

WHAT'S IT LIKELY TO COST ?

**A Guide to Budgeting for Managing
HIV and AIDS in the Workplace**

**an addition to the guidelines 'Good Donorship in an Time of AIDS',
to be used in pilot projects in Uganda and India**

Colophon:

Publication: March 2007
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Preface

We know that AIDS is negatively affecting development - one need only look at falling life expectancy rates to get a sense of its impact. What is less clear, but also true, is that AIDS is negatively affecting development *organisations*, undermining their ability to address poverty and injustice. What can be done about this? Development organizations cannot completely prevent HIV and AIDS from affecting their staff and their work, but they can take action to manage HIV and AIDS and so reduce its impacts. But how to develop and fund this work? Some donor organizations do not fund staff costs and other essential expenditure within development organizations. Others do fund such costs, but have shied away from the issue of AIDS, fearing that funding their partners' workplace policies on AIDS will be too expensive.

I am proud that STOP AIDS NOW!'s 'Managing HIV and AIDS in the Workplace' project is attempting to grapple with this issue directly through its pilot projects in Uganda and India. Previously, the project's collaborators - Cordaid, Hivos, ICCO and Oxfam Novib - have set out their commitment to encouraging partners to develop workplace policies for managing HIV and AIDS in the document 'Good Donorship in a Time of AIDS'. Now, with 'What's It Likely to Cost?', we are providing practical guidance to both local and donor organizations about budgeting for workplace policies. We hope it will prove to be a useful tool for the organizations participating in the pilot projects, and for other local and donor organizations too, who have decided not to allow AIDS to do its worst, but to take action to manage it in the workplace, and so protect their ability to fulfill their vision.

Lucie van Mens
Program Manager STOP AIDS NOW!

I Introduction

Is your organisation, or your partner, wanting to tackle the issue of HIV and AIDS in the workplace? Congratulations! One of the challenges which you will face is budgeting. What should be in the budget, and how to estimate the costs? What should not be included? What makes a good budget? This document explores these and other questions, in order to help both staff in local NGOs who are doing the budgeting, and Programme Officers in donor organisations who assess and fund the budgets.

I.1 Background

We know that local NGOs sometimes may not want to talk about HIV and AIDS in their organisation. They worry that talking about the problem might put the donor off, and that the extra costs of workplace programmes will spoil their chances of getting funding. Their fears may be accurate for some donors.

Four Dutch donor NGOs, however, want to encourage their partners to respond to AIDS in the workplace. Cordaid, Hivos, ICCO, and Oxfam Novib are collaborating through STOP AIDS NOW! (SAN!) on pilot projects in Uganda and India which aim to enable local NGOs to manage HIV and AIDS better within their organisations¹. To make their position clear, the Dutch donors agreed on a series of principles and commitments in a document called '*Good Donorship in a Time of AIDS: Guidelines on Support to Partners to Manage HIV and AIDS in the Workplace*' (published by SAN! in March 2006). It has been distributed within the donor NGOs and among their local partners in Uganda and India².

I.2 What's in this document

This document is an addition to *Good Donorship in a Time of AIDS*. Its purpose is to provide the extra information on how to budget which staff in local NGOs and Programme Officers in the donor NGOs have asked for³. The information and ideas should also be useful to people in local NGOs and donor NGOs who are not part of the SAN! pilot projects; however, they will have to ignore bits that are specific to the pilot projects.

Have you read the *Good Donorship in a Time of AIDS*? They contain useful information which we are not going to repeat here. For example, they spell out what would be the components of an *ideal* workplace policy to manage HIV and AIDS, and then look at how organisations have to adapt that ideal. If you don't have a copy of the guidelines, you could download them from www.stopaidsnow.nl/professionals or get a copy from the SAN! projects in Uganda and India. However, if you haven't read the guidelines, you can use this document by itself.

Here's what you will find in this document:

Section 2 gives a summary of the principles and commitments which are in 'Good Donorship in a Time of AIDS'. It then goes over the basics of why we should manage HIV and AIDS in the workplace and how to do it. Table A provides a 'menu' of things which organisations may do to

¹ In Uganda, Oxfam GB and Oxfam Ireland partners are also included.

² In fact, Oxfam Novib and Cordaid have adopted the guidelines for all their programs, not just Uganda and India.

³ This has been the process: the author read NGOs' draft budgets, met with NGOs and Programme Officers in Uganda, and got feedback and ideas from them and others through a workshop, meetings, phone calls and e-mails. After drafting the document, eight people from the local NGOs, donor NGOs and from outside the project kindly reviewed and helped improve it. Finance and Programme Officers from the Dutch NGOs then gave their input through two workshops. Thanks to all concerned for their help.

manage HIV and AIDS in the workplace.

Section 3 focuses on the process of budgeting: when to start, who to involve, and important issues to bear in mind.

We have provided three examples of budgets for managing HIV and AIDS in the workplace in **Section 4**, illustrating low-cost, medium-cost and higher-cost approaches. The spreadsheets are reproduced in this document as text, but they are also available as excel spreadsheet files. You can download these from www.stopaidsnow.nl/professionals.

Note that for simplicity, in the budget examples and in this document, we are talking of workplace policies which are specifically about HIV and AIDS. However, many organisations actually create policies and budgets which are more general - for example, about chronic illnesses including HIV and AIDS, or about promoting well being and good health.

Section 5 compares the features of good budgets with those of not-so-good budgets, whilst **Section 6** looks at what costs may and may not be included in a budget to manage HIV and AIDS in the workplace.

Section 7 looks at the difficult issue of how best to support staff and their dependants to get health care, including the budgeting implications. Table C outlines the advantages and disadvantages of nine methods, whilst Table D gives examples of how those methods might be combined to good effect.

The document closes with **Section 8** on how to put the costs of a workplace policy into your consolidated budget, and **Section 9** on monitoring and evaluation.

2 Managing HIV and AIDS in the workplace: the basic idea

2.1 Summary of the principles and commitments in Good Donorship in a Time of AIDS

If you haven't read *Good Donorship in a Time of AIDS*, or don't recall it very well, read Box A for a summary of the key points.

Box A:

Summary of Principles and Commitments from 'Good Donorship in a Time of AIDS'

Principles

- a) We believe that all donors should fund a share of their partners' overheads, including the cost of workplace policies, in addition to funding projects or activities.
- b) We recognise that the impacts of HIV and AIDS can cause partners to produce lower levels of outputs for the same investment.
- c) We believe that the cost of inaction is greater than the cost of action to manage the impacts of HIV and AIDS. Workplace policies are a cost-effective method which all organisations can use to reduce the impacts of HIV and AIDS on their work.

- d) We note that, as autonomous organisations, partners are responsible for developing, implementing, monitoring, and evaluating their own workplace policies. However, we will support them as set out by our commitments in these guidelines.
- e) We believe that donors and partners need to communicate openly about the challenges brought about by HIV and AIDS, and are committed to doing so.
- f) We recognise that partners need to create workplace policies to fit their context, if they are to have effective policies which they can keep-up.
- g) Partners must decide who to include in their workplace policies. We expect that their policies will attend to gender issues, and that they will not discriminate between different cadres of employees. We also prefer that direct family members are covered including, where relevant, access to antiretroviral treatment.

Commitments

- h) We commit to following the ILO key principles in our workplace policies, and expect that partners will also be guided by them.
- i) We are not, in the pilot projects, making funding conditional upon partners demonstrating that they are actively trying to manage HIV and AIDS in their workplaces. We will, however, adjust our own grant assessment processes to include attention to the issue, and will favourably view an organisation's efforts to manage the risks that HIV and AIDS presents to its work.
- j) Through the pilot projects, we will liaise with insurance companies and health management organisations, with the aim of securing affordable means of health provision for partners in the pilot projects.
- k) We undertake to provide technical, and sometimes financial, support to partners through the pilot projects as they develop their workplace policies.
- l) We want partners to integrate their workplace policies within their overall budgets, to form part of their ordinary applications for 3 years funding. We will positively consider all such applications as part of usual assessment procedures, including funding our share of the costs of prevention, care, support, and treatment. We expect that the costs of workplace policies will be up to about 4% of the total payroll (salaries plus benefits).
- m) In the interim – where partners need resources to begin workplace policies but are not due to reapply for a new 3 year grant – we will provide short-term funding through the pilot projects.
- n) If a partner's 3-year grant finishes and we have not approved a new grant, we will, if necessary, continue to provide funding for ARVs⁴ for up to 6 months. We would hope that partners will provide a similar treatment safety-net for employees on ARVs who leave the organisation.
- o) We commit to advocating good donorship among the wider community of donor agencies, with the aim of increasing the proportion of donors who are willing to support partners' efforts to manage HIV and AIDS through workplace policies. We expect that partners will also engage in advocacy to influence their donors.
- p) In situations where we and the partner have tried but failed to secure the support of all their donors to share the costs of the workplace policy, we will ensure there is sufficient funding for at least some activities to proceed.

⁴ ARV stands for antiretrovirals, the drugs which can suppress HIV, delay the onset of diseases resulting from reducing immunity, and significantly improve the quality and quantity of life for people in the later stages of HIV infection.

q) We undertake to monitor and evaluate the process and outcomes of the pilot projects, and expect to be held accountable to the commitments that we have made to good donorship in these guidelines.

2.2 Why manage HIV and AIDS in the workplace?

Managing is about organising, being in charge of something, taking control. In some parts of the world HIV and AIDS seem to be out of control; certainly the manager of an NGO cannot tame them. However, we are not usually passive when faced with things we cannot control. Take, for example, the weather: you can't stop the rain, but if there's a hole in the roof of your office, you get it fixed! And if some rain still comes in, you move your staff and computers away from the drips, to reduce the damage it causes. The same applies to managing HIV and AIDS: do what you can to help staff to be healthy and to reduce the likelihood of them becoming infected with HIV. And then, as your organisation will be affected by AIDS directly or indirectly, try to reduce the impacts which it has on your organisation and its ability to achieve its goals.

We cannot be sure about the extent of the impact of AIDS on NGOs, but, as surely as rain is bad for computers, we do know that AIDS is bad for them. One study of NGOs' experiences in Eastern and Southern Africa estimated that HIV causes staff costs to go up by 7% and productivity to go down by 10%⁵. It also discovered that smaller organisations have been harder hit.

The consequences of AIDS for NGOs include *achieving less* because:

- staff are absent from work more - they may be sick, looking after relatives who are ill, or attending funerals of family or community members;
- staff members die, and the organisation loses their skills and knowledge;
- people feel depressed, distracted, and less motivated at work;
- people do not work together well if there is whispering and stigmatisation;
- managers spend time, and get stressed about, deciding what to do - can she borrow a car to get to hospital? Shall I give him more paid leave? What shall I do about those orphans? Who can take on his workload? How will we ever get that report finished?

AIDS also causes organisations to have *higher financial costs* if they provide benefits such as health care, paid sick leave, and death benefits. NGOs will have larger increases in costs if their staff benefits are generous, or if they do not enforce the limits set out in their policies.

In extreme cases, HIV and AIDS may even lead to the collapse of organisations: if they are not achieving enough, and costing too much, they may fail to attract funding and new staff, and so close.

Managing problems involves spending time and money in order to reduce the problem and its costs. When you spend money to fix the office roof, you are raising costs in order to protect your organisation's productivity. The same applies to managing HIV and AIDS in the workplace. Your costs go up in order to protect productivity, but if you do nothing then the costs - ultimately, whether or not your organisation can achieve its goals - are likely to be higher.

⁵ James R with B Katundu, B Mboizi, E Drani, D Kwebwa & R Cidosa (2006): *The Organisational Impacts of HIV and AIDS on CSOs in Africa: Regional Research Study: Uganda, Malawi, Tanzania*, Praxis Paper 13, www.intrac.org/pages/PraxisPaper13.html

2.3 How to manage HIV and AIDS in the workplace

The challenge of managing HIV and AIDS has two main parts.

- a) Reducing the organisation's *susceptibility to HIV infection*⁶ (the likelihood of staff becoming *HIV-positive*⁷). This involves:
 - supporting staff to reduce their own susceptibility to HIV infection;
 - and making changes to how the organisation functions.

- b) Reducing the organisation's *vulnerability to the impacts of AIDS*⁸ (the likelihood of the organisation being negatively affected by AIDS). This involves:
 - supporting staff to reduce their own vulnerability to the impacts of AIDS;
 - and making changes to how the organisation functions.

Note that, much as it is 'nice to be nice', decisions about how to manage HIV and AIDS need to be made mainly in the interests of the organisation. It would be wonderful, for example, to be able to give unlimited paid leave to staff affected by HIV and AIDS, so that they can take care of their families without losing their income. However, such a decision would probably be too costly for the organisation. Fortunately, many of the activities for managing HIV and AIDS in the workplace are good for both the staff and the organisation, as Table A shows.

For each row in Table A, there are options, from a simple response to more complicated, further activities. We have called it a 'menu' to emphasise the idea of selecting some items, not trying to 'eat' the whole thing! Organisations vary in what is appropriate for them - what money they have, what they have the skills and time to do, what services are available locally. (There is more about this in Section 3.3). You could use Table A as a menu of ideas from which you can pick and mix, according to what is suitable for your organisation, ideally based on an assessment of needs and risks. You might begin with a few basic activities, then after some time add in some further activities, or use them to replace your earlier, more basic activities.

Please note also that the menu is not a complete checklist of all possible activities - you may well come up with other ways of responding. For example, for VCT we have not listed the strategy of having an in-house testing session, where a specialist organisation comes to discuss the issue with staff and then provides testing there and then (usually resulting in high levels of tests). Table A also does not include procedural activities such as needs assessment or risk analysis (to find out how best to respond), negotiating with donors (to secure funding), reviewing and revising policies and procedures (to ensure that they are consistent with the workplace policy), and monitoring and evaluation of the policy and its implementation.

⁶ *Susceptibility to HIV infection* is about the likelihood of HIV infection. It is influenced by many factors including: physiology (differences between men and women's bodies make women more susceptible); individuals' behaviour (such as number of sexual partners, using condoms, getting sexually transmitted infections treated); and wider issues including poverty, HIV prevalence, livelihood strategies, culture, illiteracy, conflict, and balance of power particularly with regard to gender. An organisation's susceptibility is down to its staff members' susceptibility, which will be affected for good or for bad by working for the organisation.

⁷ *HIV-positive* means that someone has HIV in their blood, that they have been infected with HIV.

⁸ *Vulnerability to the impacts of AIDS* refers to the likelihood of suffering adverse consequences from illness and death due to AIDS. High levels of vulnerability are associated with poverty, lack of access to treatment, fragmented social and family structures, and gender inequality. An organisation's vulnerability is made up of its staff members' vulnerability, which is affected for good or for bad by working for the organisation, and by the organisation's ways of working.

Table A: A menu of activities for managing HIV and AIDS in the workplace

a basic activity...	...and/or another activity...	...and/or a further activity
supporting staff to reduce their susceptibility to HIV infection		
giving staff a leaflet on HIV and AIDS	regularly updating staff with information on HIV and AIDS	training some staff as peer educators
basic education sessions on HIV and AIDS for staff	more interactive sessions, perhaps involving someone who is HIV-positive, where staff discuss and reflect on HIV and AIDS	workshops which aim to help individuals to assess their own susceptibility and to come up with ways of reducing it
putting up a poster encouraging use of condoms	putting out condoms for staff to take	having single-sex discussions where staff can talk about condom use, and how to tackle problems around condom use
giving staff information on where they can get VCT ⁹	paying for the costs of VCT	helping staff to think about the risks and opportunities of knowing their HIV status
giving staff information to share with their families	holding basic education sessions for family members	holding interactive workshops for family members
making changes to how the organisation functions regarding susceptibility		
problem: staff who travel may have sex whilst away from home		
provide condoms for staff to take with them	arrange single-sex discussions for staff who travel to come up with their own solutions e.g. masturbation as an alternative to sex whilst away from home, always using condoms	change ways of working so that staff have less need to travel e.g. making better use of the phone and e-mail

⁹ VCT stands for Voluntary Counselling and Testing for HIV.

a basic activity...	...and/or another activity...	...and/or a further activity
problem: cultural norms within the organisation encourage sex		
find out what norms within the organisation may make staff more susceptible e.g. staff getting drunk together as part of being a team	prohibit inappropriate norms and behaviour e.g. swapping sex for favours within the organisation, or with community members	use discussion groups to come up with ways of changing norms e.g. that it's OK to drink non alcoholic drinks, or that teams can relax by eating or watching a film together
supporting staff to reduce their vulnerability to the impacts of AIDS		
putting up anti-stigma posters	having a workshop where staff can understand their own biases and beliefs, and the causes and effects of stigma	pro-actively hiring staff who are HIV-positive
providing information about <i>positive living</i> ¹⁰	having a workshop about positive living	allowing HIV-positive staff time off to belong to positive living support groups
giving information about where to get free treatment	paying for treatment of opportunistic infections	paying for ARV treatment
giving information about how to prevent mother to child transmission of HIV	targeted support to staff and partners who are pregnant	paying for interventions to reduce the risk of babies born to staff being HIV-positive
making changes to how the organisation functions regarding vulnerability		
problem: working for our organisation may undermine positive living		
keep the workplace clean, to reduce the chances of opportunistic infections	make sure that any food or drink provided by the organisation is healthy	alter workloads or tasks if a HIV-positive member of staff is overworked or stressed

¹⁰ *Positive living* is an idea originally developed by a group of HIV-positive people. It entails acknowledging that one has HIV infection; eating a well-balanced diet; exercising, whilst also getting rest and avoiding stress; practising safer sex or abstaining from sexual activity; getting treatment for opportunistic infections; getting ARV treatment if possible; and attending to one's mental and spiritual health.

a basic activity...	...and/or another activity...	...and/or a further activity
problem: staff are absent too much, particularly for attending funerals		
make sure everyone knows what the limit is for each different kind of paid and unpaid leave	keep track of how much leave each staff member takes, and enforce the limits	come up with a policy which will reduce the time staff spend attending community members' funerals
problem: senior managers are spending too much time on issues to do with HIV and AIDS		
develop a workplace policy so that decisions are determined by that policy, rather than on a case-by-case basis	appoint a welfare committee to visit sick staff and to arrange funerals	appoint a focal person, and train them in counselling skills, so that affected staff go first to them
problem: when someone is absent, things slow down or go wrong		
established shared systems and records, so that colleagues can get to each others' work, and information is not only carried in people's heads	identify the key posts - where one or two people being away would have a big impact - and give on-the-job training to others to learn the most crucial parts of those jobs	budget for the costs of temporary staff to do the work of absent staff, or to provide more support to those who have taken on the absent staff member's workload
problem: when someone leaves, it takes ages to replace them		
find out why it takes so long to replace staff when they leave	find ways of speeding up the process of recruiting	create a supportive workplace where staff are willing to talk about their health and to give notice where possible e.g. of retiring on health grounds

3 The process of budgeting

3.1 Start at the beginning!

At what point does budgeting happen in your organisation? For many NGOs, no one does any maths until the project idea and activities are well-formed.

When it comes to managing HIV and AIDS in the workplace, you need to be thinking about costs and from the beginning. Budgeting should, from the outset, be part of developing a workplace policy and the activities to manage HIV and AIDS in the workplace.

Here are some questions which you should ask early on in the process:

- What are the *rough* costs of different activities and benefits?
- What about cost-sharing, would staff be willing to do this? How much might they be able to contribute? What can our organisation contribute?
- What is our budget limit? In December 2005 the Dutch donor NGOs set a limit that the total should not be more than about 4% of the payroll (see Box B in Section 3.3) - so how much is that? Do we need to go up to that maximum?
- What activities might we begin with, and what might we phase-in in years to come?

By answering such questions early on, it should be possible for you to have a sense of the kinds of activities that you can afford. This means you can reduce the risk of raising expectations among staff, and then having to disappoint them. For example, consulting them about getting health insurance for all staff members plus four dependants, and later finding that you cannot afford to include any dependants.

It is essential, also, to take *time* into account: you need to be able to afford both the money cost of, for example, having workshops, as well as the time cost of spending staff time on them. You probably do not charge staff members' time to different budget lines, but when staff gather in a meeting or a workshop, there is the impact of what they are not doing elsewhere - which is usually what they are funded to do.

3.2 Who should be involved?

For most organisations, deciding how to manage HIV and AIDS in the workplace becomes the task of drafting, finalising and then enacting a workplace policy. This policy may be specifically for HIV and AIDS, more generally for chronic illnesses, or more positively about health and wellness. Whichever it is, the task should not be left to one person; it needs the ideas and knowledge of people from different parts of the organisation. The team might involve, for example, a representative from the Board, someone from the Human Resources team (who knows about staff benefits and so on), someone from the Finance Department (who would take the lead on the budgeting), and someone with knowledge about HIV and AIDS. The team should involve and consult with members of staff and of the organisation's board during the process of drafting and finalising the policy and developing the activities.

3.3 Issues to bear in mind

Table A in Section 2.2 listed the types of activities which you might do in order to manage HIV and AIDS in the workplace. However, there is no 'ready-made' set of a policy, activity plan and budget

which you can photocopy and use! This is not possible because organisations vary so much. It is also not desirable because going through the process of deciding what to do is useful in itself. So, you must try to respond in the way that best fits your organisation. What are the context issues you should bear in mind?

Strategy: you don't have to do everything at once! What activities in Table A will you prioritise? A phased approach may make sense. For example, you might begin with VCT, stigma and positive living and then later include ARV treatment, because experience suggests that this is the best way to get people to take up ARV treatment. Or you might begin first with staff only, and then later include family members in some activities.

staff time: whatever activities you decide on, staff need to have time to do them. The 'opportunity cost' of a workshop is the work which staff do not do because they are at the workshop! Perhaps you need to budget for extra staff time, rather than expecting staff (e.g. a focal person) to take on more responsibilities?

staff capacities: do you have the skills to do the activities yourselves? You may need outside help, for example, to run workshop sessions, or to give all staff the skills to run their own discussion groups.

finances: is your organisation financially secure, or a 'subsistence NGO', which sometimes goes hungry when funding runs out? Many of the activities in Table A do not need much money, or have cheap options. For example, rather than have staff travel to a special workshop about HIV, you might integrate HIV discussions in other regular meetings. However, remember that any benefits you give to staff need to be sustained, at least for the period of their contract, ideally for longer. Also bear in mind that the costs of your workplace policy need to be in proportion to your overall costs. The Dutch donor NGOs set 4% of payroll as a rough maximum - see Box B below.

cost sharing: getting a contribution from staff might make health care more affordable. Or it may open up options, e.g. of subsidised health insurance for dependants.

sustaining the funding: in *Good Donorship in a Time of AIDS* each partner is asked to try to get their other donors to fund their share of the costs of the workplace policy. The Dutch donors are willing to fund their share, or to fund 100% of *at least some activities* if you and they have tried and failed with your other donors. However, the Dutch donors are only committing to funding workplace policies as part of their usual 3-year grants. *If your grant is not renewed, then the funding stops, including the money for your workplace policy*¹¹. So it is important that you talk to your other donors - are they willing to provide additional funding now? Will you be able to get your workplace policy funded by integrating the costs in the consolidated budget for your next grant application? Could your Dutch donor also talk to your other donors? What share might each donor take? And what will you do if you don't get all the funding? Talk to your Programme Officer about these issues, and explain your strategy when you apply to the Dutch donors for funding.

equity: In some cases, the Dutch donor NGO is funding a small part of a much bigger organisation e.g. a project with five staff in an organisation with 100 employees. It would not be fair to have a workplace policy which only covers the five staff in the project, but the Dutch NGO is unlikely to be able to fund the workplace policy for all 100 staff. In such situations it becomes even more important that the organisation gets its other donors to take their share of the costs of the workplace policy.

likely need: If you are budgeting for paying for health care costs, rather than insurance, remember that most people who are HIV-positive do not need treatment, because there is a long time in which people are infected with HIV but in good health. So, if you have 80 staff and believe that 10% of them, or eight members of staff, are likely to be HIV-positive, you should budget not for 100% of them, but for about 25% of them (two staff) needing treatment for opportunistic infections or ARVs

¹¹ The exception to this is that the donors are willing to pay for ARV costs for up to 6 months if this is needed to keep ARV treatment. The 6 months are to give the organisation and the individuals concerned time to find alternative ways of getting ARV treatment.

(depending on what you are offering). You must also factor in that the number of staff on treatment will grow over time as others among the eight reach the stage of needing treatment. There is also the complication that over time some of those on treatment, perhaps 15%, will need to take more expensive second line ARVs.

making changes to the policy: bear in mind that a policy is not fixed forever! Include a date that it is in force until, after which it may be revised. You can also include clauses in the policy such as 'dependent on funding' if you are not certain of being able to fund all elements of it. Similarly, of course, a budget only covers a certain period. You can put in 'guesstimates' knowing that, so long as you keep track of expenditure properly, you will have a better idea of the costs when you do the next budget.

local services: be alert to changes in local services which may affect your budget, such as the chance to have your staff included in a new service offering free testing and treatment.

Box B: The 4% limit

Good Donorship in a Time of AIDS states: "we expect that the costs of workplace policies will be up to about 4% of total payroll (salaries plus benefits)". This means gross monies paid to staff (salaries plus any benefits that are treated as income and taxed as such) plus payments which the organisation must make to the government in relation to salaries.

Example for a organisation in Uganda:

Total gross earnings of all staff including taxable benefits	\$50,000
+ 10% to the National Social Security Fund	\$5,000
+ 0.2% of 5 years gross earnings including benefits for Workmen's Compensation Insurance (0.2% x \$50,000 x 5 years) Note: will be 0.3% if organisation buys higher cover of WMCI with Group Personal Accident	\$500

Total	\$55,500
Rough maximum for the workplace policy is 4% of Total	\$2,200

4 Examples of budgets

This section contains three examples of budgets. These budgets illustrate how different kinds of organisations might take different approaches to managing HIV and AIDS in the workplace. They also show the key features of what makes a good budget (see Section 5 for more on this).

The spreadsheets are reproduced in this document as text, but they are also available as excel spreadsheet files. You can download these from www.stopaidsnow.nl/professionals.

Please note!

- The budgets are all made-up (not real) - they are just examples. Your own budget will be shaped by the activities which you chose, and how things are done in your organisation e.g. when per diem are paid. You will also probably prefer to use your own budget format - there is no need to copy these.
- The budgets are in a pretend currency, the £, rather than Rupees or Shillings or Euros¹².

¹² We have used a pretend currency for three reasons: so that the budgets are not tied to the costs and currency of any one country; to avoid the danger that readers might take the figures as the 'right prices' to use in their own budgets; and to

- They are for workplace policies focusing on HIV and AIDS. However, your organisation might take the more general approach of having a workplace policy for chronic illnesses including HIV, or for promoting health and well being.
- For simplicity, the budgets all cover one year. In reality, your budget, at least for the Dutch donors, will be for either:
 - a) the amount of time remaining in your grant with the donor; or
 - b) 3-years, with the workplace policy costs included within the overall budget for a new phase of program funding. See Section 8 for more ideas on this.
- They do not include the costs of developing a workplace policy on HIV and AIDS, as these are budgets for *implementing* such a policy. However, organisations could discuss with their donors whether they are willing to fund the process of developing a policy e.g. in year one, followed by sums for implementation in years two and three.

Example 1 is a sample budget for a **low-cost** approach to managing HIV and AIDS in the workplace. It is for an organisation called X which has 14 staff and an average salary including benefits of \20,000. X has not done anything about HIV and AIDS before, nor provided any health care for its staff. The organisation has only one donor, with funding agreed for the coming year only. X's budget shows a very rough way of calculating how much money to put into an emergency fund for staff with chronic illnesses; a more complex method is shown in Section 4.6 of *Good Donorship in a Time of AIDS*.

Example 2 is a budget for organisation Y's **medium-cost** response to HIV and AIDS in the workplace. This organisation has 29 staff and an average salary including benefits of \26,000. Y has been doing basic HIV and AIDS sessions with staff for some time, and already gives its staff support to get health care. It now wants to move on to more focused sessions for staff, and better health care provision.

Example 3 shows a **higher-cost** budget. Organisation Z has 19 members of staff and an average salary including benefits of \32,000. It has been doing HIV and AIDS sessions with staff for some time, and now wants to train peer educators and to invest in mini-workshops throughout the year for staff. It is also budgeting to change the way in which it gives staff support to get health care, using cost-sharing to subsidise giving staff and two dependants comprehensive health insurance. Z is also budgeting for a little staff time to manage implementing the workplace policy, and for some temporary staff time to help cover for any absences.

The examples follow at the next pages.

reduce the need to research the real costs of all the items.

Example 1:**A budget for a low-cost approach to managing HIV and AIDS in the workplace**

Note, this is a made-up example using a made-up currency, the \.

Workplace policy budget for organisation X for January to December 2007

No*	Item or activity	Unit cost in \	No	Total in \	Notes
1	One 1-day HIV/AIDS education session				For all staff, to be held at our head office in January
	Facilitator's fee	400	1	400	
	Refreshments for 15 participants	12	15	180	14 staff + facilitator
	Travel & accommodation for 7 staff members	21	7	147	7 staff are based in the field & must travel to session
	Flip charts	10	1	10	
	Boxes of marker pens	5	2	10	
	Masking tape	2	2	4	
	Note books	1	14	14	
	Reams of copying paper	8	1	8	
	Subtotal			773	
2	Give all staff an HIV/AIDS information pack including where to get VCT and treatment locally				We will make the pack with free materials.
	Subtotal			0	
3	Supply condoms to all staff	0	10	0	Free boxes of condoms from MoH.
	Subtotal			0	
4	Two 1-day workshops with an HIV-positive facilitator on stigma and positive living				For all staff, 1 at head office in April, 1 at field office in May
	Facilitator's fee	400	2	800	
	Refreshments for 15 participants	12	15	180	14 staff + facilitator
	Travel & accommodation for facilitator	21	2	42	
	Flip charts	10	2	20	
	Boxes of marker pens	5	2	10	
	Masking tape	2	2	4	
	Note books	1	14	14	
	Reams of copying paper	8	1	8	
	Subtotal			1.078	
5	Basic health insurance for staff members				
	Basic cover for 14 members of staff	160	14	2.240	With QPS insurance
	Subtotal			2.240	

6	Emergency fund, for chronic illness among staff members				Fund to be used to assist staff, if possible, with up to 80% of costs of treating chronic illness. Based on 2.5% HIV+ and needing treatment, 2.5% other illnesses.
	Estimate 5% of 14 staff might have chronic illness	14	5%	0,7	Based on 2.5% HIV+ and needing treatment, 2.5% other illnesses.
	Cost of ARVs and tests for one year for 5% of staff	160	0,7	112	Private costs. ARVs also available for less from public service.
	Allowance for other treatments	500	0,7	350	Based on 10 nights in hospital.
	Subtotal			462	
7	Family welfare fund				This is a fund started and managed by staff; they contribute 1% of their salaries to it, we want to add 0.5% to this.
	0.5% of staff salaries			1.400	
	Subtotal			1.400	
	GRAND TOTAL			5.953	

* these numbers go with the numbered activities in the text of the workplace policy

Funding Plan	
Gross staff salaries including benefits	280.000
Plus 10% national social fund	28.000
Plus workers insurance (0.2% of 5 years salaries)	2.800
Total salaries including benefits plus tax	310.800
GRAND TOTAL as a % of payroll	1,9%

We are requesting 100% from donor Q, as we do not have any other donors. For 2008 we plan to submit a new phase grant application to donor Q, and to also apply to donors R and S. For those applications we will put our workplace policy costs in our core budget, and so share them among the donors.

Example II:**A budget for a medium-cost approach to managing HIV and AIDS in the workplace**

Note, this is a made-up example using a made-up currency, the \.

Workplace policy budget for organisation X for January to December 2007

No*	Item or activity	Unit cost in \	No	Total in \	Notes
1 Reducing the likelihood of staff getting HIV infection					
1 a	Four half-day workshops (on VCT, talking with partners, stigma in the workplace, and condoms)				For all staff, 1 per quarter
	Fees for 2 facilitators for 4 half-days	250	8	2.000	
	Tea and snacks for 31 participants for 4 half-days	5	124	620	29 staff + 2 facilitators - we will provide this
	DVD on stigma	20	1	20	We will pay for this
	Stationery			100	We will provide these
	Subtotal sought from donors			2.000	
	Subtotal our contribution			740	
1 b	Single-sex lunchtime discussion groups				
	Lunch for 29 staff @ \10 per person for 12 months	290	12	3.480	Lunch provided to encourage attendance
	Subtotal sought from donors			3.480	
1 d	Supply condoms to all staff				
	Male condoms per box of 1,000	750	3	2.250	More reliable supply than the free ones from the government
	Female condoms per box of 50	200	1	200	Not available for free
	Subtotal sought from donors			2.450	
2 Reducing the impacts of AIDS on the organisation					
2 a	Personnel officer to attend 1-day training on HIV, non-discrimination and confidentiality in the workplace				Course run by Business Council for HIV/AIDS
	Training fee	150	1	150	
	Subtotal sought from donors			150	

2 c Health care for 29 staff + dependants				
Increase to health expenditure cap per staff member (can also be spent on dependants)	250	29	7.250	We have already budgeted for \300 per person, but the sum is inadequate, hence the increase. Insurance company advised us to budget at average cost per person of \50.
Critical illness fund held by insurance company, for 29 staff +58 dependants	50	87	4.350	
Subtotal sought from donors			11.600	
GRAND TOTAL			20.420	
Less our contribution			740	
TOTAL SOUGHT FROM DONORS			19.680	

* see workplace policy for more detail. We have not included any activities which do not need budgeting for, so there are missing numbers here. For example, we plan to review all our policies and procedures to ensure that they are consistent, and we will also be carrying out monitoring of the process.

Funding Plan	
Gross staff salaries including benefits	754.000
Plus 10% national social fund	75.400
Plus workers insurance (0.2% of 5 years salaries)	7.540
Total salaries plus benefits plus tax	836.940
TOTAL SOUGHT as a % of payroll	2,4%

We are requesting 50% of the total from donor Q, we think we can get the remaining 50% from donor R. (Our other donor, S, says it will not provide additional funding.) If we fail to get the 50% from R, and if Q is not able to plug the gap, then we will not include dependants in the health scheme.

Example III:**A budget for a higher-cost approach to managing HIV/AIDS in the workplace**

Note, this is a made-up example using a made-up currency, the \.

Workplace Policy budget for organisation Z for January to December 2007

No*	Item or activity	Unit cost in \	No	Total in \	Notes
Overall: guiding the process of managing HIV/AIDS in the workplace					
	15% of Focal Point's salary	36.000	15%	5.400	Includes 10% social fund and workers insurance
A Reducing susceptibility to HIV infection among staff					
A1 Training 4 Peer Educators					
	Fees for 2 day training for 4 staff	150	4	600	2 male, 2 female, to be trained by Fight AIDS Today.
	Travel allowance for 4 staff	5	4	20	
	Per diem for 2 days for 4 staff	10	8	80	
	Accommodation for 1 night for 4 staff	12	4	48	
	Subtotal			748	
A4 Monthly well-being mini-workshops with guest speakers					
	Speakers' expenses (on average)	150	12	1.800	On topics requested by staff e.g. wills, healthy living, talking to children about sex.
	Subtotal			1.800	
A5 Supply condoms to all staff					
	Male condoms per box of 1,000	750	2	1.500	Staff take fewer if we provide the ones we can get for free. We have some left over from last year which are OK to use.
	Female condoms per box of 50	200	0	0	
	Subtotal			1.500	
B Reducing the impacts of AIDS on the organisation					
B1 Health care for 19 staff + 2 dependants each**					
	Comprehensive insurance for 19 staff + 38 dependants = 57 people	320	57	18.240	We are switching from having a limit of \500 per staff member to insurance for staff + 2. Estimate 6% HIV-positive but half don't know status, so pre-existing is 3% of 57 = 1.7
	Plus additional premium of \30 for people with pre-existing conditions e.g. if know they are HIV-positive	30	1,7	51	
	Less staff contribution to insurance: average of 10% per person insured	32	57	1.824	
	Less money budgeted for capped health scheme for staff + direct dependants	500	19	9.500	
	Subtotal			6.967	Cost-sharing is on a sliding scale according to salary, from 5% to 30%; average contribution is 10%. Old scheme, already funded in consolidated budget.

B3	Temporary staff to reduce workload when staff are off sick				Based on salary of a Grade IV Programme Officer
	Cover equivalent to 3 months	3.400	3	10.200	
	Subtotal			10.200	
GRAND TOTAL				26.615	

* see workplace policy for more detail. We have not included cost-free activities such as improving our recruitment procedures and updating induction packs, hence there are missing numbers here.

** staff can purchase additional insurance for more dependants at \320 per person for comprehensive, \230 per person for standard, and \160 for standard cover.

Funding Plan	
Gross staff salaries including benefits	608.000
Plus 10% national social fund	60.800
Plus workers insurance (0.2% of 5 years salaries)	6.080
Total salaries plus benefits plus tax	674.880
GRAND TOTAL as a % of payroll	3,9%

We have agreement from donor Q to fund 40% of this budget and believe donor R will also provide 40%. We shall apply to donor T for the remaining 20%. If there is a shortfall, we will use free condoms as supplied by the government, and reduce the amount allocated to providing temporary cover.

5 What makes a good budget?

Table B compares the qualities and contents of a good budget with one which is not so great. You could use the table to judge a budget from your organisation - its good points, and ways in which it could be improved.

Table B: Good Budget and Not-so-good Budget

Good Budget	Not-so-good Budget
<p>Has been done on a spreadsheet.</p> <ul style="list-style-type: none"> ✓ You can change items and costs and the total changes automatically. This is really useful when looking at the cost implications of different decisions. ✓ So long as the formulas have been put in correctly, the answer is always accurate. 	<p>Has been done in word processing.</p> <ul style="list-style-type: none"> ✗ If any changes are made you have to recalculate the total by hand. ✗ It's easy to make mistakes when doing calculations, but difficult to find out where the mistake was made.
<p>Is given to the donor as a spreadsheet.</p>	<p>Is given to the donor as a text document.</p>
<p>Uses the same numbered headings as in the text of the policy or proposal.</p> <ul style="list-style-type: none"> ✓ Makes it easy to see which costs go with which activities. 	<p>Uses different words and headings.</p> <ul style="list-style-type: none"> ✗ It's harder to link the budget to the text of the policy; it's as if they've been written by different people.
<p>The budget and the text state the same things - they are consistent.</p>	<p>The budget and the text say different things, which is confusing e.g. the text says to train 3 peer educators but the budget has costs for 8.</p>
<p>You can understand it without looking at the text, because the budget lines make sense by themselves e.g. 'half-day workshop on positive living for 20 staff'.</p>	<p>It's more difficult to know what budget lines mean because they don't explain themselves e.g. 'workshop'.</p>
<p>The reasoning behind the calculations is clear.</p> <ul style="list-style-type: none"> ✓ There are notes to justify or explain points where needed e.g. 'fund for HIV treatment is no of staff x prevalence rate of 8% x 25% HIV-positive and needing treatment x yearly ARV costs of \$xxx'. ✓ Makes it easier to use the budget to make another one for the next period, even if new staff are responsible. ✓ Makes it easy for donors to understand. 	<p>It's hard to know where the figures have come from.</p> <ul style="list-style-type: none"> ✗ There aren't any notes. Only the people involved in the calculations know what they did. ✗ Makes it harder to do the budget for the next period, if the people involved have forgotten what they did, or if new people are involved. ✗ Makes it harder for donors to understand and to support. ✗ Programme Officers need to ask more questions, this slows down the process of assessing the funding application.

Good Budget	Not-so-good Budget
<p>The total cost is shown as a percentage of the organisation's salaries plus benefits.</p> <p>✓ The NGO and the Programme Officers can see whether the costs are below the 4% limit set by the Dutch NGOs in <i>Good Donorship in a Time of AIDS</i> (see Box B in Section 3.3). Other donors will also be interested in this percentage.</p>	<p>The total cost is not shown as a percentage of the organisation's salaries plus benefits.</p> <p>✗ The NGO may submit a proposal which is too expensive in relation to its salary bill. They will have to revise it, which will cause disappointment and delay.</p>

If your organisation's budgets do not fall into the 'good budget' category it will be worth investing in learning how to use a spreadsheet to create better budgets. Improved budgets will help your organisation in many ways, not only to do with funding how you manage HIV and AIDS in the workplace.

6 What costs can and can't go in a budget for managing HIV and AIDS in the workplace?

6.1 Costs which can be included

The eligible costs are ones that you can justify as being part of managing HIV and AIDS in the workplace. Some of the activities in Table A mainly involve spending *time* rather than money. For example having discussion groups, developing a policy, or improving recruitment systems. Others do involve expenditure, including spending money on:

- ✓ information materials - where they are not available for free
- ✓ training staff as peer educators or counsellors - who will be serving other staff
- ✓ refreshments - for participants in discussion groups or workshops
- ✓ facilitators' fees - if the organisation needs help to run a workshop
- ✓ consultants' fees - if the organisation needs specialist help
- ✓ travel - if staff have to travel to workshops or to get treatment
- ✓ accommodation - if staff need to stay overnight for workshops or to get treatment
- ✓ per diem - if staff are away from home for workshops
- ✓ condoms - if they are not available for free
- ✓ counselling & VCT fees - if these are not available for free
- ✓ cleaning materials - only if the organisation has not already budgeted for these
- ✓ first aid kits - if needed
- ✓ health care, medicines - if providing health care to staff
- ✓ health insurance - if providing health care to staff through insurance
- ✓ staff costs - if paying for additional staff time to implement the policy and its activities e.g. part of a focal point's costs
- ✓ temporary staff - to cover for staff who are unwell
- ✓ legal advice - if needed to check that the policy fits the legal context of the country's employment laws
- ✓ increases in recruitment & replacement costs - if these have been under-budgeted in the consolidated budget

Note, these are costs which *could* be included, and there may be others which we have not thought of. However, this doesn't mean that they *should* be included! For example, hiring a consultant can be an expensive and less participatory way of getting a task done. You need to use your judgement, and to be able to justify spending money on the items you put in the budget. For example, you might justify buying condoms if free supplies are unreliable, or if you believe that staff are more likely to use 'higher status' commercial condoms. Remember that donors will be most likely to fund expenditure which invests in protecting the organisation's productivity and ability to achieve its outcomes despite the effects of HIV and AIDS.

6.2 Costs which should not be included

There are three types of costs which are not eligible.

Costs which are already covered in other parts of your organisation's budget

If you include such costs again, then you will be guilty of 'double counting'. For example, if your organisation already buys cleaning materials for your offices, you cannot budget for buying them twice. Here are some ways of dealing with this:

- If your organisation already budgets for the item, you could include a budget line for it, but show the cost as zero. Add a note to explain that the costs are covered in the consolidated budget.
- Alternatively, don't include the item at all (or any other activities with a cost of zero). You should state in your budget that items and activities which are covered in the consolidated budget have not been included.
- If you are budgeting some extra money for an item which is already in your consolidated budget, include only the extra cost in the workplace policy budget, not the total cost of the budget line. Add a note to explain that the other part of the cost is in the consolidated budget.

Note, the problem of double counting only arises when you are making a separate budget for managing HIV and AIDS in the workplace i.e. until the costs become part of your consolidated budget.

Costs which are not part of managing HIV and AIDS in the workplace - for example:

- Administration costs such as electricity and office rent;
- Other general costs such as vehicles and computers and video players;
- Costs to do with HIV and AIDS projects *outside* of the organisation e.g. an HIV and AIDS campaign for community members, supporting groups of people living with HIV and AIDS, mainstreaming HIV and AIDS within programs;
- Other organisations' costs of managing HIV and AIDS in their workplace e.g. if you have client organisations, or lead a network.

Costs for activities or items which are hard to justify - for example:

- Funeral costs and terminal benefits because they are not only about HIV, and do not directly help the organisation's productivity. Most organisations already budget for these items, but if an organisation has not, and wants to do so, it could start putting them in its overall budget for staff costs, and include them in all budgets submitted to donors;
- Developing your own HIV and AIDS materials for staff when there are already plenty available;
- Providing gumboots and hard hats, because these are for health and safety in general, and should be budgeted for in the relevant programme;
- Training all staff in peer education or counselling when only a few are needed for the workplace;
- Sending spouses with staff whenever they travel to reduce the chance of extra-marital sex!

7 Budgeting for health care

You probably already have experience of budgeting for education sessions and workshops. Budgeting for health care with regard to HIV and AIDS is more of a worry - you may have less or no experience of it, and there are much larger cost implications.

This section looks in more detail at the tricky issue of health care: Table C sets out nine methods and their advantages and disadvantages, including the budgeting implications. The methods come from talking to organisations in Uganda, but hopefully the analysis will also be useful in other settings¹³.

When thinking about the different options, you need to bear in mind what each offers in terms of reducing staff susceptibility to HIV (and other health problems) and their vulnerability to the impacts of AIDS (and other health problems), and what each will cost, against what you can afford. The best solution for your organisation may involve a combination of methods (see Table D in Section 7.1).

Different options may also have implications for where you allocate the costs in your consolidated budget. This may be important in terms of minimising the amount by which your overheads rise as a result of managing HIV and AIDS in the workplace.

Remember also that it's not only about ARVs. All organisations can and should encourage staff to learn about positive living, to seek treatment for opportunistic infections, to eat nutritious food, and generally to reduce both their likelihood of becoming ill and the consequences of being unwell.

In addition to the options in Table C, in many organisations staff organise their own schemes, such as savings and credit groups, or condolences funds. These can be very important in terms of giving staff practical financial help, as well as building morale among staff through acting together. Organisations can support these self-help groups by, for example, deducting payments through the payroll, or allowing groups to use meeting rooms.

¹³ See also the outcomes of a CARE workshop involving staff from around the world which can be found in Briefing Paper 4 of a set of five useful papers entitled *HIV & AIDS in the Workforce*, available from <http://icarenews.care.org/hivaids/>

Table C: Different methods for supporting staff to get health care

Method	Advantages	Disadvantages
<p>1 No health care costs paid for by the organisation.</p> <p>Staff use public services or pay for private services. The organisation gives them information on where to get VCT, treatment for opportunistic infections, ARVs, and encourages them to go.</p>	<ul style="list-style-type: none"> ✓ No health care cost to the organisation. ✓ No health care to budget for. ✓ No extra work on administering a health scheme. ✓ Fewer worries about funding and sustaining the workplace policy. ✓ Staff choose where they get health care. 	<ul style="list-style-type: none"> ✗ Free or low-cost services may not be available locally, especially ARVs. ✗ Private services may be unaffordable. ✗ Services may be of lower-quality and less effective than private health care. ✗ Staff may have to wait more, and therefore miss more work, to get treatment. ✗ Staff may postpone getting treatment, so their condition worsens.
<p>2 Organisation gives each staff member a sum of money for their health care.</p>	<ul style="list-style-type: none"> ✓ Very easy to budget for: no of staff x sum. ✓ Confidential. ✓ The limit can be set at a level which the organisation can afford. ✓ Easy to administer e.g. 1/12th of the sum added into each month's salary. ✓ No potential for abuse of the scheme. ✓ Staff choose where they get health care. ✓ Likely to be popular with staff if they prefer to have the money in their pockets, and so have control over how they spend it. 	<ul style="list-style-type: none"> ✗ The organisation has no control over how staff use the money. The effect on staff members' health may be very small if they spend it all on dependants' health care, on ineffective 'treatments', or on other things unrelated to health. The effect might even be negative if the sum is spent on unhealthy practices e.g. alcohol, illegal drugs, buying unsafe sex. Expenditure is also likely to be controlled by men and biased in their favour. ✗ The sum is likely to be too small to cover treatment for chronic illnesses. ✗ Likely to be unpopular with donors, who want to be sure that funding is well spent on protecting the organisation's ability to deliver its outputs despite the effects of HIV and AIDS. ✗ Some of the sum may be lost to tax if it is paid through the payroll.
<p>3 Organisation refunds health care expenses up to a limit.</p>	<ul style="list-style-type: none"> ✓ Budgeting is relatively easy: no of staff x sum x % they are likely to claim. ✓ Easy to monitor trends in average 	<ul style="list-style-type: none"> ✗ Not confidential as receipts must be linked to staff members. ✗ If the sum is spread between too many dependants,

Method	Advantages	Disadvantages
<p>Organisation sets an annual limit for each member of staff. Staff pay for medical expenses, hand in their receipts, and are then paid back.</p>	<p>expenditure per staff member.</p> <ul style="list-style-type: none"> ✓ The limit can be set at a level which the organisation can afford. ✓ The policy can allow staff dependants to be included. ✓ Staff choose where they get health care. 	<p>the positive effect on the staff member's health may be very small.</p> <ul style="list-style-type: none"> ✗ A lot of administration work, collecting receipts and refunding staff. ✗ Open to abuse: staff bring in receipts for health care they have not received.
<p>4 Organisation sets aside a sum of money per staff member, and uses it to refund health care expenses.</p> <p>Same as 3, only at the end of the year, if a member of staff has not used all their sum, then they are given what is left.</p>	<ul style="list-style-type: none"> ✓ Budgeting is very easy: no of staff x sum. ✓ The limit can be set at a level which the organisation can afford. ✓ The policy can allow staff dependants to be included. ✓ No potential for abuse of the scheme. ✓ Staff choose where they get health care. 	<ul style="list-style-type: none"> ✗ Not confidential as receipts must be linked to staff members. ✗ The sum is likely to be too small to cover chronic illnesses. ✗ If the sum is spread between too many dependants, the positive effect on the staff member's health may be very small. ✗ A lot of administration work, collecting receipts and refunding staff.
<p>5 Organisation buys basic health insurance for staff members.</p> <p>In Uganda this costs about \$90 per person per year.</p>	<ul style="list-style-type: none"> ✓ Very easy to budget for: no of staff x insurance premium. ✓ Confidential - staff have ID cards and get treatment without having to get approval from the organisation. ✓ Staff get private health services, which are likely to be of higher quality than public health services. ✓ Cover includes unlimited outpatients, and limited inpatients. ✓ ID cards mean that organisation's investment is focused on the staff members' health, rather than being spread among dependants. ✓ Easy for the organisation to include 	<ul style="list-style-type: none"> ✗ Cover excludes chronic conditions including HIV and AIDS, and the inpatients limit might be exceeded. So this insurance would only help staff to get basic health care. ✗ Staff have to use the facilities which the insurance company is linked to. ✗ Costs may be too high for some organisations - the total cost of insurance will be greater than the total the insurance company pays to the health care providers (this is how insurance companies make a profit!) ✗ Monitoring is not possible because organisation gets no feedback from the insurer - has no way of knowing whether or not staff are making claims, and what their actual costs are.

Method	Advantages	Disadvantages
	<p>dependants with their own insurance cover.</p> <ul style="list-style-type: none"> ✓ Can give staff the options of: buying cover for dependants; cost-sharing cover for dependants; or paying to upgrade their own health insurance. 	<ul style="list-style-type: none"> ✗ If organisation offers cover for dependants with cost-sharing, this makes budgeting harder, as it will not know how many staff will take up the offer.
<p>6 Organisation buys standard health insurance for staff members.</p> <p>In Uganda this costs about \$130 per person per year.</p>	<ul style="list-style-type: none"> ✓ As for 5, but with higher cover for expenses as an inpatient. 	<ul style="list-style-type: none"> ✗ As for 5, though the inpatients limit is less likely to be exceeded. ✗ Costs are higher.
<p>7 Organisation buys comprehensive health insurance for staff members.</p> <p>In Uganda this costs about \$160 per person per year.</p>	<ul style="list-style-type: none"> ✓ As for 5, but with chronic illnesses including HIV included, and even higher cover for expenses as an inpatient. ✓ Can pay an additional premium to buy cover for staff with pre-existing conditions e.g. if already known to be HIV-positive. 	<ul style="list-style-type: none"> ✗ As for 5, except that chronic illnesses including HIV and AIDS are included. ✗ In Uganda, second line ARVs are excluded. ✗ Cover for people known to be HIV-positive before taking out insurance may be expensive.
<p>8 Organisation has a health (or emergency) fund.</p> <p>Staff members in need of money can ask for assistance. The organisation determines rules for the fund e.g. what needs are eligible, whether there is a maximum payout per staff member, whether the staff member must pay a percentage of costs.</p>	<ul style="list-style-type: none"> ✓ Can be used as a top-up to other methods i.e. in combination with any of 2 to 7. ✓ A combination (e.g. with 3 or 5) is likely to be cheaper than 7, comprehensive health insurance. This is because relatively few staff will claim for chronic illnesses and HIV. ✓ Very flexible in terms of what emergencies are eligible and how much to give each person who applies (can favour most vulnerable staff). ✓ Easy to do cost-sharing e.g. staff contribute % of salary which organisation then matches. 	<ul style="list-style-type: none"> ✗ Budgeting is difficult: no of staff x likely % applying for emergency funding x likely average cost of emergency. ✗ Not confidential - staff must approach the manager with their problems. ✗ Puts stress on the manager responsible for the fund. ✗ Possibility that the fund runs out. ✗ Demands on the fund will rise over time, assuming that 'for life' treatment such as ARVs work. On-going costs will accumulate, as more staff draw on the fund. ✗ Need arrangement with donor(s) if the fund is under spent. ✗ Staff applying to the fund may not be treated equally;

Method	Advantages	Disadvantages
		likely manager will show favouritism and discrimination.
<p>9 The organisation sets up a third party fund for chronic illnesses including HIV and AIDS.</p> <p>Another organisation e.g. an insurer or service provider (a hospital, or in Uganda, JCRC), holds the fund and draws on it when eligible people get treatment for chronic illnesses.</p>	<ul style="list-style-type: none"> ✓ As for 8. ✓ Confidential if combined with 5 or 6, as staff members will already have ID cards. ✓ Easy to include dependants if combined with 5 or 6. ✓ Decisions rest with third party so managers are not faced with extra work or stress. ✓ Flexible e.g. organisation can specify what conditions and treatments are eligible - could include second line ARVs. ✓ Organisation receives information as to how many staff are using the fund, and expenditure per person (but not the identities of the people). This is useful for monitoring the workplace policy. 	<ul style="list-style-type: none"> ✗ Budgeting is difficult, but easier than 8 because the fund can only be used for chronic illnesses: no of staff x likely % having a chronic illness x cost of treatment. The third party can advise based on their experience. ✗ Not confidential if combined with 2, 3 or 4, as the third party needs to check with the organisation that the person is eligible (or organisation needs to give approval of person to third party). ✗ Have to trust that the third party will act honestly. ✗ Possibility that the fund runs out. ✗ Demands on the fund will rise over time, assuming that 'for life' treatment such as ARVs work. On-going costs will accumulate, as more staff draw on the fund.

note: prices for insurance are from December 2006, and apply to partner organisations involved in the SAN! Project in Uganda. Partners outside of the SAN! project may pay higher premiums if they are insuring less than 25 people. For a summary of the insurance options in Uganda, contact the SAN! project office.

8 Including dependants

Many organisations want to include staff members' spouses and children in their health schemes. There are some good business-minded reasons for doing this:

- staff will spend less time away from work looking after sick relatives;
- staff are less likely to get their relatives' infections e.g. TB;
- staff are less likely to share drugs with relatives (this causes their own treatment to be ineffective and, with ARVs, leads to drug resistance and a need for more expensive second line ARVs);
- staff will have less guilt, and better morale, knowing that their family members can get the same treatment as them.

However, there are also some problems with including dependants:

- if using health insurance, then who to include also means who to exclude. No organisation can afford to pay for all dependants, so staff have to select which of their children are in the scheme and which are outside of it. This seems divisive and unfair - are more sons included than daughters? However, it is better to have some children included than none.
- where the organisation provides a sum per staff member for health care, or expenses up to a limit per staff member, then it can allow all direct dependants to be included. However, for staff members with a large number of dependants this means that the sum is spread very thinly. There is little money for the staff members' health care, which is the organisation's priority.

There is no perfect solution to these problems - except universal free access to excellent health care! Until that happens, the better options may involve a combination of methods, such as those presented in Table D.

Table D: examples of combinations of methods to support staff to get health care

One method...	...plus another	Comments
3 The organisation refunds health care expenses up to a limit for staff members only.	8 The organisation has a health (or emergency) fund for staff only.	A low-cost option. The organisation has excluded dependants from health care, but may still involve them in awareness-raising and workshops.
5 The organisation buys basic health insurance for staff members only.	9 The organisation sets up a third party fund for chronic illnesses including HIV and AIDS for staff members and a specified number of dependants.	Staff members' health is taken care of, as are chronic conditions for a number of their dependants. Staff are left to cover their dependants' day-to-day health care costs.
7 Organisation buys comprehensive health insurance for staff members.	7 Organisation cost-shares the purchase of comprehensive health insurance for up to a specified number of dependants per staff member.	The high cost of comprehensive insurance for dependants is shared with staff members. The proportion paid by the staff member could vary according to salary. Staff can decide whether or not to opt to buy for insurance for their dependants. For

One method...	...plus another	Comments
		budgeting, the organisation would need to find out what staff intend to do.
6 Organisation buys standard health insurance for staff members plus a specified number of dependants.	9 The organisation sets up a third party fund for chronic illnesses including HIV and AIDS. Each staff member is eligible; up to a specified number of dependants may also be included through cost-sharing.	Cost savings are made by buying standard rather than comprehensive insurance, and then having a fund for the few people who will have chronic illnesses. For staff, the option to pay to have dependants eligible to access the fund for chronic illnesses is akin to buying insurance, only cheaper.

It is also quite possible that the ideal combination might also involve a third option of an emergency fund to deal with unforeseen needs.

Of course, when making decisions, you need to keep in mind *the reason for providing health care* (it's not only about being nice), what your organisation can *afford and sustain*, what *staff can contribute* and what *they would prefer*.

9 Putting workplace policy costs into your consolidated budget

It is not ideal for partner NGOs or Programme Officers to be dealing with separate funding applications for a workplace policy. This is happening at the moment because many of the organisations in the SAN! project are needing new funding to respond to HIV and AIDS in the workplace during a 3-year funding cycle. As each organisation applies for a new 3-year grant, they should put the costs into the consolidated budget.

You may decide simply to add a line or two to your budget for the workplace policy. Or you may want to allocate the different costs to different existing budget lines, so that the workplace policy costs are integrated with other costs. (If any donor wants more detail, they can look at the actual budget for the workplace policy.)

Table E outlines some ideas.

Table E: Integrating workplace policy costs into your consolidated budget

Activity or item in a workplace policy	Possible budget lines to include them in
Education sessions, workshops	<ul style="list-style-type: none"> ✓ Training ✓ Capacity building <ul style="list-style-type: none"> ✓ For programme staff, allocate to their programmes (learning about HIV and AIDS so as to be better able to respond and not stigmatise in the field)
Condoms	<ul style="list-style-type: none"> ✓ Health and safety

Activity or item in a workplace policy	Possible budget lines to include them in
	<ul style="list-style-type: none"> ✓ Staff costs (part of the benefits package)
Health costs	<ul style="list-style-type: none"> ✓ Staff costs (part of the benefits package) ✓ For programme staff, allocate to their programmes (they need to be healthy to run the projects)
All activities	<p>Take the total budget for managing HIV and AIDS in the workplace and include it</p> <ul style="list-style-type: none"> ✓ as an extra percentage on all salary budgets ✓ or as an extra cost per employee in all salary budgets

I 0 Monitoring and evaluation

For budgets, monitoring means tracking what has been spent against each budget item. This is the same for workplace policies as for any other expenditure in your organisation. You need good financial systems to monitor the expenditure and to report to your different donors.

For health care budget lines other than health insurance, it may be particularly important that you monitor expenditure during the year. This will give managers a sense of how much money is left 'in the pot'; whether there is going to be an under spend, or whether the fund is going to run out, or need topping up. This information will be important to someone managing an Emergency Fund, as it may affect the amount of assistance they give to staff requesting help.

Tracking actual expenditure is, of course, also very useful for creating new budgets. Over time, it should get easier to do budgets for managing HIV and AIDS in the workplace as you gain more experience. For example, how many condoms staff are likely to take, whether you need facilitators for your workshops, and expenditure per person on chronic illnesses. However, it is important to keep up to date - ARV costs have reduced in recent years, and the availability of ARV treatment has improved. In the future, ARV treatment costs may rise as more people have HIV which is resistance to first line ARVs, and have to use the much more costly second or even third line drugs.

In terms of evaluating the budget, you need to check that your organisation is getting 'value for money', by comparing the outcomes of an activity against its cost and the cost of alternatives. For example, how much are staff using the health insurance policy? Is there a cheaper way of providing them with the same standard of health care? You won't get any information from the insurance company, so would need to find a way of asking staff without breaking confidentiality. Perhaps you could ask them to write down what medical assistance they have had over the past three months, without putting their name on the paper. From that you could get some sense of how much use, on average, staff are getting from the scheme, and whether or not it seems to be good value.

For more ideas about monitoring and evaluation the process of developing and implementing a workplace policy, see Section 4.7 of *Good Donorship in a Time of AIDS*.

I 1 Finally...

Budgeting for managing HIV and AIDS in the workplace is a challenge, but for learning organisations every challenge is an opportunity! No budget is perfect, but creating one is part of the bigger chance which we have - the chance to limit the effects which AIDS has on our work, and to help staff members too. We can let HIV do its worst, or we can do our best to manage it - good luck with *your* efforts.