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Who Needs an HIV Policy?

Informal workplace responses to HIV in Nigerian, Kenyan and Malawian CSOs

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Are we becoming obsessed by HIV policies? In a laudable effort to encourage partners to adjust to HIV in the workplace, some donors are focusing on an HIV policy as the essential and only response. An HIV policy, however, may not always be appropriate for all civil society organisations (CSOs). Many small or community-based CSOs do not operate on the basis of written policy. They may have their own informal coping mechanisms that are not written down – and which may sometimes be an effective way to address HIV and AIDS in the workplace. To better support CSOs develop resistance to HIV and AIDS, we need to know more about these informal responses.

Informal responses are largely invisible to outsiders. In consequence, there is almost nothing written about informal workplace responses. A Google search comes up completely blank. As a consequence, INTRAC commissioned three short research studies in Nigeria, Kenya and Malawi to find out how CSOs without HIV policies were responding to HIV in the workplace. The research reveals that many CSOs are actively responding to the threat, without having a formal policy. Simply using the existence of a formal HIV policy may therefore not be a good indicator of CSO response to HIV in the workplace. The research shows that there are some good reasons for CSOs not to formalise their response into policy. In some cases an inappropriate organisational policy may even undermine individuals taking responsibility themselves for HIV and AIDS.

This is an important finding for well-intentioned donors who have set themselves a specific target of 'percentage of partners with HIV policies'. The research concludes that donors need to focus on the bigger question of how to help CSOs become resilient to HIV, not reduce this simply to having a written policy. Donors should also look for, accept and value the informal efforts. This does not mean the emphasis on formal policy response is misplaced – merely that it needs to be complemented by recognising the role of informal responses too. The findings from the study reinforce the fact that CSO response to HIV is not amenable to one-size-fits-all solutions – they have to be looked at on case-by-case basis.

An HIV workplace policy

An HIV workplace policy typically sets out how an organisation will address HIV and AIDS as they affect its own staff (as distinct from the communities it serves). Usually it will cover prevention measures as well as guidelines for care and treatment of staff.

Workplace policies come in different forms – some may focus exclusively on HIV and AIDS, while others may cover other critical illnesses too and still others, address broader issues of health.

A policy obsession?

HIV policies are a vital tool in helping CSOs respond to HIV and AIDS in the workplace. But because they are the most easily measured response, there is a danger that they will become the only way to gauge whether a CSO is devising strategies to cope with the realities of HIV. Some European INGOs have made workplace policy a conditionality for all new funding. Others have given themselves targets of having 80% of partners in sub-Saharan Africa with an HIV policy. But the danger is that if we focus too much on workplace policy, it may make partners feel under pressure to develop policy as a funding hoop. If CSOs do not own the policy development process, they probably will not implement it.

Many CSOs are already responding to HIV and AIDS but *without* a formal policy document. Some of these agencies are too small or informal (such as community-based organisations) to have any written policies, let alone an HIV one. They do not make decisions based on written policies. But they do have coping mechanisms. They may be small activities that individual staff are doing to support each other in relation to HIV and AIDS (or any other illness). For example, this may be having a staff member in charge of funerals, or visits to the sick; or a person who people always go to with their worries and concerns; or identifying facilities for voluntary testing. Because these activities are not very visible, they are often not costed. Time is borrowed from other work. It appears to outsiders (and some staff) that the organisation is doing nothing, when this is not actually the case.

The research project

To find out more about these less visible, informal responses to HIV and AIDS, we undertook a short action research project in three African countries (Nigeria, Kenya and Malawi). Local researchers undertook semi-structured interviews with a cross section of staff from 14 CSOs (n= 48). The purposive sampling method was adopted to identify CSOs who are responding to HIV and AIDS in the workplace, but do not yet have an HIV policy in place.

The aim of the research was to:

- make visible non-HIV policy responses to HIV and AIDS in the workplace;
- find out what motivated this response and how it can be supported;
- explore the links between informal and formal responses.

This research is only a start. The extremely limited sample sizes and short time for data gathering means that these conclusions must be taken as tentative at best.

Study sites

Nigeria
The national HIV prevalence in Nigeria has fallen from 5.8% in 2001 to 4.4% in 2005, but there are still almost three million people infected with the virus and two million orphaned children. It is estimated that about 2.4 million workers in different sectors are HIV positive. The Nigerian government launched the national workplace response policy on HIV/AIDS in 2005 as one of the intervention efforts to curb the menace of the disease.

Kenya
HIV grew from 5% prevalence in 1990 to an estimated 14% by the end of 1998, when it was declared a national emergency. Currently, HIV prevalence rate is approximated to be 7.4%, up from 5.9% in 2006. There is a national HIV/AIDS Policy Act 2006 which is yet to be given a commencement date, but few organisations have put this into practice yet.

Malawi
Malawi has a generalised heterosexual epidemic. Overall, the national rate of infection amongst adults (15-49 years old) is estimated at 12-14%, with the highest levels of infection in urban areas. HIV/AIDS is now the leading cause of death in the most productive age group (15-64 years old), resulting in 86,000 deaths annually.

Description of informal responses

We took informal responses to mean 'undocumented practical responses to HIV and AIDS that were not part of an existing HIV policy'. These were largely ad hoc, unstructured and mostly spontaneous actions, initiated by individuals, including managers from within their cultural context. From the three studies, the plethora of informal responses to HIV in the workplace can be usefully categorised by organisational and individual actions.

Organisational responses	Individual responses
Prevention	
Training	Advice and information
Staff meetings, retreats, discussions	
Peer educators	
IEC materials	
Condoms	
Facilitating access to VCCT	
Treatment	
Hospital referrals and leave	Taking to hospital
Medical cover	Advise to test
ART	Donating blood
Care and support	
Sick leave	Practical personal errands
Adjust workload	Cover work
Home visits	Visits out of hours
Individual counselling	Encouraging/building confidence
Support groups	Comforting/condoling
Funeral expenses and time	Gifts of money and material items
Income generating activities	Escorting the bereaved using own resources
Employing PLWHA	
Elimination of stigma and discrimination	

The following examples illustrate some of these different initiatives. One CSO in **Kenya** was working on prevention activities with:

> Staff retreats for employees, board members and community project leaders give time for reaching participants with HIV messages. There was also the opportunity for group counselling. This led to increased awareness on HIV/AIDS, employees self-behaviour examination, sharing and support.

The **Malawi** study highlighted some treatment responses:

> "A secretary boldly approached a male driver and a female technician who had been chronically ill and asked them to go for a check up at the hospital. They agreed. Both tested positive, declared their status to the confidant, and accessed ARV treatment. After staying home for a while, they are now back to work and working normally. But for the secretary, who knows if they would be alive today?"
>
> "Another young administrative officer was told late one afternoon that a member of staff fell critically ill while attending a workshop. She knew the man had been shying away from the hospital and was only taking medicines from local market largely because he could not afford good service. She waited for the man at the bus terminal up to about 6pm and took him using her personal car to one of 'middle class' private hospitals knowing that the public hospital would give little attention at that hour. She

> also had called her personal friends who are clinicians to attend to him. After receiving the attention, she paid the bill from her own money."

Other organisations in **Nigeria** have set aside funds for staff welfare in emergency situations. This can be used by staff living with HIV and AIDS to cover transportation costs and medical bills (though these funds are not necessarily tied to HIV/AIDS).

The informal responses to HIV in the workplace were particularly strong in the area of care and support. Some of the examples included:

> "The organisation has a strong support group that is dedicated to helping other members in the areas of *counselling*. There is a well trained professional counsellor who is living with HIV and AIDS, and whose job description includes guiding other staff in making choices and taking informed health-related decisions and other actions that have implications for their well-being."

> "Employees organise all home visits to visit colleagues either when sick, bereaved or for other ceremonies. Some employees make personal contributions to support their colleagues when sick, and pay them a visit in hospitals and at home. The home visits were also done mainly after work or during weekends to avoid clashing with the organisation management. At times, formal requests were made by some employees to visit the sick at home or hospital and attend burials. The study shows that home visits intended to provide moral and psychosocial support to the person in need while reaching out to them as 'family members' working in the same organisations".

Analysis of findings

The research undertaken in Nigeria, Kenya and Malawi clearly reveals that many **CSOs are actively responding to the threat of HIV in the workplace, without having a formal policy**. The research showed that informal responses exist widely and in smaller organisations in particular are yielding positive results. The interpretation of this is that organisations do have a policy even if it is not written down.

But none these CSOs could be considered for funding if the criterion of having a workplace policy was a condition of grant. As findings from the study show, on its own, the existence or otherwise of a **written policy is not necessarily a good indicator** of an HIV response.

There is clearly **value in the informal responses**. They are more of the 'human touch' – the compassionate response of individuals to human suffering. They are about people taking responsibility to look after their fellow human beings without being compelled to. Much of these responses are culturally influenced and reflect an individual's beliefs and character. These responses tend not be documented, nor amenable to policy legislation. But they should in no way be denigrated, particularly because they address issues of stigma and discrimination. They can provide invaluable psychological support and encouragement. The research revealed not surprisingly that informal responses to HIV go up when someone falls sick in an organisation. They tend to be spontaneous, rather than waiting for someone to ask for help.

There appears to be **distinctive differences** between taking an informal approach and a formal policy response. For example informal responses tend to cost less, because the costs are borne voluntarily by individuals. Also, having a policy puts more emphasis on treatment expectations (ARVs) and tends to address issues that have budgetary and legal/contractual implications. These differences are illustrated below:

Informal response	Policy response
Individual initiated	Organisation-wide
Invisible	Measureable
Care	Treatment and prevention
Reactive	Proactive
Lower organisational cost	Higher organisational cost
Discriminate to the likeable	Fairer
Voluntary	Binding
“Our communal responsibility”	“My individual rights”
Middle/lower staff also engaged	Top management

The reality however is that these distinctions are not so clear cut. Boundaries are not obvious. There is **considerable overlap between the informal and the formal**. The awareness and care activities described in the research amongst CSOs without a policy are extremely similar to what CSOs with policies are also doing. Those with policies include lots of the informal responses of those CSOs who do not have a policy document and vice versa. Many CSOs inhabit a grey area somewhere between the two (and also move across both response types).

The main difference appears to be simply whether the responses are written down or not. This raises questions about what makes a policy:

- Is it just writing it down that turns an informal response into policy?
- How long should a policy be before it is considered a policy? (Half a page? One page? Five pages?)
- Can policies be just descriptions of past responses? Or principles or guidelines to steer practice? Or do they have to specify exactly what will happen? Is there a graduation in formality?
- How legally binding is a policy? Can it be merely a statement of intent?
- Where does the informal end and the formal begin?

The research reiterated the value in documenting responses. Having a written policy assists in ensuring that all staff are treated fairly and with consistency. It enhances the possibility of continuity in response. It encourages better planning and therefore budgeting of response. Having a written document helps to integrate the HIV response with other systems and policies. It enables legal compliance with national legislation. It also provides an accountability framework for funds received from donors to finance HIV responses. A written document clearly demonstrates to staff that the organisation takes their welfare seriously. It can also serve to highlight and therefore address gender imbalances in responding to HIV and AIDS in the workplace.

The very process of developing a policy can be extremely valuable in and of itself. The discussions may stimulate behavioural change and some of the informal responses we have described. The process of policy development may indeed be as important, if not more, than the final document.

Advantages of having a policy	Disadvantages of having a policy
Ensures fairness and consistency in how individual staff are treated. Makes budgeting easier and enhances continuity. Gives something to show the donor and can provide accountability for funds spent. The process of developing it can be useful in itself, in terms of raising awareness about HIV, addressing gender issues and demonstrating care for staff welfare. Enhances integration with other polices such as staff terms and conditions. Gives clarity to managers and employees on what to do.	Ties the organisation into a framework of expenditure they may not feel they can afford (particularly after donor funds stop), Reduces flexibility of response. Time-consuming to develop. Detracts from the spontaneous and human face of support, undermining individual responsibility. Creates a gap between NGO staff and the communities they are working with. Can create a false sense of security that enough has been done, while cultural attitudes of stigma are left untouched.

Formal and informal responses to HIV in the workplace are **not mutually exclusive**. They can be complementary. It is not about either/or, but both/and. There is a need for both *organisational* support as well as *individual* care. There is a need for *rights*, and also *responsibilities*. There is a need for *law*, and also *love*. We need both the formal and the informal.

The balance between the two **needs to fit with the particular organisation**. Smaller, younger, less formal, 'pioneer' organisations are more likely to use informal responses. Insisting that such 'early-stage' organisations develop a policy on HIV and AIDS may be counter-productive. The response to HIV needs to fit the stage of the organisation, its age, its size, its leadership, its level of formality and its stage of development.

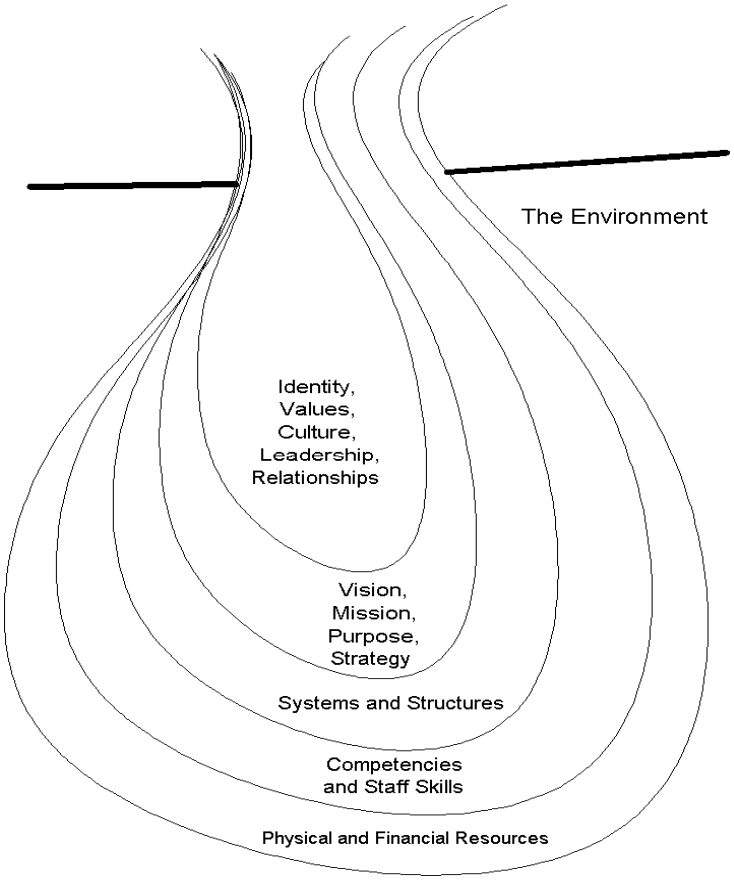
Furthermore the research showed that **policy should emerge and grow out of existing practices.** A policy should not be parachuted in from outside. Some NGOs create their policy simply by putting their name on the top of another agency's policy. Good practice responses were employee-led processes backed up by management. Therefore it is important to identify and document the informal responses that already exist. In this way more formal responses can be rooted and emerge from what already happens. For example, one organisation in Malawi actually said they will only develop a HIV workplace policy when they establish what is working informally and then they will formalise by writing and adding few important item.

In any HIV policy, **some flexibility is necessary**. Perhaps it is not surprising that most CSOs in Africa describe their HIV policy as 'draft'. For many, it has been 'draft' for many years. CSOs may have good reasons to keep policy 'semi-formal' and therefore flexible.

While in general, encouraging a policy response to HIV is positive and highly beneficial, it is important to appreciate the downsides and be aware of the dangers of an **exclusive emphasis on policy.** Addressing HIV solely through policy may undermine the 'human touch'. Putting something down as a formal organisational policy can reduce individual initiative and responsibility. The voluntary spirit that characterised the informal response is not amenable to notions of accountability. A policy can even undermine the spirit of mutual support, especially if it is just seen as a donor funding conditionality or merely a funded project.

An exclusive emphasis on policy can lull an organisation into a false sense of security. A policy in and of itself will not necessarily do anything to address the power of the prevailing culture. There is a danger that having a policy will give CSOs a false sense of having done enough, while leaving fundamental issues of power, decision-making and gender relations untouched.

Ultimately how a CSO responds to HIV will be **determined more by their culture**, not whether or not a policy exists. The culture is therefore a better indicator of response, but is notoriously difficult to measure. Leadership is key to determining culture, especially in small, informal or founder-led organisations. A workplace response to HIV is therefore much broader than simply having a policy. It involves addressing issues throughout the organisational 'onion' (see diagram below). This model illustrates the inter-relationships between the different elements of any organisation.



In this model, the outside layer of the 'onion' represents the physical and financial resources which a CSO needs – money, buildings, vehicles, equipment. Inside that layer are the human skills required to carry out the activities – the individual staff competencies and abilities.

Further inside are the structures and systems (such as monitoring and evaluation systems, personnel systems, financial management systems) needed to make an organisation work. Inside that, the vision, purpose and strategy of the CSO.

Right at the heart of an organisation lies the core of a CSO – its identity, values, leadership, culture, motivation and theory of development.

The benefit of this model is that it shows the interrelation between the different components of an NGO. There is a need for coherence and consistency between the components and an understanding that changing one component will have ramifications for the rest of the organisation. The model shows that to bring about organisational change in response to HIV in the workplace requires change at all levels, not simply at the policy or systems level.

We need to see organisations holistically. It therefore requires a **more organisational development (OD) approach to change** – one that looks at change in the context of the whole 'onion'. With HIV it is even more important to ensure that the gender dimension is central to any OD process. In looking at culture, African cultural values of 'Ubuntu'[1] such as:

- sharing and collective ownership
- the importance of people and relationships

[1] The term 'ubuntu' as commonly found in the Nguni languages of southern Africa, and words with a similar meaning are found throughout sub-Saharan Africa. It has resonance throughout Africa, however and describes the notion that 'I am because we are' or 'my humanity is caught up, is inextricably bound up, in what is yours' (Desmond Tutu).

- participatory leadership
- loyalty and;
- reconciliation

may need to be harnessed to encourage organisational response to HIV.

Implications for donors

These findings raise important questions for donors:

- How do we accept and value the informal, without relenting on the encouragement to the formal (where appropriate)? How do we encourage better **research and documentation of these informal responses**?

- How can we **take a more nuanced approach**, looking at CSO response on a case-by-case basis? Is there any room for developing different forms of 'policy' (from 'description' to 'guidelines' to finally 'policy')?

- How do we maintain our focus on **the 'big questions'**, not the 'easy measures'? 'Is this response really helping the organisations and individual survive and grow through HIV?'

- If we push hard for formal policy responses, then what level of responsibility will we take for **funding the implementation** over the long-term?

- Given that ultimately the response to HIV in the workplace is more influenced by the **culture and leadership of the organisation**, how do we assess and address such intangible, but clearly essential, elements?

Implications for CSOs and capacity building providers

There are also a number of important implications and questions for CSOs and CB providers. These include:

Appreciate, encourage and reward individual initiative in responding to HIV in the workplace. One or two people, not necessarily the leaders, can alter the atmosphere and even culture of the organisation. The research highlighted the important role that such individuals played, both as confidants and advocates. How do we better acknowledge and therefore encourage people to practice compassion and openness in the workplace?

One way of doing this is to **create a compassionate working environment**. Greater attention could be paid to addressing cultural issues by intervening and discussing values/virtues in organisation. Such issues should set the tone for everything - not only, but also including, response to HIV. How do we foster this compassionate working environment?

In encouraging an organisational response to HIV, as capacity builders and change agents we need to take a holistic approach. We need to look broadly at **wider organisational elements and take broader OD approach to change** (illustrated earlier by the onion model)**.** How do we do that when we are only asked to look at the technical aspects of policy development?

There is value in helping CSOs **document what they are already doing 'naturally'** in response to HIV. This is the unofficial 'policy'. It is something organic, not imposed from outside. Certainly this 'policy' can be further developed. How do we help organisations recognise and document what they are doing – but then take them **one or two steps further?**

It is also important for CSOs and capacity building providers to **talk openly and honestly with donors** to help them understand how they can better support partners to respond. In some cases this will be providing encouraging feedback, in others suggesting better alternative actions. We need to take responsibility for helping donors improve, treating them as authentic partners, and not simply waiting obsequiously for their money. What opportunities can we make or take?

Conclusions

This research showed that indigenous coping mechanisms for addressing HIV and AIDS in the workplace do exist. These informal responses are invisible to those who merely look for formal HIV policy documents. Such informal responses are particularly apparent in smaller, younger NGOs who do not operate by policy. We should not undervalue the unwritten, especially in oral cultures and informal organisational contexts.

While not reducing our commitment to building organisational resilience to HIV and AIDS, we may need to be more discerning and selective about our exclusive focus on a policy tool to address this, after all a hammer is not the only tool we use in building. By insisting on policy response alone we run the risk of inadvertently subverting and swamping these informal responses. An official HIV policy may undermine people taking responsibility for HIV themselves and may compromise an existing spirit of care and voluntarism. There may be avoidable costs in formalising a policy – in time, money and even in stigma. There is a danger that having a policy will give CSOs a false sense of having done enough. An HIV policy will not do much to address the power of the prevailing culture.

There is considerable overlap between the informal and formal. They are not mutually exclusive. We need to understand more about both to encourage partners to respond in an appropriate way for them in their context. We must encourage CSOs in Africa to respond to HIV in the workplace. This definitely includes a policy response for many more formal CSOs. But it is much more than that.

Ultimately how a CSO responds to HIV will be determined more by this culture, not by whether or not a policy exists. Rather than focus exclusively on HIV policies, instead we may need to assess organisational culture and encourage the individual virtues that catalyse and characterise the best responses.

This paper may have lessons for policy-dominated approaches to change in other areas of development, such as gender or rights. A policy document approach may fit some cultures and contexts more easily than others. Donors may need to examine in more depth the contextual and cultural influences on the actions they advocate to partners. An approach to change that fits a large European NGO working globally may not be necessarily appropriate for a small, African community-based organisation. We should avoid being seduced into a numbers game, where an easily measureable, policy solution is deemed to fit all partners everywhere. We need to take a much more contextually aware approach to change. We should encourage organisations to develop policies, but only where this fits their particular situation.