change in talking about HIV and AIDS and encourage others to be responsible.

5.5 VCT uptake increased

Because of promotion of VCT in the organisation, as explained in 4.3, managers in 37.9% of organisations believe VCT among staff has increased. One key informant (focal point person) had this to say about VCT as an effect of workplace policy in their organisation:

"VCT uptake has increased and there is much openness about it. Staff go for testing and they are not shy about – like telling us that I have come from testing for HIV/AIDS or I am going to test. They do this with a lot of ease". (AMFIU)

Of the staff, about one-fifth (19.9%) said that the workplace policy has motivated them to go for VCT, whereas more than one third (36.0%) reported that they had already gone on their own initiative, had an HIV test when they were getting married, or had routine testing when in the hospital or when pregnant. One male staff said it was a requirement by the organisation (UJCC) to get tested (in 2004).

5.6 Increased number of staff on ART

Four organisations reported an increased number of staff on ART. All organisations that reported having an HIV positive staff have them on ARVs. The managers said that with the workplace policy being implemented, this is now easier for them to do. (For confidentiality reasons, organisations of the quotes below are not named)

"Before, for a person who gets ARVs, it involved a lot of lining at that place and it would take a lot of time. And before, sometimes we would have to send someone to do it for her. She would be asked to come here. But now, she gets a day off and goes there"

"I am going to talk about this person. She used to hide. She used to take her drugs in secret places somewhere. But now she does it in the open. Her CD4 had gone down sometime back. But now she is just okay. But she has never been open to everybody but she is free. And I was going to find a way of asking her to be our kind of facilitator. You see such a person is very good at such things. So I want to make it a formal arrangement".

Only 20 (8.5%) staff know someone in the organisation on ARVs, about the same number as those who know about an HIV positive fellow staff member.

5.7 Workplace more gender sensitive

Nine NGOs reported a more gender friendly workplace. However, this does not imply that other workplaces are not gender friendly, because it may mean they already were. The experience of the change in NOWUDU, an organisation for women with a disability, is interesting though.

“In NUWODU, gender awareness came because of the workplace policy. It is because of the workplace policy that made us bring in gender. Initially NUWODU was giving priority to only women on HIV/AIDS issues. But because women kept facing resistances from their husbands, it was impossible to exclude men in addressing these issues. Also in the workplace we are paying more attention to the relations”.

Only 16 staff (6.8%) report that gender relations have changed because of the workplace policy, and just 5 report how: by being more open to talk with the other genders about HIV and AIDS.

5.8 More involvement of family members, and spill over outside the workplace

In 10 organisations, family were reported to be more involved because of the workplace policy. NGOs involved staff's families, and also surrounding community members, in workplace policy activities such as VCT days and IEC campaigns. Most organisations said they desired to include not only their staff in the benefit of the workplace policy, but also his/her family members. In situations where the workplace policy only caters for staff members, this has been because of budget limitations; the issue of who is and who is not covered by workplace policy did in some cases become a point of contention during development:

“We are targeting the relatives of staff. I don't know whether other organisations are looking at that but for us we are targeting that; you cannot support the staff as an individual, also family members need to benefit”. (CEFORD)

“I think actually the main thing is the openness. I think there was no way we could start discussing our private family affairs before, but in this aspect we are discussing serious family issues especially in fact recently we were with the Uganda Women's Network and we were discussing will making. So I think that is key”. (OWUNET)

Almost half of the staff (46.2%) reported being able to now discuss workplace policy and AIDS issues with family and friends outside the workplace – which can be considered a spill over effect of the workplace policy. The 85 who reported on what they mainly talk about mentioned: 1) prevention and protection from HIV (60.0%); 2) VCT (15.3%); 3) how the workplace policy supports staff (11.8%); and 4) stigma and discrimination (7.1%). Five staff said they talk about how to care for the sick (5.9%). Table 20 shows differences between groups of staff in discussion of workplace policy with people outside the workplace.

Table 20: Staff discussion of workplace policy with family and friends, by background variables

<i>Background variable</i>	<i>N</i>	<i>Discuss with others</i>	<i>Not discuss with others</i>
Sex			
Male	125	66 (52.8%)	59 (47.2%)
Female	111	43 (38.7%)	68 (61.3%)
Age group			
20-29	85	33 (38.8%)	52 (61.2%)
30-39	100	47 (47.0%)	53 (53.0%)
40-49	42	24 (57.1%)	18 (42.9%)
50 over	9	5 (55.6%)	4 (44.4%)
Marital status			
Married/divorced	153	78 (51.0%)	75 (49.0%)
Single	83	31 (37.3%)	52 (62.7%)
Job category (N=232)			
Management	40	24 (60.0%)	16 (40.0%)
Support	74	30 (40.5%)	44 (59.5%)
Technical	89	39 (43.8%)	50 (56.2%)
Administration	29	14 (48.3%)	15 (51.7%)
ALL	236	109 (46.2%)	127 (53.8%)

Males are more likely to discuss HIV and AIDS as an effect of the workplace policy than their female counterparts. By age, the younger staff of 20-29 years of age are less likely to discuss HIV/AIDS with family members and other people outside the workplace. The married staff are more likely to discuss compared to the singles; and managers discussed it more compared to other levels of staff.

5.9 Linking and learning

Because of the workplace policy, 69.0% of organisations reported increased linking with and learning from other organisations: 62.1% linked with other SAN! partners, 55.2% with various service organisations generally, 65.5% said they linked with organisations for IEC, 44.8% for condoms, and 37.9% for training. These organisations enter networks to share information, ideas, condom distribution/accessibility, IEC materials, and resource persons who conduct trainings. At district level, organisations worked with District Health Services and local government structures. Some items or services require money while others are free; for instance, condoms from the District Health Services are free, while hiring VCT facilitators may cost some money.

By sharing information during SAN! training and workshops, organisations have learnt much from each other; they reported obtaining skills from the SAN! network to help execute their work, especially in the development and implementation of a workplace policy. Partner organisations also networked on more specific items with each other. For instance, the Uganda Women's Network was in discussion with the BUSO Foundation on how to write a will before someone dies. A respondent from JIDECO appreciated the role played by CDRN in their capacity building as follows:

“At first we were supported by CDRN, in the initial stages. Then it was, I think sometime last year when we started working closely with SAN!, we submitted the draft we had to SAN!. They [CDRN] also advised and put in their comments which we incorporated in the draft”. (JIDECO)

NUWODU reported networks with the Uganda AIDS Commission, TASO, and NAPHOPHANU. From TASO they are provided with counselling, and in turn NUWODU provides information to TASO. Members of NUWODU also access ARVs and support that

includes food from TASO. With the Uganda AIDS Commission (UAC) there is information sharing and attendance of planning meetings organised by the commission. The focal point persons and managers usually establish the links, though networks are also created by networking organisations, e.g. UAC inviting an NGO to be on the committee for planning, as happened to NUWODU.

5.10 Raised staff performance / less absenteeism

Only two organisations reported increased staff performance as a result of the workplace policy being put in place and implemented. Though the reasons behind this were not explored, one may assume they could include the fact that because staff on ART are of better health, they will therefore be more productive and less absent, or that through the workplace policy staff on ART have been assigned more appropriate jobs, amongst other reasons.

5.11 Negative effects of the workplace policy

In the staff survey, 33 people (14.0%) reported negative effects as a result of the workplace policy, but only 19 elaborated on what those negative effects entail. Ten staff (52.6%) fear that the expenses may be too high for the organisation, some adding that the promises of the workplace policy may thus not be fulfilled. Seven staff (36.8%) believed that all the attention to HIV and AIDS may actually increase discrimination of HIV positive staff. None of the managers in the IDIs reported negative effects for the organisation as a result of the workplace policy.

“I wouldn’t say there are negative effects. Although what I would imagine that maybe if somebody was to test and they were positive, we don’t know how you handle it”. (Environment Alert)

6 UTILIZATION OF SUPPORT STRUCTURES

Support structures within the Uganda SAN! project include the Local project coordinator's Office, and the three lead organisations which provide training, supervision, and guidance. The two documents 'Good Donorship in a time of AIDS' (GDG – or good donorship guidelines), and 'What's it likely to cost' (budget tool – BT), provide direction on how to develop a workplace policy and an accompanying budget, as well as what support can be expected from the donors.⁵ The SAN! project database is a tool for the project management and for organisations to monitor activities and progress. This chapter analyses the utilization and usefulness of these structures and guidelines, as reported by the respondents in the IDIs, speaking for their organisations.

6.1 Good Donorship Guidelines and Budget Tool

Awareness

Most respondents were aware of the GDG; 24 (82.8%) knew about the document. However, only 7 (29.2%) had read the whole document, while 17 (70.8%) had read part of it. Less than half of the respondents, 11 out of 27 (40.7%), had seen the document 'What's it likely to cost'. Moreover, not everyone could grasp all that they read.

"We have read through the GDG document though we have not actually mastered it". (KALI)

"I read them sometimes back. I would think I have forgotten some of the phrases and as I start developing it definitely I intend to come back to SAN! to consult on how I can make my budget good enough to be funded. And to know where I shouldn't – my limitations; so that I don't go beyond what is expected". (JIDECO)

Some had just seen the GDG document, but had not read it. The respondent from KARUDEC said: *"I have seen the document but not read it, it is on the shelf"*. However, there were a few organisations such as FIDA where the respondent indicated they were not even aware of the guidelines.

Source of information on GDG and BT

Most organisations (20) reported that they had received the GDG through the SAN! project coordinator when they had started developing their workplace policy. This came in the form of a soft and hard copy. They reported that the GDGs were printed, photocopied, and distributed to the rest of the staff. *"It was forwarded to me by SAN! and then later I got the hard copies. They were sent to my office"* (TOCINET). Two NGOs received the GDG from their lead organisation, one from the local project group, and one from CONCERN.

Perceived usefulness of the GDG and BT

Evaluating the usefulness, 15 (62.5%) organisations considered the GDG very useful, and 9 (37.5%) somewhat useful. Concerning the BT, of those 11 who had seen it, 8 (72.7%) found it very useful, while the other 3 (27.3%) found it somewhat useful.

They reported that the guidelines were useful in budget development and in planning processes. They said guidelines have helped them to make budgets that are realistic and not exaggerated. The formula was important to help them make calculations for the budget; it also provided them with a reporting format. Furthermore, the GDG provided for organisations

⁵ The documents can be downloaded from the STOP AIDS NOW! website.

insight into permitted activities, and on how to develop a work plan. CEFORD even used the GDG for making other budgets that are not related to the SAN! project.

“And this one is also helping us to really understand the planning processes. But whatever we plan must not be very, very ambitious, must be in line with the priority and should also have a focus on deliverables. It is very important to have a budget that is very realistic and not exaggerated. The budget that is in line with what is in the policy, so in line with the commitments”. (FURA)

“I think those things are very useful. I still think because we followed the guidelines, that is why we received the money”. (Health Need)

“When we began writing the HIV policy we never had knowledge of it. But since it was something to refer to, it helped us a lot to develop the HIV policy”. (TOCINET)

“The significant part was in budgeting so I made sure I had to read something about it before I submitted my budget and I adjusted according to what it required me to do”. (AMFIU)

“I found it very useful because it has examples – it has actually successful stories from other organisations how they have implemented – those who have even reached the stage of implementation and it is worthy appreciative”. (MADEFO)

“It gave us an insight on many other activities that could be done without money. It was found useful because it has examples of successful stories from other organisations on how they implemented it”. (VEDCO)

“But even leave alone the HIV/AIDS policy; even for other budgets. You still look at that and it somehow guides you”. (CEFORD)

Principles and commitments in the GDG

The GDG spells out 7 principles. Respondents from 22 organisations answered on how many of the 7 principles they understood: nine (40.9%) understood all; 2 (9.1%) understood between 4 and 6; 7 (31.8%) understood 1-3; and 4 (18.2%) did not understand any. Some could not remember all the principles, but those who did mentioned that it specifically spells out what an organisation should do. For example, if an organisation has donors funding some programmes, they are not expected to request more funds for what is already covered. It provides guidance on specific aspects that money should be requested for. The principle which most organisations talked about was that of the commitment of the funding agencies. Others indicated the following:

“The third one (c⁶) for me is more of a theory. Is the policy enough? Is it enough merely having a workplace policy? Does it go beyond that?” (CDRN)

“I did not understand them well; okay these copies are on open table whoever gets time, reads it, but you know as an organisation of very many programmes sometimes we have not done some kind of training. We have to sit and see how best we can pass through this document. But it is there for whoever wants to read”. (KALI)

⁶ ‘Workplace policies are a cost-effective method which all organisations can use to reduce the impacts of HIV/AIDS on their work.’

The GDG spells out 10 commitments which donors must honour. Concerning having an understanding of the commitments of donors, 20 answered: 8 respondents (40.0%) said they understood 9-10; 8 (40.0%) understand 1-4; and 4 (20.0%) understand none of them.

"We found it complicated but when we got used to it, it became easy to use. The budgeting part was good. The commitment principle was an inspiration – that here is a donor who is committed to supporting workplace policy". (CDRN)

"I didn't read it with that critical mind but if I looked at it once again I will give you my opinion. But in general I think it was something that was done in good faith to develop the capacity of the organisation and I think it is positive". (VEDCO)

The commitment of donors to pay an amount up to 4% of staff salaries towards the workplace policy was the commitment remembered by most, but was also the commitment most organisations had problems with. They said that if the salary of staff is low then the 4% is a very small amount and not adequate to cover many activities.

"The 4% is very small, it should be made open. The 4% is too small. For example, KADP's 4% is between ten and fifteen million [shillings]. And when you look at the insurance, when we tried to calculate, it went to around fifteen million shillings. And the 4% is a maximum of 15 million. So I feel it is not realistic. I think the 4% goes only for sensitization, and other small activities. But it cannot be enough". (KADP)

"It tells you on how to calculate what you can get from your donor but at the end of the day you find that what you come up with is way below what you need. Because it also depends on how much you are getting from your donor; and also the number of staff and all that. By the time you settle down to work out within the figure that you will have got out of those calculations, it is very small. So if at all an organisation didn't have any medical scheme which is already being catered for by another donor or probably budget support, you will not be able to meet all the demands that the HIV/AIDS question meets. You will only be able to do a little part of it. So for me my thinking is that it would be good if all they would require just a budget on its own to address issues of HIV/AIDS. Otherwise you can't offer full support with that money that comes along with the good donorship guidelines. However it is a drop in the ocean which helps you get somewhere. I would suggest that we develop budgets depending on our needs. And whatever budget you come up with, make the discussion for the budget; be determined on what you have phrased and what you are going to undertake". (FHR)

"The 4% is very, very small; that is why for us we are not chasing for this money. For us we are chasing big money. Actually let me tell you that is why you see Kampala organisations are not chasing this money. It is a waste of time in terms of paperwork, in terms of what and only you are asking for one hundred twenty thousand instead of looking for a bigger donor, and you get money which is going to give you money and live. Then what you can do you can also integrate its activities in your organization". (WOUGNET)

The commitment principles were appreciated, with donors being committed to supporting workplace policy development and implementation. However, most respondents were not satisfied with how donors lived up to their principles and commitments: only 2 (9.1%) out of 22 answering said donors did live up to their commitments, 13 (59.1%) said partly, and 7 (31.8%) considered that they did not live up to their commitments.

A few wanted the GDG to be revised, especially the 4%, because they felt that it provides information on how to calculate what the organisations can get from the donor, but in the end the amount you come up with is way below what the organisation needs to execute workplace policy activities. Further, they indicated that it depends on how much an organisation receives

from a donor, the number of staff in an organisation, and existing support from other donors. So if an organisation does not have any medical scheme which is already being catered for either by another donor or probably budget support, some of the demands will not be met.

6.2 SAN! project database

The majority, 25 out of 27 (92.6%), of organisations access the SAN! database. All respondents indicated it was the focal point person who filled in the database as he/she was mandated to do so.

Most organisations were of the opinion that the database is user friendly, and that it helps organisations to know what progress they have made by tracking what has been implemented and how far they have gone in all activities. Respondents stated that the questions to be filled in the database act as checks of what is expected of organisations.

"It is very easy by the way because it keeps telling you if you know you haven't done this, skip this question, and go on. So I go through because basically what I am saying it doesn't change. What I saw the other time is what I see. So if you don't implement it, it remains the same. So I just go skip – and I am through". (WOUGNET)

"Yeah, it is user friendly because actually for me I did not attend the workshop but when our colleague from TEDDO just told me that you type in this and you will get all the instructions there. Actually that's what I did. I typed in the name of the thing and I opened them I begin working on it. It simplifies work other than sitting to write all the activities that you have conducted. At least me I just enter". (COU EDU)

"Yes, it is user friendly because it reminds you of what you have done and what you have failed to do and what you need to attend to; because whenever I fill I say "Eh, have not done this, I think I should focus on this so that the next time filling in at least I have somewhere to start". (JIDECO)

Though it was reportedly user friendly, some reported that there are at times periods when the organisation has not done anything and therefore there is nothing to report, and that there is nowhere to indicate that nothing was done in that quarter. There were also some other concerns that could lead to improvements of the database, if taken up.

"It is useful because you get to know what is going on but it takes time. The challenge is what do we do with that information, the punching is not a problem, but how do we use that information". (CDRN)

"That is also has the problem of giving the fill-ins only and it stops at that. It does not make somebody express herself/himself, for example if one has a challenge and you really want SAN! to know about it, one is limited. If there was a way for one to write a narrative – a brief one, that would be far better". (CEFORD)

One of the main problems for some was their computer network issues, as illustrated by the quote from KARUDEC: "Yes [it is user friendly], but after filling it when we send it, it does not go." Another reported that it has a lot of information that one has to keep filling. They would recommend deleting some sections.

"There are some sections that are not user friendly. I remember actually I almost sent an e-mail – I don't like it – the dates? Why do you need all those dates? I don't like the dates because I have to get – go to the email, look for the time I sent it, look for... ah!" (KADP)

6.3 Structural support by project coordinator, local project group, and lead organisations

Nearly all organisations, 27 (93.1%), have received support from within the SAN! structure: 26 (96.3%) from the SAN! project coordinator, 17 (58.6%) from the lead organisation, 5 (17.2%) from the local project group, 6 (20.7%) from other SAN! partner organisations, and 3 (10.3%) from the Dutch programme officer (EA, KADP, and KARUDEC). In this section, first are given some views on the support provided by the project coordinator and lead organisations, then the generally most valued support by the SAN! structure; after which the needs for support are specified.

Support by project coordinator and lead organisations

Organisations reported that support visits by the project coordinator helped in the formulation of the workplace policy, as he/she guided them on how to develop the workplace policy. Organisations continued to consult him/her about whether they were on the right track in the development process. The supervisory role of the project coordinator was also important when organisations were doing the budgeting; they would exchange information and see if things were working.

“He was helpful during the process of developments, we shared a lot and he would advise. He would pose questions, comments that made it possible to clean [improve] our policy”. (AMFIU)

Those organisations that said they had benefitted from the Lead Organisations mainly reported that they were given support by lead organisation focal point person, who actually physically came to share information with them and to guide them on how to develop their workplace policies. Additionally, some Lead Organisations were reported to help in providing condoms.

“She found us when we had already developed our policy; so she just went through and guided us and said this is okay, this one maybe needs some improvement, and all that”. (MADEFO)

“We have received only condoms and they did evaluation of our progress in as far as workplace policy is concerned”. (VEDCO)

Most valued support from SAN!

Several organisations value the SAN! capacity building workshops that guided them in the development and implementation of their workplace policy. This was echoed by partner organisations such as TOCINET, TAP, IRDI, BUSO, KARUDEC, LABE, TEDDO, VISSION TERUDO, and CEREDO.

“I can give a degree of the support they have given but as I informed you every support they have given us is quite tangible and I commend them because without SAN!’s support we wouldn’t have been having this policy in place. The process started with attending meetings called by SAN!, then you get the idea, then you develop that idea, you do a document, then the document becomes a policy, then you start implementing, then spotting the main programme, then allocating the specific parts. So all those are attributes to SAN! and they are also consistent in terms of giving us support whenever we call on them”. (EASSI)

Information sharing and reminders about how to develop and implement their workplace policies is what some organisations like MADEFO and NUWODU consider most useful:

“I consider their being in touch with us most often. Though they have not been here physically but they have been communicating to us most often. Almost on

weekly basis trying to ask us how far have you gone, can you tell us where you are stuck, how do we come in, can you send us a copy of whatever you have done so that we can see how we can help. So I consider really that they gave us a lot of input, they have been supporting us through keeping us in touch and reminding us most often". (MADEFO)

The database was also important for some organisations. Two organisations said it is the database they valued most; these are COU-EDU and WOUUNET. *"It simplifies work other than sitting to write all the activities that you have conducted. At least me I just enter."* Other organisations like EASSI and AMFIU mentioned a number of other items in terms of what SAN! has done for them, like providing the 'Twelve Box Framework' training, IEC materials, and video documentaries, as well as condoms.

"So SAN! has done a lot of things – you know IEC materials, we do not buy condoms, posters, the video, recently they gave us two video documentaries, which I organised staff to watch you know – they are now part of our assets. So they have done quite a lot and will still give more". (EASSI)

Need for more support

Respondents were asked what more support they wished to get. Several needs were expressed that included support visits by the project coordinator and lead organisation, especially for implementation of the workplace policy, more training, financial support, workshops at organisational level, and assistance with self assessment at the organisational level. LABE said they would like to receive support in the form of literature materials such as flyers. Some of the needs for support are illustrated in the quotes below:

"We need them to visit physically, not calling. At least once in a while, maybe like twice in a year or three times in a year, to come down and check on what is taking place because sometimes hearing on the phone is not very good. (KAPD) Most of the support has been at really a very high level like calling these workshops, but we need this support to come a bit down at an organisation level, like sit down an organisation for two days, go through the budget, go through the work plan, brainstorm on the various activities that can be done. Then also, since it is a pilot project, it would also be important that we have some budget support – direct budget support". (VEDCO)

6.4 Involvement with Applied Research (AR)

In-depth interviews show that respondents in 23 organisations (79.3%) have seen and read AR reports. However, only 6 (30.0%) out of 20 said they had used the AR reports: HN, COU-EDU, COU-TEDDO, CDRN, ACORD, and AMFIU.

About two-fifths of staff (41.1%) have been interviewed by the AR before; and 63 (26.7%) have seen one or more of the AR reports. Table 21 show the differences between levels of staff in terms of having seen AR reports.

Table 21: Seeing of AR reports, by staff level

<i>Level of staff</i>	<i>Seen AR report</i>	<i>Not seen AR report</i>	<i>All</i>
Managers	10 (25.0%)	30 (75.0%)	40
Support	14 (18.9%)	60 (81.1%)	74
Technical	30 (33.7%)	59 (66.3%)	89
Administrative	9 (31.0%)	20 (69.0%)	29
TOTAL	63 (27.2%)	169 (72.8%)	232

Surprisingly, relatively few managers have seen AR reports compared to technical and administrative staff. Support staff has seen relatively the least AR reports.

7 INTERNAL EVALUATION OF THE WORKPLACE POLICY

This chapter provides the information on internal reflection and evaluation processes, sustainability measures, and highlights points in their workplace policy that organisations and staff are proud of.

7.1 Plans for review of workplace policy

When asked whether they have plans to review their workplace policy, 14 (51.9%) out of 27 planned for such review. The main response was that policies will be reviewed to make them more user-friendly, and most reviews are planned annually. However, other organisations have no such plans for workplace policy review because they are not yet fully implemented, as the respondent of CEREDO said “...if the money comes then we shall see what to do. When the money is not there then there is no motivation to do it.” Examples of how, when, and why organisations will review their workplace policies are summarised in Box 1.

Box 1: Examples of planned reviews of workplace policies by NGOs

- To make it in line with the health insurance policy
- After putting it in practice, you find the shortcomings. I think we should be free to review it to serve us better
- Possibly when we have time, we have to sit down and review it with the board members and the executive board
- We have like two organisation reviews every year. And we feel that during each review we also have to review the policy
- Because we realized it is not only the staff that matters. If they have a new child at home, if the husband or a wife falls sick at home, or any member of the family falls sick, it will eventually affect us. We already agreed that it is a household issue; it's not necessarily a boardroom issue. So I would love to have three more persons on board to be provided for with medical care.

7.2 Sustainability measures

Most NGOs, 26 out of 28 (92.9%), have measures in place to sustain their workplace policy after SAN! donor support stops. Their sustainability strategies include training their own peer educators, writing proposals for funding, mainstreaming HIV/AIDS in other organisational budgets, and internal fundraising mechanisms.

Training Peer Educators

Because training and information sharing is a continuous process, some organisations have thought it wise to train their own peer educators who can carry on training other staff even when the SAN! project and its funding have stopped. It was on such grounds that one of the respondents said:

“...we have peer educators. They were trained at the end of last year. So without funding, I believe they can still continue to do their work. Even the sensitization – we have the HIV/AIDS focal persons in each and every health centre. So without the funding, we can still continue”. (ACORD)

Writing proposals for funding from other sources

Four organisations emphasised that they can use the workplace policy guidelines as presented in the GDG and BT to write project and budget proposals to other donors, for help in running the stipulated activities in the workplace policy. They consider the workplace policy in a way also to be a lobbying tool for funding, as was expressed in the following:

“Because by the time we were developing our policy, our manager was saying, apart from giving us a conducive environment for sensitization, treatment, and support, it is going to be a tool for lobbying. We shall use it as a tool, even the local government can also give us funds”. (KADP)

Mainstreaming HIV/AIDS in other budgets

Realising that dealing with HIV as an isolated issue requires more funds and may not be sustainable, some organisations have resorted to mainstreaming HIV/AIDS related activities.

“The way we were trained, but now having had the last training in Kampala last year, the mainstreaming programming, we realized it was in need of mainstreaming so that it does not stand alone. And having been taken as a cross cutting issue – HIV as a cross cutting issue. So we realized it is now important for incorporation into other programs and in other policies available at the office” (FURA)

Introducing an administrative fee for all project funding

VEDCO intends to ask all their funders to always add an administrative fee in the funds given them; this money VEDCO intends to direct towards activities of the workplace policy. In this way, they can sustain the workplace policy programs as other programs continue to receive funding, as their focal point person explains:

“We are developing a resource mobilization policy like, for example, before we jump into any monies from some donor, we must have our own condition that is to be filled like if we are saying that for all money we get there must be an administrative fee maybe of 5%. The same thing is going to apply to some of these things. There must be a contribution towards HIV/AIDS workplace policy support of a certain percentage which we have not yet agreed upon. But that means that every project that comes on board, as long as they are our projects, by policy there will be an allocation on the budget towards that cause”. (VEDCO)

Internal fundraising mechanisms

Those organisations that have embraced workplace policy are really committed to dealing with HIV/AIDS at their place of work, and this can be demonstrated in the levels and amounts of resources they have or continue to put towards it, as the following quote summarises:

“Quite almost everything, because even the computers we use here; the telephones we communicate between our partners when we are organising for such functions between EASSI, SAN!, service providers – we use telephone, we use what, we use stationary when we have such workshops like on VCT, we spend a lot of money on stationery while organising – you know and I allocate twenty hours for HIV/AIDS per month... All those are resources but we have created space for it and the budget line for it. We have a committee which meets every month to discuss the progress of the workplace policy implementation”. (EASSI)

Other organisations are involved in various methods of resource mobilization to fund workplace policy as a sign of commitment towards achieving the goal to deal with HIV/AIDS at

the workplace. For example, BUSO Foundation is looking to farming as an alternative source of resource mobilization, as the Executive Director says, *“We are venturing into cultivation of cereals to improve on our source of finances and this will help us meet some of our set objectives.”*

Such internal mechanisms for raising funds may include members' own contributions, as it is reportedly done in AMFIU:

“We have some other avenues of getting some internally generated income. We charge membership fee, we have publications which we sell, and we are trying to develop our resource centre so that it can earn something”.

7.3 Self reported good practices

In IDIs respondents were asked what they considered to be especially good in their workplace policy document, or activities that other organisations can learn from. Managers highlighted several points, including having an focal point person with a clear job description, openness to discuss HIV/AIDS issues, the participatory nature of workplace policy development, reduction of stigma and discrimination, and recognition that HIV/AIDS is a workplace issue.

Having an HIV and AIDS focal point person with clearly stated duties

Apart from having an operational workplace policy, organisations are happy that they have focal point persons who are the day to day coordinators of HIV/AIDS activities within the organisation, enabling some significant achievements to be realised so far. EASSI is proud to have clearly stated duties for the focal point person, who receives support from the management.

“The duties of focal point person are clearly stated in workplace policy; unlike in other organisations, the focal point person is appointed and duties not clearly stated. I am proud that it now forms part of my job description, unlike prior when it was under human resources. I am happy that we have implemented most of the activities we intended to do”.

Openness about HIV/AIDS

Openness about HIV and AIDS in the workplace, especially in the form of staff discussing HIV/AIDS issues amongst themselves, was regarded as very positive. In this way, people can share information with regards to service provision, and what one ought to do upon discovering an HIV positive diagnosis. Even the VCT uptake and condom usage/demand increased as a result of the workplace policy:

“...I am proud of the fact that now the staff are open. Ever since we started discussing these things, they are more open and of recent they are willing to go and test; I am not very sure if they test, whether they will declare their results or not. But I am one of those who is ready now. If staff in other organisations can emulate this, then it is a good practice”. (EASSI)

The participatory nature of workplace policy development

Organisations are proud that they involved everybody in the development of the workplace policy, and feel that the workplace policy is embraced by all the staff and therefore owned by all, which can lead to its sustainability. This also facilitated easy implementation because the workplace policy contains the views of the majority.

Recognizing HIV/AIDS as a workplace issue

NGOs expressed that they value the fact that staff acknowledge HIV/AIDS as a workplace issue, and that they no longer feel threatened with the loss of their job if they should be diagnosed HIV positive. They are satisfied that in their organisation, at recruitment stage, there is no discrimination based on one's HIV status.

Maintaining confidentiality

Managers in IDIs reported that they are satisfied that staff recognize that openness about HIV/AIDS does not necessarily mean that they cannot keep their HIV status a secret. The guidelines for disclosure are such that staff have the liberty and freedom to choose whom to disclose to so as to access ART through the workplace policy initiative. AMFIU is proud of their contingency funds that ensure that people on ART do not have to disclose.

“When someone finds out that he/she is infected, she/he is free to talk to anyone of their choice. But in case of paying for the treatment, money passes through the manager to pay for the bills. But I [focal point person] have signed money for staff treatment twice so that others don't know who is taking the money. In case an infected staff needs money for treatment bills, I sign on that person's behalf and hand over the money to him/her, then get a receipt and I account for it”. (KADP)

Having a stand alone or incorporated workplace policy

Having a stand alone workplace policy is in itself perceived by some managers as good practice. Even if only a few activities are being implemented, the information sharing, and creation of an enabling environment for people to work without fear of losing their jobs due to HIV status, have been mentioned as strong points in favour of an organisation having a workplace policy. To others, they are proud that their workplace policy is being incorporated into the general policy of the organisation, which enables it to be implemented with minimal resources as it can be mainstreamed in the budgets of other activities.

Involved management

NGOs were also satisfied at having involved the board and management staff of their organisation as part of the workplace policy committees, because then the workplace policy has more chance to succeed.

“The biggest thing is to involve the big people because that is where the problem comes from. The moment you have the support of management and board then it cannot fail. But what happens is that sometimes you find like you are the focal person and it is only you who is looking at it working while every other person does not want even to listen”. (AMFIU)

Health insurance cover for spouse and close family

To have health cover not only for staff but for their immediate family is something that most staff appreciate, and some NGOs that have such arrangements think that this kind of initiative can be emulated by other organisations. This has financial implications for the organisation, but still the organisation can do a lot in so far as provision of referral services is concerned.

Staff's opinion on workplace policy strong points

We also asked staff what they liked most about their organisation's workplace policy and 153 reported. What was most often mentioned was job security, mentioned by 36 staff (23.5%), followed closely by care and support for staff with HIV, mentioned by 34 (22.2%). Staff also liked the increased awareness about HIV and AIDS (n=29, 19.0%), the fact that there was less stigma and discrimination (n=24, 15.7%), and the openness in the workplace to talk about HIV and AIDS related issues (n=22, 14.4%). Seven staff (4.6%) mentioned they liked that family

members were also cared for in their workplace policy. These points concur with the issues that managers are proud of.

7.4 Identified challenges

Most organisations (n=25, 86.2%) said they face challenges in the implementation of their workplace policy. The main reported challenges encountered were related to funding, time, and turnover of staff. Most organisations reported that not all activities they wanted to do could be implemented as they lacked funding, and so could only carry out those that needed less or no funding. They felt that donors' responses to their requests regarding workplace policy funding were not given much attention.

"The challenges now are like the awareness raising workshops for staff and family members. Then the issue of training the HIV/AIDS focal person and then the what – because I would suggest the money which we would get from Cordaid maybe we could leave it for treatment of people who may be willing to reveal their HIV/AIDS status. Then the other activities we could look for it elsewhere".
(NUWODU)

There were also reported time constraints in executing the workplace policy activities. Implementing and overseeing workplace policy activities was an added workload to already busy focal point persons, as illustrated in the quote below:

"The challenge I even told you one which I am going to tell you is the time, because compromising with the work I do everyday in the office. Much as the organisation encouraged you to go ahead but they would want also to know at the end of the day what have you done for the organization". (LABE)

There was also the reported challenge of high labour turnover, especially in the loss of those focal point persons who were already trained by SANI!. Their replacements would also need training to implement the workplace policy activities effectively.

8 CONCLUSIONS AND RECOMMENDATIONS

In this concluding chapter both the promising practices and the challenges of workplace policy implementation are highlighted, as gathered from the findings of this study. In this chapter the NGOs will not be mentioned by name. Promising practices can serve as examples and motivation for other NGOs, as well as providing a basis for recommendations. Challenges (already solved by some organisations) have to be faced, and will be addressed in the recommendations to different actors: organisations, Uganda project level, and SAN! donors respectively.

8.1 Promising practices

An examination of the SAN! partner organisations' implementation of workplace policy programmes revealed a number of promising practices that may lead to effective workplace policies, using criteria such as participation, ownership, sustainability, implementation of activities, and reaching many people.

Making the policy available and known to all staff

It is a good practice to make the policy available to all staff, as many organisations do, in both hard and soft copies. Some organisations realized not all staff can read English and have therefore translated the workplace policy into the local language. Officially, the launching of a policy is a good way to let everyone know about it, as one organisation did. Some organisations realized that continually discussing the policy in routine meetings is a good way of keeping staff informed and up to date, as well as informing newly recruited staff, and increases understanding of the contents.

Starting workplace policy activities before donor funding is received

It is a good practice that all (but one) organisation reported implementing workplace policy activities such as awareness raising and sensitization on preventive measures and stigma reduction even before they had received donor funding. They started activities that cost no or little money and were inventive in securing access to free services for IEC, VCT, condoms, and ART. Other organisations even implemented more costly activities like obtaining training from outside facilitators with their own money.

IEC materials on HIV and AIDS

It is good practice to have widely available IEC materials on HIV/AIDS in the workplace, in the form of posters, pamphlets, newspaper clippings, magazines, and videos, as it was found that staff appreciate the materials and nearly all make use of them.

Making condoms available for staff

Facilitating access to condoms for staff is a good practice conducted by more than half the organisations. To put these condoms in easily accessible but private places is the best way, since one of the reasons for not buying condoms from shops is that people want more secrecy. It was good practice that some organisations made them available in different places, and in male and female toilets.

Open discussions on HIV and AIDS

It is good practice that staff in most organisations now discuss HIV/AIDS related issues freely amongst themselves. Through this openness they can share information and sorrows.

Discussing HIV and AIDS issues and the workplace policy in routine staff meetings is also good practice.

Reaching over the workplace border

A promising practice that many staff and organisations are involved in is spreading the benefits of the workplace policy out to the wider community. Staff discuss workplace policy issues, including insights from training, with family, friends, and neighbours. One staff member reported sharing the information in his church (and thus reaching a large audience). It is a good practice that staff take the condoms provided for them in the workplace not only for themselves but also for others – their family, friends, and neighbours – who for one reason or another – money, shyness, or seeing no need – cannot or do not access them easily.

Inviting neighbouring communities to VCT days, as some organisations did, is good practice, with promising effects of higher VCT figures.

Linking and learning

A very promising development is that through the SAN! project, all participating organisations are networking amongst themselves and beyond for information sharing, access to free IEC, condoms, training, and referral services.

Job description with time allocation for focal point person

A promising practice was a clear job description for the focal point person, with time allocation reported by one organisation.

Sustainability measures

All sustainability strategies represent good practice, including integration of the workplace policy into organisational work plans and budgets, writing proposals for funding from other donors (using the guidelines from SAN! GDG and BT), and the internal training of peer educators.

8.2 Challenges in the implementation of workplace policy

Several challenges were identified in the implementation of workplace policy programmes by partner organisations, as explained in 7.4, and some challenges are identified by the researchers.

Late or no funding by the donor

The late or absent funding of budgets by SAN! donors delayed implementation of workplace policy activities. Most organisations started to carry out those that needed less or no funding, but this could lead to loss of momentum and loss of enthusiasm among managers and staff.

Time constraints

There were time constraints in executing the workplace policy activities. Implementing and overseeing workplace policy activities was an added workload to already busy focal point persons, while other staff did not always have time to participate in workplace policy activities.

High staff turn over

High staff turn over in some organisations has affected the implementation of workplace policy activities. As some new staff are not very familiar with SAN! project activities, they need to be taken on board to be on the same footing as other staff. It was noted that the effect is felt more if the focal point person or the director leaves the organisation.

Unclear position of lead organisations

Lead organisations seemed not to be well facilitated to follow up SAN! activities, e.g. dissemination of reports and other important information, and some staff seemed not to know what 'lead organisations' meant, which in some instances caused controversy.

Signature of organisations

Faith based organisations (FBOs) have objections against discussing some issues against their faith, including the possibility/reality of premarital and extra marital relations. Prevention in such organisations of sexual transmission of HIV is limited to abstinence and faithfulness. Talking about condoms, let alone providing them in the workplace, is considered inappropriate and unneeded. Only one FBO supplies condoms in the workplace for staff.

8.3 Recommendations

To organizations

- Continue with internal awareness raising on the workplace policy and IEC, focusing on issues which staff would like to know more about, as were identified in this report: among others related to ART and PMTCT. Refresher trainings should also be organised regularly because of new staff. Pay special attention to include support staff in training.
- Provide all new staff with a copy of the workplace policy, and explain the contents.
- Start/continue implementing workplace policy activities that do not require much funds instead of halting everything waiting for funding. For those just starting the workplace policy process: categorize specific activities in workplace policy to be implemented and accomplished with clear timeframe and targets, such that those activities requiring less funding can be started while waiting for funds to implement those that are more costly.
- Reduce work related risk of HIV infection. Health services related risk should be minimised by always having protective gear available. Provide all office cars with well equipped first aid boxes. Maintain office cars well to reduce potential traffic accidents. Furthermore, during all duty travel, all staff should be encouraged to carry condoms – this study showed that most staff who felt at risk had felt so because of sexual temptations during duty travel.
- Share with and learn from other partner organisations. For instance, organise exchange visits.
- Link with services, IEC, and training institutions. Be keen to identify free services.
- Specify the job description of the focal point person with attached time allocation.
- Internally share what has been gained in training of individual staff. For instance, internally train more peer educators.

To Uganda project coordination (project coordinator and lead organisations)

- The project coordinator should involve more stakeholders, especially the government and other senior HIV/AIDS related organisations dealing with HIV policies and funding like UAC, AIC, and TASO, to popularize the project.

- The project documents GDG and BT should be better disseminated, and continued sensitization and explanation on them should take place during support visits and training.
- More support supervision/visits should be emphasized to motivate and support those organisations that have not done much in the way of workplace policy implementation. Possibly involving neighbouring peer NGOs which have performed well with workplace policy is good practice.
- More clustering of regional SAN! partners should be considered. E.g. Karamoja can have its own lead organisation, considering the distance involved between eastern and northern partners.
- There should be a rotational mechanism for partner organisations to become lead organisations, rather than one organisation being the only lead organisation in the region.
- The term 'lead organisation' can be changed; this is because it seemed to be understood and interpreted to mean that one organisation is a leader of the other.
- In the database template, add a space for narrative, where organisations can pose questions or insert details.
- The applied research team should be given a role in AR report dissemination. Dissemination should not stop at giving out reports, but also be done through workshops, dialogue, and other publications.

To SAN! donor level

- Funding agencies should screen in a timely fashion and release funds promptly to allow NGOs to implement their workplace policy programme activities.
- New programme managers should be initiated in workplace policy at the start of their job, either by their superiors, the previous programme manager, or the SAN! coordinator in the Netherlands.
- The project leadership in the Netherlands should be at the forefront to identify, link, and even negotiate for further/continued funding from other donors, since they are better placed in that respect.
- Lessons learnt and identified good practices from this project should be shared with other agencies/countries.

9 ANNEX 1: Data collection tools

SAN! UGANDA PROJECT - Managing HIV and AIDS in the Workplace IDI Instrument for measuring the implementation and effects of workplace policy

Background Information

Name of organisation:

Number of staff: # male; # female

Employment terms staff: # fixed contract; # temporary contract; # volunteers

SAN! donor:

Other donors:

Position of all respondents: a) b) c)

Sex of all respondents: a) b) c)

Date of interview:

Name interviewer(s):

Duration of interview:

Introduction

My name is from the research team of the SAN! Uganda project Managing HIV and AIDS in the Workplace. We have been to your organisation before (Phase 1 and 2) to study how your organisation is progressing in relation to workplace policy development and implementation. We are here in the Third Phase to study the implementation and effects of your workplace policy. I hope I can ask you some questions. Maybe, if you do not have the answers to all questions, you could refer us to someone within the organisation who knows. All you say is kept confidential so feel free to share with us your experiences. To not forget any important detail you have shared with us, I ask you whether we can tape record this discussion.

A: Development and Status of Policy

1. What is the status of your workplace policy?

Final

Draft back from SAN! with feedback

Draft submitted to SAN! (*when*)

Operational (*since when*)

2. Under what arrangements was your policy developed?

(a) Under SAN! arrangements

(b) Other arrangements (*specify*)

3. How would you describe the format of your workplace policy?

(a) Is it a stand alone policy?

(b) Is it incorporated in HR or health policy? (*specify*)

(c) What are the reasons for having either a stand alone policy or having it incorporated? Advantages of one compared to the other.

(d) Was it a point of contention? If so, what were the discussions for one or the other?

B: Contents of the workplace policy

Introduction: We are not asking for all contents, this was done in the first and second phase – this phase is about implementation and effects.

4. What do you consider to be special/particular in your workplace policy?

(a) Compared to other SAN! partners' policies

- (b) Anything left out that you think will later be included

5. Are there issues that raised arguments or discussions? Which issues? *Probe on (if not mentioned already):*

Condom use

Access to treatment

Who to be covered in workplace policy

If yes, what were the discussions and arguments, raised by whom, and what consensus did you come to?

C: Dissemination of the workplace policy

6. How did you disseminate your workplace policy to staff? *Probe*

(a) Was it officially launched? (*How*)

(b) Is it translated? (*Into which languages*)

(c) Is it on the notice board, or in the HIV/AIDS corner, or Resource Centre?
(*Observe*)

(d) Did each staff get a copy, hard or soft? (*If hard, ask to see the workplace policy*)

D: HIV and AIDS Focal Point Person

7. Who is the HIV focal point person in the organisation?

(a) Sex

(b) Position (*human resources, communication, programme officer, etc.*)

(c) When appointed

- How long on the job?

- Is the person the first focal point person or were there others before?

- Why is the previous focal point person not on the job anymore?

(d) Training received in workplace policy

(e) Duties and activities of focal point person

(f) Time available for the workplace policy

E: Training of HIV focal point person, director, managers

8. Which trainings have you attended in relation to workplace policy? (*Ask for every respondent*)

(a) Organised by SAN! and by others (*for SAN! probe on training according to list*)

1) Directors

2) workplace policy development

3) Peer education

4) 12 Box Model

5) Capacity building of lead organisations

6) Database

7) Good donorshop guidelines

8) Other

(b) Usefulness of the trainings – how did you apply the knowledge and skills you gained?

F: Implementation

9. Which activities of the workplace policy are being implemented? (*Probe for details & see probes case studies*)

(a) Awareness raising on the workplace policy, HIV/AIDS

(b) Sensitization

(c) Prevention

(d) Condom distribution **SEE PROBES**

(e) VCT promotion and access – Where to access?

- (f) Disclosure and confidentiality **SEE PROBES**
- (g) Stigma reduction **SEE PROBES**
- (h) Non discrimination **SEE PROBES**
- (i) Gender concerns **SEE PROBES**
- (j) Access to treatment **SEE PROBES**
- (k) Care and support
- (l) Training of staff (by whom, topic, who were the trainers, etc.) **SEE PROBES**
- (m) Counselling – by peers, external counsellors

G. Funding and expenses

10. So far how much have you spent on the workplace policy?
Probe for spending for by specific activities, including launching, translating
11. What is the source of funding for the workplace policy activities? And how much do you get from each source?
- (a) Dutch and/or other donor and/or own resources
 - (b) Have you received funding from the Dutch donor?
 - (c) Budget for workplace policy submitted when? When SAN! funds received?
 - (e) Discussions with SAN! donor about the budget? Problems? Who is involved in the discussions?
 - (f) How much own resources available

H. Effects

12. What noticeable results do you attribute to workplace policy? (*Probe on each item and how it is demonstrated*)
- (a) Level of awareness raised on HIV and AIDS
 - (b) Stigma reduction **SEE PROBES**
 - (c) More openness to discuss issues related to HIV and AIDS
 - (d) Staff disclosed HIV positive status **ASK PERMISSION FOR CASE STUDY**
 - (e) VCT uptake increased (*how do you know?*)
 - (f) Staff on ART – how did the person disclose? **ASK PERMISSION FOR CASE STUDY**
 - (g) Raised staff performance/less absenteeism (*how do you measure?*)
 - (h) Linking and learning. *Probes:*
 - Who are the partners they network with? SAN! partners, and others, services providers etc. (*Name them*)
 - What activities link them – what do each provide in the linkage: services, IEC, training, condoms, etc.
 - Who established the links, how, when? Who maintains the links?
 - Money involved – or reciprocity
 - What have they learned from each other?
 - (i) Staff takes the condoms **SEE PROBES**
 - (j) Workplace more gender sensitive **SEE PROBES**
 - (k) Involvement of family members in HIV and AIDS discussions at the workplace
 - (l) Resource mobilisation / budget for HIV and AIDS interventions
 - (m) Any **negative effects** of the workplace policy?

I. Good Donorship Guidelines (GDG) and Budgeting Tool (BT)

13. Do you have knowledge about the SAN! GDG document? (*Show the document*)
- (a) *If Yes*, How did you get to know about it? Through SAN Coordinator, lead organisation, program officer Netherlands, local project group, website, donor organisation, other organisations?
 - (b) How did you get it? Hard copy or soft copy
 - (c) Did you read the whole document?
 - (d) Have you shared it with others in the organisation?

14. How useful were the GDG to the development and implementation of your workplace policy? How did you use them? Which particular part did you use?
15. Do you remember any of the principles stated in the document? Name the principle. (*We know there are many, and maybe you do not remember all.*)
16. Do you understand the principles contained in the GDG – and do you think they are appropriate? *Interviewer to carry a list and go one by one to probe:*
 - Donor's share
 - Recognition of HIV/AIDS impact or performance
 - workplace policy cost effective method
 - Donor support
 - Open communication
 - workplace policy to fit organisation's context
 - What should be contained in policy.
17. Are there any principles that you think can be deleted from or added to the ones contained in GDG?
18. Do you remember any of the commitments by the donors as stated in the GDG document?
19. Do you understand the commitments by the donors, as specified in the GDG? *Interviewer to carry a list and go one by one to probe the key commitments:*
 - Donors' funding
 - Insurance scheme
 - Technical and financial support
 - 4% budget of total payroll,
 - Short term funding provision of funds for ARVs
 - Advocacy to other donors
 - M&E
20. Are there any commitments that you think can be deleted from or added to the ones contained in GDG?
21. (*Now we have gone through the principles and commitments*) What is your opinion about how the donors have lived up to their principles and commitments? Were these commitments met?

Really probe for answers:

 - What do you think of the 4%?
 - Was the budget within the 4%?
 - If not, what are the highest budget lines?
 - Did they receive feedback from the review committee also on the budget?
22. Have you seen and read the document entitled 'What's it likely to cost?' (*show the document*) about how to make budgets for your workplace policy?
23. *If yes:* How useful was this document to you? Did you use it to make your budget? How did you use it? What in particular was useful?
24. If no, what other guideline(s) did you use (if any) to make your budget?
25. Have you used the GDG to start a dialogue with other donors?

J. M&E and Project Database

25. What monitoring and evaluation tools are being used to assess the process and impact of the activities?
 - (a) SAN! tool (*how is it useful*)
 - (b) Own tool (*ask to see*)
26. Do you access the SAN! database?

If Yes: (a) Who fills?

 (b) Is it user friendly?

 (c) Is it useful? In what way?

If No: Why not?

K. Support from SAN! structure in development and implementation of workplace policy

27. Did you receive any support in the development and implementation of your workplace policy? *Probe for:*
 - From whom: project coordinator, local project group, lead organisations, the Dutch donor programme officer, SAN! coordinator Netherlands
 - Type of support
 - How often
 - Feel that support was/is adequate
 - What more did you expect

L. Evaluation

28. Are there some specific activities in the workplace policy that face(d) challenges during implementation? Name them, explain why (lack of funding?).
29. What plans are put in place to overcome them?
30. Have you planned for review of your workplace policy, or have you already reviewed it? When and how?
31. What sustainability approaches/strategies have been put in place?
 - (a) Exit strategy but not stopping activities. (Pay from own budget, put workplace policy activities in general plan and budget)
 - (b) Write proposals for funding from other sources
 - (c) Others/Specify
32. What do you consider to be good practices by your organisation that others can learn from?
33. What have you valued most in the support from SAN!/? (*Probe also for GDG*)
34. What do you recommend to the local SAN! project coordinator, local project group, lead organisations, SAN! Netherlands donors, to better support the process of workplace policy implementation?

M. Applied Research

34. Were you involved as a respondent in the previous phases of AR? (*Ask all respondents*)
 - (a) Phase I
 - (b) Phase II
35. Have some reports and factsheets on AR been disseminated to your organisation? *If yes:*
 - (a) Which reports (Phase 1 case studies, Phase 1 staff survey, Phase 1 factsheets, Phase 2 implementation report, Phase 2 Factsheets). Soft or hard copy?
 - (b) Have you read them / some
 - (c) Did you / the organisation use them (*how*)

- (d) Where is it kept?
- (e) Staff access to reports?

36 Do you have any recommendations to the AR team?

N. Conclusion

37. What are you proud of in your workplace policy?

O. Observations

Observations during visit: condoms, documents, HIV and AIDS notice board, AIDS corner, etc.

SAN! Uganda Project Phase 3
Survey of staff measuring implementation and effects of workplace policy

Interviewers name:

Date interview:

Start time interview:

Introduction:

I am from the research team of the SAN! Uganda project of HIV and AIDS workplace policy development – my name is We have been to your organisation before. We are here to study the implementation and effects of the workplace policy in the Ugandan organisations. We therefore want to talk to different staff members in all the 76 organisations in the project and hear their experiences. You were selected to be one of them. I hope I can ask you some questions. I ensure that all you say is confidential and will not be shared with your organisation. I will not write your name on the form.

A. Personal information

1. Sex:
 - 1) Male
 - 2) Female
2. Age:
3. Marital status:
 - 1) Married
 - 2) Single
 - 3) Widow / widower / divorced / separated
4. Job title:
5. Job category (*filled later by interviewer*):
 - 1) Management
 - 2) Support
 - 3) Technical
 - 4) Administrative
 - 5) Other
6. Do you have a fixed or a temporary contract, or volunteer?
 - 1) Fixed
 - 2) Temporary
 - 3) Volunteer
7. How long have you been working in this organisation?
8. How many years have you held this current job?
9. Do you go out for fieldwork or seminars where you have to stay overnight? Yes / No
If yes: How often in a month does this happen? (If per two months, note down)

B. Knowledge on HIV and AIDS workplace policy

10. Are you aware whether your organisation has a workplace policy for HIV and AIDS? Yes / No
If yes: How did you get to know about the workplace policy?
 - 1) Involved in development
 - 2) Got a copy
 - 3) Official dissemination to all staff

4) Other (*specify*)

C. Prevention

11. Have you ever been at risk of contracting HIV in the workplace or during travel? Yes/No
If yes: Why and when?

12. What measures do you personally take to prevent HIV infection? (*multiple response*)

- 1) Abstinence
- 2) Being faithful
- 3) Using condoms
- 4) Other (*specify*)
- 5) None

D. VCT

13. Do you think everyone should know their HIV status? Yes / No

14. Have *you* ever gone for VCT? Yes / No

If yes: How many times?

When was the last time?

Was this because of the workplace policy or your own initiative?

- 1) workplace policy
- 2) Own initiative
- 3) Other (*specify*)

E. Disclosure

15. Is someone in your organisation HIV positive? Yes / No / Don't know

If yes: Has the person disclosed his/her status to you? Yes / No

16. Is someone in your organisation on ART? Yes / No / Don't know

If yes: Has the person disclosed this to you? Yes / No

17. If you tested HIV positive, to whom would you tell this within the organisation (*multiple response*):

- 1) No one
- 2) The head of the organisation
- 3) Your immediate supervisor
- 4) The HIV focal point person
- 5) Your peers
- 6) Everyone
- 7) Other (*specify*)

If would not disclose: Why?

If would disclose: Why the particular person(s)?

F. Attitudes towards PLHIV

18. What is your view if a person is infected with HIV?

- 1) Is it *always* the fault of the person
- 2) *Sometimes* the fault of the person
- 3) *Never* the fault of the person?

If sometimes: Please explain

19. Do/would *you* (*ask the question according to whether there is an HIV positive person*) feel comfortable working next to a person with HIV? Yes / No

If no: Why not

20. (Ask the question according to whether there is an HIV positive person) Are / would people with HIV or AIDS (be) treated differently (stigmatization / discrimination) in this organisation? Yes / No
If yes: How / why
21. Do you / would you treat co-workers with HIV or AIDS differently (stigmatization / discrimination)? Yes / No
If yes: How / why

G. Preference for place of ART

22. *If you would need ART, where would you prefer to get this? (Interviewer to mention options)*
- 1) Private for a fee
 - 2) Free services by government
 - 3) Free by service organisation,
 - 4) Other (*specify*)
- Why would you prefer this place?*

H. workplace policy activities and participation by respondent

I would now like to ask some questions about which activities related to the HIV and AIDS Workplace Policy have taken place / are taking place in your organisation, and about what you have participated in. I am going to mention various possible activities.

23. Awareness raising / sensitization on HIV and AIDS? Yes / No
If yes: How (multiple response):
- 1) Routine discussions
 - 2) Training
 - 3) Other (*specify*)
- Did you participate? Yes / No
24. Provision of IEC materials? Yes / No
If yes: Do you ever make use / look at the IEC materials in your organisation (posters, Aids Corner) Yes / No
25. Are condoms provided in the workplace for staff? Yes / No / Don't know
If yes: Where?
Are they always available? Yes / No
Did you ever take some? Yes / No,
If yes: When was the last time?
Do you use them yourself – or for others? (*Explain*)
26. Do you buy / get condoms from places other than the workplace? Yes / No
27. Does the organisation promote access to VCT? Yes / No
If yes: How (multiple response):
- 1) Information
 - 2) Staff session
 - 3) Family day
 - 4) Other
28. Do you know where to access VCT? Yes / No
29. Do they take measures against discrimination / stigmatization of PLHIV? Yes / No
If yes: What measures

30. Do they promote disclosure of HIV status? Yes / No
If yes: To whom do they advise to disclose?
31. Do they ensure confidentiality of HIV status and being on ART? Yes / No
If yes: How
32. Do they pay attention to gender in their HIV and AIDS workplace policy? Yes / No
If yes: In what ways
33. Do the staff have access to ART through the organisation? Yes / No / Don't know
If yes: How
 1) Insurance
 2) Referral to free treatment
 3) Organisation pays for services
 4) Other (*specify*)
- If yes: Who is covered by access to treatment with ARV?*
 1) Staff only
 2) Staff and one dependent
 3) Staff and... (*specify*)
 4) Don't know
34. Do you know where to access ART? Yes / No
35. Do staff contribute to (general) medical treatment? Yes / No
If yes: How much (indicate: Month, Year)
36. Does / will the organisation support staff who are HIV positive? Yes / No
If yes: In what ways

I. Training

37. Have you participated in any training / seminar(s) organised by your organisation on HIV and AIDS? Yes / No
If yes: What was the content of the training?
 Do you share the information from the training with others? Yes / No
 With whom (*probe for outside workplace*)

J. Effects of workplace policy

Questions on whether the workplace policy have any effect on you personally? Interviewer, make clear this refers to how it has changed – not how it was already

38. Has the workplace policy contributed to your increased knowledge on HIV and AIDS?
 Yes / No
If yes: What have you learned?
39. Do you feel you have enough knowledge about HIV and AIDS? Yes / No
If no: What would you like more information on?
40. Did the workplace policy change your attitude towards PLHIV? Yes / No
If yes: How
41. Has the workplace policy changed your openness to discuss / talk about HIV and AIDS?
 Yes / No
If yes: Please explain
42. Has the workplace policy changed your attitude towards disclosing your status if you yourself would be HIV+? (*i.e. would you disclose now?*) Yes / No / Would have already disclosed

43. Did the workplace policy motivate you to go for VCT? Yes / No / already went before

44. Do you now feel supported by the organisation if HIV would affect you or your family?
Yes / No / Not applicable
If yes: In what way?

45. Do you now feel confident of job security, even if you would be HIV+? Yes / No

46. Do you think the workplace policy also has negative effects? Yes / No
If yes: Please explain

K. HIV Focal Point Person

47. Do you know who the HIV focal point person is in your organisation? Yes / No

48. Do you know what the focal point person does? Yes / No
If yes: Which activities

L. Applied research and dissemination

50. Have you been interviewed by the AR team before? Yes / No
If yes: When

51. Have you seen any report of the applied research? Yes / No
If yes: Which report?
1) Case study
2) Survey of staff
3) Phase Two report
4) Other (*specify*)

M. What is good about workplace policy

52. What do you personally like most about the workplace policy in your organisation (if anything)?

End

Time of interview:

Total time used for interview:

Do not ask these questions – fill them later

Name of organisation:

Number of staff: # male, # female

workplace policy status: 1) final, 2) draft

Status of implementation of activities: yes / no

Type of policy: 1) stand alone, 2) part of human resources / health policy

10 ANNEX 2: Background of organisations in Phase Three

Organisation		Location			Signature		Donor	Funds for WPP from	
Acronym	Full name	Centre	N / E	West	FBO	Sec		SAN! donor	Other donor
ACORD HASAP	-	X				X	O	X	
ACORD GULU +	-		X			X	O		
AMFIU	Association for Micro Finance Institutions in Uganda	X				X	O		
BUSO #	-	X				X	O		
COU EDUC	Church of Uganda		X		X		I		
CDRN +	Community Development Resource Network	X				X	C	X	X
CEFORD	Community Empowerment for Rural Development		X			X	O	X	
CEREDO	Catholic Education Research Development Organisation		X		X		I		
DETREC +	Development Training and Research Centre	X				X			
EASSI	East African Sub- Regional Support Initiative	X				X	C	X	X
EA #	Environment Alert	X				X	O		
FHRI	Foundation for Human Rights Initiatives	X				X	H		
FIDA	The Uganda Women Association – Uganda	X				X	O		
FURA	Foundation for Rural Advancement			X		X	O		
HEALTH NEED	-		X			X	I	X	
HOSPICE +	Hospice Uganda	X							
IRDI	Integrated Rural Development Initiatives	X				X	C		
JIDDECO	Jinja Diocesan Development		X		X		C		

	Coordinating Organization								
KADP	Karamodja Argro-Pastoral Development Programme		X			X	C	X	
KALI	Karambi Action for Life Improvement – Kasese			X		X	O		
KARUDE C	Kagando Rural Development Centre			X	X		O	X	
LABE	Literacy and Adult Basic Education	X				X	O		
MADEFO	National Agricultural Movement of Uganda		X			X	C		
NOGAMU +	National Organic Agriculture Movement of Uganda					X	H		
NUWOD U	National Union of Women with Disabilities in Uganda	x				X	C	X	
SSD	Social Services and Development		X		X		C		
TAP	TESO AIDS Programme		X			X	I		
TEDDO	Church of Uganda Teso Diocese Planning and Development Office		X		X		I		
TOCINET	Tororo Civil Society Network		X			X	O		
TPO +	Trans-Cultural Psycho-Social Organization	X				X	C		
UFFCA+	Uganda Fisheries and Fish Conservation association	X				X			
UJCC	Uganda Joint Christian Council	X			X		C&I		
VEDCO #	Volunteer Efforts for Development Concerns	X				X	O&H		
VISION TERUDO	Vision Teso Rural Development Organization		X		X		I	X	X
WOUGNET	Women of Uganda Network	X				X	H		
		14	12	3	8	21		9	3

IDI only
+ Survey only

O = OXFAM/NOVIB
I = ICCO
C = CORDAID
H = HIVOS

11 ANNEX 3: Reported activities in organizations

Name	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
ACORD #	X	X	X			X	X	X	X	X	X	X	X	X	X	X				X
AMFIU	X					X														
BUSO	X								X											
COU EDUC	X	X					X					X								
CDRN # +	X	X	X			X	X	X	X			X	X							
CEFORD #	X	X	X			X	X		X	X	X	X	X	X	X	X			X	X
CEREDO	X	X				X			X	X	X	X	X							
EASSI # +	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X		X	
ENVIRON A	X	X	X	X				X	X				X		X	X				X
FHRI	X	X				X		X	X			X		X		X				
FIDA	X								X											X
FURA	X	X				X	X	X						X						
HEALTH N #	X	X					X	X	X	X	X	X	X	X	X					X
IRDI	X					X		X					X							
JIDECO	X	X							X					X						X
KADP#	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X	X
KALI	X	N A	X	X		X	X	X	X			X	X							X
KARUDEC #	X	X	X	X	X				X	X	X	X	X	X	X	X			X	X
LABE	X				X	X	X	X			X	X	X							
MADEFO	X		X				N A	X		X			X				X			
NUWODU #	X	X				X	X	X	X	x					x					
SSD																				
TAP	X							X												
TEDDO	X	X				X			X											
TOCINET	X	X				X		X	X	X										
UJCC	X	X	X						X			X	X	X	X					
VEDCO	X	X						X				X	X		X				X	X
VISION T # +	X	X	X	X		X	X	X	X	X				X	X					X
WUGNE T	X					X		X			X	X	X				X			
	2 8	19	1 1	6	3	1 7	12	1 8	1 9	1 0	8	1 5	1 6	1 0	9	6	3	1	7	9

Received funds from SAN! donor

+ Received funds from other donor

- A. Awareness raising and sensitization
- B. Internal routine discussions
- C. Internal training for all staff
- D. Training for all staff by external trainers
- E. First aid box
- F. HIV/AIDS Notice board

- G. AIDS corner
 - H. Condoms for staff
 - I. VCT promotion
 - J. Guidelines for disclosure (certain person)
 - K. Guidelines for confidentiality
 - L. Stigma reduction measures
 - M. Non-discrimination measures
 - N. Attention to gender
 - O. Access to free ART
 - P. Arrangement with private facility for ART
 - Q. Insurance including ART
 - R. Staff pay part of salary for health/insurance
 - S. Measures for care and support
- Counselling