Praxis Paper 24

Looking After Number One:
Donor support for HIV and AIDS in the workplace

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Executive summary

International donor agencies are responding positively to the threat of HIV in their own workplaces. They support a broad health and well-being approach, emphasising testing and treatment. The majority admitted, however, that they do significantly less for their partners. This inconsistency raises questions about donor obligations, responsibilities and values. Moreover, it may undermine the long-term effectiveness and sustainability of the development work they support.

This paper synthesises the findings from a six-country research project looking at the workplace responses of 50 international agencies – bilateral, multilateral and NGOs – working in India, Malawi, Uganda, Kenya, Burundi and Ghana.

HIV response within donor agencies

Forty-two of the 50 international donor agencies in the research were proactively responding to the threat of HIV in the workplace. This was largely a result of adapting a global agency policy, rather than a sense of immediate threat from the local environment. Four out of the 6 National AIDS Commissions in the study did not have workplace policies.

While some agencies were consistent in implementing their global policy across the different country offices, other agencies were more varied. This reveals how much individuals and the attitude of country-level leadership profoundly influences how energetically global policy is applied within separate country offices.

Donor response to HIV was usually part of broader approach that encompassed health and well-being. Donors tended to contract out their response to HIV and AIDS through private sector medical insurance (which may have reduced the sense of threat). They put greater emphasis on testing and treatment and were doing less on prevention activities. The focus is more on local staff than expatriates. They assume high levels of staff knowledge about HIV and some are concerned that staff are getting bored with the issue. Donors were doing little to directly address ongoing issues of stigma, and disclosure of status was still rare.

Donors were generally positive about the impact on behaviour of their workplace response. They believed the benefits outweighed the costs. Only a few had any systematic monitoring and evaluation information. Very few gave detailed financial information about the costs. This is partly because data was not disaggregated for HIV; confidentiality measures hid real costs; and a fear they would not compare well with other agencies.

There was little evidence that donors were learning from each other in this field. Most were responding to internal head office policies, rather than finding out from other agencies what was working for them.

HIV workplace response with partners

None of the international donor agencies interviewed supported workplace responses with partners to the same extent. Only an exceptional few had a proactive strategy and were investing considerably in the issue. Most, however, left the onus on the partner to approach them. They assumed that partners will look after themselves.

Some provided technical assistance and some financial support for policy development. But only three of the 50 agencies interviewed explicitly stated that they support the costs of partners implementing workplace policies. Although most donors were positive in principle, their grant systems did not make this easy and they feared the costs would be too high. Long-term commitment to the workplace response to HIV in NGOs was absent, particularly in light of the current tightening of aid resources and increasing focus on the private sector.

This inconsistency raises uncomfortable questions about underlying values:

- Are local partner employees valued the same as international agency staff?
- If it is cost effective to support internal responses to HIV, why is it not cost effective to support partner responses?

Recommendations to donors

The recommendations arising from this six-country study are that donors:

1. **Know and understand that it makes good business sense to support partners** to implement HIV workplace programmes. HIV causes costs to rise and efficiency to fall. Donors and INGOS must understand that the funding they 'invest' in partner organisations' programmes will be more effectively utilised and more sustainable when the organisation is functioning at its optimum. This means proactively addressing HIV.

2. **Develop proactive strategies to support partners** in responding to HIV in the workplace. They should take the initiative to discuss with partners how they can develop locally owned and appropriate responses.

3. **Invest in partners' implementation** of their workplace response. This investment should go beyond technical assistance and be consistent with the support they offer to their own staff.

4. **Advocate to and collaborate more with other donors** in implementing workplace programmes. This will help share costs. They can also jointly advocate with national governments for appropriate legislation to encourage HIV resilience.

5. **Adapt their global policies on health and HIV**. Global policies should be tailored to the prevalence, culture and needs in the national context.

6. **Support HIV focal point people** with the time to develop internal and external support for HIV workplace responses.

7. **Continue to address issues of prevention and stigma**. Staff knowledge about HIV is still far from perfect and some attitudes are still discriminatory.

8. **Develop their own monitoring and evaluation systems** so that they know more about whether their workplace programmes are making a difference.

9. **Investigate and replicate good practice** and set up fora to share learning with other donors.

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1. Introduction

Donor support to HIV and AIDS in the workplace is critical, but fragile. It is under threat as more and more reports confirm that international donors are cutting back on HIV/AIDS funding[1]. Workplace responses to HIV may be one of the areas of investment that gets cut. To ensure that they remain firmly on our agenda we need to know what is already being done to address HIV in the workplace within donor agencies and INGOs and analyse the level of support they also give to partner organisations.

HIV and AIDS shine a light deep into our organisations. They force us to confront our underlying individual and organisational values and beliefs. As this research shows, HIV and AIDS ask us questions that we might rather not answer:

- How do we treat our staff and colleagues who are living with HIV?
- What support is given to partner organisations as they confront HIV in the workplace?
- Are local counterparts treated as equals?
- Is it financially viable to continue supporting partner organisations to respond to HIV in their workplaces?

These are questions that we cannot ignore, especially in the current economic crisis, when many international donor agencies are slashing their budgets.

This research report synthesises the findings from the six-country research project looking at the workplace response of 50 international agencies – bilateral, multilateral and NGOs – in Burundi, Ghana, India, Kenya, Malawi and Uganda. It shows that donor agencies and INGOs are responding positively to the threat of HIV and AIDS in their own organisations. They have comprehensive workplace policies that include a range of benefits and provisions including health insurance, prevention activities and access to high quality treatment, care and support. The majority admitted however, that they are doing significantly less for their partners. Partner organisations are actively encouraged to develop HIV workplace policies but support for implementation – both financial and technical – is limited. Essentially donors are 'looking after number one'.

1.1 HIV and AIDS and the workplace

HIV workplace policies and organisational responses to HIV and AIDS have been on the donor, INGO and local NGO agendas for some time. Many organisations have formulated workplace responses. Some are informal practices that have emerged organically in response to an organisation's experiences. Others are formal policies that have been written as a result of a conscious policy formulation process. Local partners are often encouraged by their donors to develop a workplace policy. Some receive funding or technical support to develop their response to HIV and AIDS. Others receive less support but are expected to provide evidence of a policy as part of the funding process. In the case of donor agencies and INGOs, policies are often formulated in the head office and filtered down to country offices. A number of donors and international NGOs, in addition to their own internal workplace policy, also support their partner organisations to develop workplace responses. But why are workplace policies so important?

[1] See MSF 2010, 'No Time to Quit' www.msf.org/source/countries/africa/southafrica/2010/no_time_to_quit/HIV_Report_No_Time_To_Quit.pdf

HIV and AIDS impact organisations in a number of ways. Organisations, particularly those working in areas of high HIV prevalence experience at least one, if not all, of the following:[2]

- Loss of skills through staff sickness and death
- Loss of organisational memory and history as experienced staff leave
- High levels of absenteeism as staff cope with their own illness, care for relatives and attend funerals
- Low morale as staff struggle to cover increasing workloads and deal with the loss of staff
- Delays in project implementation as staff are frequently absent
- Failure to meet the needs of beneficiaries as the organisation struggles to survive
- Increased staff expenditure related to medical costs of sick staff
- Frequent recruitment of new staff to replace those who have died or are too sick to continue working.

Workplace policies have become vital tools in responding to HIV and AIDS in the workplace. They address HIV prevention and establish how the organisation will respond to HIV-positive staff, including the benefits that will be provided. The process of developing organisational policies and responses is as important as the policy itself. It can lead to the creation of an open and accepting environment where stigma and discrimination are confronted and issues around HIV and AIDS are openly discussed and addressed.[3]

1.2 The research project

This research project builds on earlier studies undertaken by INTRAC on HIV and AIDS in the workplace.[4] It also draws on the conclusions of the 2009 INTRAC–STOP AIDS NOW! publication: ‘HIV in the workplace: 20 ways for INGOs to help partners’.[5]

To understand more about the extent of donor support for HIV and AIDS workplace responses, we undertook a short action research project in six countries (Burundi, Ghana, India, Kenya, Malawi and Uganda). Local researchers undertook interviews with staff from 50 donor agencies, international NGOs and administrators of the Global Fund across the six countries.

The research aimed to:

- Ascertain the extent and trends of in-country donor responses to HIV and AIDS in the workplace both within their own organisations and in the support to partners
- Analyse the congruence (or otherwise) of support within donors and INGOs and the support they offered to their local partners.

Whilst this was a limited study undertaken within a short timeframe, the outcomes are significant. This is especially the case since HIV and AIDS are not going to disappear

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[2] Rick James with Brenda Katundu, Betsy Mboizi, Emily Drani, Daudi Kweba and Rogers Cidosa (2006), ‘The Organisational Impacts of HIV/AIDS on CSOs in Africa’ (INTRAC Praxis Paper 13); Rick James and Bunmi Dipo-Salami, Leonard Satali and Everlyne Nairesiae (2008), ‘Who Needs an HIV Policy? Informal workplace responses to HIV in Nigerian, Kenyan and Malawian CSOs’ (INTRAC Praxis Note 46)
[3] Rachel Smith and Project Empower (2010), ‘The means is the end: Reflections on the process of developing HIV workplace policies’ (INTRAC Praxis Note 50)
[4] Rick James et al. (2006) ‘The Organisational Impacts of HIV/AIDS on CSOs in Africa’ (INTRAC Praxis Paper 13)
[5] Hanna Ferguson and Rick James (2009), ‘HIV in the workplace: 20 ways for INGOs to help partners’, (INTRAC and STOP AIDS NOW!)

overnight. The global economic crisis will also take time to resolve and donor funding will take time to stabilise again.

1.3 Study sites

The six study sites covered a cross section of different HIV epidemics. High prevalence countries in southern Africa – Kenya, Malawi and Uganda, were included along with lower prevalence countries – Burundi, Ghana and India. The latter, India, whilst being a low prevalence country, has significant absolute numbers of people living with HIV (2.5 million).

Overview of the study sites

	Burundi	Ghana	India	Kenya	Malawi	Uganda
HIV prevalence rate	2.97%	1.9%	0.36%	7.1%	12%	6.5%
Epidemic trend	Stable	Stable	Variable	Stable	Stable	New infections increasing
No. of people living with HIV and AIDS	160,000	267,069	2.5 million	1.4 million	951,666	1 million
VCT – no. of people who have accessed HIV testing	30,827 (18.1% for women, 16.66% for men)	1,120,000 tested by June 2009	10.1 million	Around 40% tested, target of 80% in 2010	535,685 accessed testing in 2009	15-20% of Ugandans know their status
No. of people accessing ART	17,604	31,997	217,781 accessing free ART (however, many people access ART privately which is not reflected in the available data)	135,800	312,467	105,000
% of those in need of ART receiving treatment	*Not available*	33%. An estimated 72,000 people are in need of ART.	*Not available*	38-45% Most treating facilities are in peri-/ urban areas. Limited access in rural areas where an estimated 70% of people living with HIV live.	65% Though there are challenges with access in rural areas where people may have to travel long distances to reach the treatment centres.	50% of people living with HIV (PLHIV). However, ARV drugs are often out of stock in Government health centres.
National response	Activities around HIV and AIDS	National HIV/AIDS and STI	Indian Government is	The national response to	National AIDS Commission coordinates	The Government of Uganda

	are coordinated under the National Council for the Fight against AIDS (CNLS).	Policy provides the framework for the response. HIV/AIDS Work Place provides guidelines for the formulation of workplace policies and programmes.	responding through a National AIDS Control Programme. In 2009 the Ministry of Labour and Employment launched the National Policy on HIV/AIDS and the World of Work.	HIV and AIDS is coordinated by the National AIDS Control Council.	the national response to HIV and AIDS. It is guided by the National Action Framework. HIV and AIDS are mainstreamed in the vast majority of Government departments and workplace mainstreaming is also gaining ground within the CSO sector.	has a multi-sector structured response to HIV and AIDS. This is coordinated by the Ugandan AIDS Commission. A policy on HIV/AIDS and the World of Work has been developed to address HIV in the workplace.

1.4 Research limitations

With a limited budget, this research was undertaken over a short period of time. Country studies only allowed for eight days work. The data gathering was therefore limited to one staff person's perspective on the organisation's approach to HIV internally and with partners (though considerable effort was made to ensure researchers talked with the appropriate respondent). There was no time to triangulate findings.

On the financial side, most respondents were unable or unwilling to provide researchers with accurate information about the actual costs involved. Nor did donors have rigorous enough systems to be able to provide strong evidence of the impact, making any cost-benefit assessment impossible.

2. Findings – Internal workplace responses

2.1 The perceived threat of HIV

The research shows that HIV and AIDS in the workplace is high on the agenda of the vast majority of donor agencies and INGOs. HIV was recognised to be a threat, although the perceived degree of threat varied. The HIV risk amongst expatriate staff of donors was often perceived to be lower. As one respondent pointed out, "although it is hardly thought of, the expatriates are equally at risk… especially for those whose partners are not resident in the country". Importantly, several organisations said that this threat was offset by the benefits provided in the workplace response.

While almost all respondents recognised HIV as a threat to organisations, opinion was divided as to whether the issue of HIV in the workplace was growing in importance. In Uganda, only two of the nine organisations interviewed felt that this was the case. Both organisations were under pressure to 'visibly increase' their responses to HIV in the workplace. The other seven felt that interest is waning. Changes in priorities, intangible results and the availability of free ART (antiretroviral therapy) were cited as the main reasons.

Another agency demonstrated deeply divided opinion between its different country offices. In Ghana, this agency's respondent felt strongly that focussing on HIV in the workplace is:

> "a waste of resources, [it is] inefficient to do things on HIV alone, [we should] concentrate where people need help most, such as chronic diseases, diabetes, high blood pressure, hepatitis and unbalanced and social security issues…"

The respondent felt that any efforts should only be concentrated on working with most at risk populations. This view was not held by the other five country offices of the same agency. For example in India, another low prevalence country, the same agency was seen by other donors as leading the response. This reveals that even when there is an overarching policy, individuals still have a major influence on how it is implemented.

Conversely in Burundi, Malawi, Ghana, and India, HIV workplace policies and responses are gaining momentum. In Burundi, donors and INGOs have tended to focus on HIV 'out there' in the community rather than within their own workplaces. More recently there has been increasing investment in workplace responses to HIV. Agencies have experienced the costs of HIV through lost staff and absenteeism. With the roll out of free ART, in particular, agencies in Burundi see workplace responses as a cost effective way to limit the impact of HIV on their work.

2.2 Donor and INGO internal responses to HIV

Internally, most donors and INGOs routinely provide high quality and comprehensive support to staff living with HIV and AIDS (SLHIV). Forty-two of the 50 agencies in the study had HIV workplace policies in place either as standalone documents or included within other human resource guidelines. These policies and responses are generally well funded and well established, many had been in place for at least two years.

Overwhelmingly, most of the policies were adapted from global policies originating from their headquarters. As one respondent said:

> "The impetus for developing the workplace policy was top down. The headquarters in Germany provided the organisation with technical papers and toolkits, as well as the broad framework of the policy, which the organisation could adapt to the local situation."

In one case however, the policy was seen as a rigidly imposed set of provisions rather than an appropriately adapted and contextualised response. As the interviewee reported:

> "It was a matter of following norms laid down by headquarters or parent bodies, often based in other, first-world countries, rather than the result of perceiving a significant risk to the organisation from HIV and AIDS from an analysis of the local environment."

There were exceptional examples where policies were developed in-country. Two INGOs in Burundi had developed their policies in-country. The initiative in one of these organisations came from employees in response to their situation and experiences. In one Indian agency, staff took the initiative to convene discussions, draft the policy and get it adopted. This was after initial awareness raising sessions about HIV workplace policies.

The HIV policies and responses of the agencies in this study had a similar set of guiding principles in common, including:
- promotion and protection of human rights
- gender equality
- participation of people living with HIV
- the right to information
- the right to social protection in prevention, treatment, care and support.

The policies covered the staff of the donor agency or INGO. Some organisations also extended their workplace policy to include employees' family members and dependents. One agency even extended benefits to the domestic workers of expatriate staff.

The policies typically covered all or a combination of some of the following provisions:

Workplace policy management and implementation	**Voluntary counselling and HIV testing (VCT)**
▪ Recruitment and training of peer educators and/or HIV focal point persons ▪ HIV workplace coordination committees ▪ Periodic Knowledge, Attitude and Practice (KAP) surveys ▪ Monitoring and evaluation of activities ▪ World AIDS Day programme of activities	▪ Onsite counselling and testing (some regular, some ad hoc) ▪ Recommendations of VCT centres and encouragement to staff to test ▪ Information and encouragement to test for other sexually transmitted infections (STIs) and opportunistic infections (OIs)
Prevention	**Treatment, care and support**
▪ Information and awareness workshops on HIV and AIDS and prevention (some include employees' families and dependents) ▪ Distribution of information materials ▪ Provision of condoms (male and female) ▪ Health fairs covering a range of health issues including how to prevent HIV, STI and TB infection ▪ Provision of Post Exposure Prophylaxis (PEP) [6]	▪ General medical insurance which includes HIV and HIV related illness ▪ Programmes for specific HIV care and treatment ▪ Enrolment in private health clinics ▪ Referral to Government ART centres ▪ 'Solidarity funds' – staff contributions towards a fund which is used to assist SLHIV ▪ Education on stigma and discrimination ▪ Health and wellbeing approach covering a

[6] Post Exposure Prophylaxis (PEP) is a course of anti-retroviral treatment that can prevent HIV infection once the virus has entered the body. It is prescribed to people who have been at high risk of

▪ Where HIV is linked to sexual violence measures are taken to reduce the risk of violence e.g. discouraging overtime, employment of security guards, secure transport, training on sexual violence	range of health issues and illnesses including HIV, cancer, blood pressure, diabetes, alcohol/drug use, social security

Most of the agencies surveyed took a 'health and well-being' approach.[7] They do not have a standalone HIV policy. Rather they have policies which address a range of health issues, including, but not focussing solely, on HIV and AIDS.

Several agencies in the study did not have an HIV workplace policy. For one organisation it was not for lack of interest or priority. The organisation had been helping other organisations, as the respondent reported:

> "We have been busy assisting organisations to draft their [HIV workplace policies] policies. We have no HIV workplace policy of our own yet".

Two organisations in Uganda and Ghana had both developed workplace responses to HIV without having a formal HIV workplace policy. As INTRAC's 2009 research shows, informal responses can be just as important as formal adopted policies[8].

Waning interest?

Several organisations reported that interest and energy were waning. One organisation in Ghana reported that "due to an intensive workplace programme for six years, people are getting tired and bored with HIV information". This was echoed in Kenya and Uganda where one respondent noted: "In the beginning it was OK, these days it takes so much energy and a lot of creativity to have people attend the sessions". Stigma, fear of stigmatisation and self stigma also hindered staff uptake of services. This was despite a reported reduction in stigma in the workplace. In India, the perception of low risk continues to lead to a low staff demand for services.

Respondents in Uganda and India also mentioned an 'I know it all attitude' preventing employees from trying to learn more. This was particularly the case amongst senior staff who saw the policy as applying mainly to the 'lower cadre' staff.

There was also a marked difference between the impact of HIV workplace policies on local and expatriate staff in several organisations. Local employees were generally receptive to the workplace policy. Conversely, many expatriate staff felt that the policy did not apply to them. A respondent in Uganda noted that the head office in the expatriates' country of origin often does not have a workplace policy meaning that "these programmes and activities sometimes do not make sense to [expatriate staff]". This perception was exacerbated in the organisations surveyed where they had a comprehensive medical insurance policy for expatriate staff and a local policy (not covering HIV) for local staff.

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exposure to HIV. PEP makes HIV infection less likely, however it is not guaranteed to prevent HIV from taking hold. Condoms remain the most effective way of preventing HIV infection.

[7] More information about health and wellbeing approach to HIV in the workplace can be found in, 'Wellness in the Workplace: Boosting organisational immunity to HIV/AIDS' (INTRAC Praxis Note 39)

[8] Rick James and Bunmi Dipo-Salami, Leonard Satali and Everlyne Nairesiae (2008), 'Who Needs an HIV Policy?: Informal workplace responses to HIV in Nigerian, Kenyan and Malawian CSOs' (INTRAC Praxis Note 46)

2.3 Policy costs

> "The cost is minimal compared to the value of our staff."
> Respondent in Burundi

> "Though the costs [of the HIV workplace policy] may be high, it pays off in the end. When one considers how much we would be spending on new staff, it is worth it."
> Respondent in Uganda

It was difficult to find out the exact costs of the donor and INGO HIV workplace policies. Less than a third of the 50 organisations interviewed gave actual or estimated costs. Most of the organisations interviewed were unwilling to discuss expenditure and budgets. Many simply did not know how much the workplace response costs. Others said this was confidential information. For a number of organisations, the cost of internal mainstreaming was not disaggregated from the overall budget for HIV programmes, making it difficult to extract. Many respondents were concerned that this information could reflect poorly on their organisations when their expenditure was compared to the budgets of others.

Varied costs

Although difficult to get concrete information, several organisations were able to give some figures and estimations. These figures are however, limited by insufficient data on how many employees are covered by each organisation's policy. These reveal that the budgets and expenditure of the workplace policies varies dramatically. In India one organisation budgeted US$7,500 per year. Yet in Uganda one organisation had a budget of US$200,000 per year allocated to the workplace response. Other organisations allocated costs per person per year. These varied from around US$1,200 to $1,800. Other organisations calculated the costs as a percentage of overall staff costs, varying from 5% to 7%. The table below summarises the variance in costs:

Country	**Costs of/budget allocations for HIV workplace policy implementation** ***(Each bullet point denotes a different organisation's response)***
Burundi	▪ Not interested in knowing the cost ▪ 5% of staff related costs
Ghana	▪ €12,000 (US$15,100) per year for all staff plus a preventive health package (funding for partner organisations' workplace policy implementation is separate) ▪ Approximately $48,000 for training staff ▪ $50,000 per year ▪ Costs are negligible – HIV in the workplace is not a priority
India	▪ US$7,500 per year ▪ Total budget for all HIV activities of US$300,000-350,000 but this was not disaggregated
Kenya	▪ 7% of staff costs ▪ Group insurance cover of KSHS150,000 (US$1,840) per staff ▪ Insurance cover of KSHS100,000 (US$1,220) per staff ▪ 3% of the operational budget (but less than 1% actually used)
Malawi	*Not able to get costs from any organisation interviewed*
Uganda	▪ US$20 per person added to the health insurance package for HIV-related issues. ▪ Total budget of US$200,000 for the HIV workplace programme ▪ 3% of each programme budget for HIV mainstreaming but this is for both internal and external activities.

2.4 Staff access to ART

The costs of responding to HIV are obviously related to staff access to ART. ART is free or heavily subsidised by the governments of all of the countries included in the study. Despite this, coverage is patchy. It is easier to access ART in cities and large towns. Access in rural areas is problematic and many people still find themselves travelling long distances to

receive their ARV drugs. Most donors and INGOs are located in capital cities and large towns. Their partner organisations however, are often located countrywide, with a number in rural areas.

Employees in most of the donor agencies and INGOs interviewed have access to ART through medical insurance policies and/or membership of private health facilities, both of which are paid for by the organisation. In some agencies, employees are referred to the government ART centres. A small number of agencies were doing nothing to facilitate access to ART for their staff.

ART's positive impact in a Ugandan organisation

One donor agency interviewed in Uganda reported the positive benefits of ART in one of their private sector partners:

"Between 1998 and 2003 the organisation lost twenty-four workers to chronic illness, generally death due to AIDS. This is a story common to many organisations in southern Africa. Such loss of staff can lead to crisis in an organisation. Skills are lost, morale is damaged, projects and programmes get delayed, beneficiaries suffer and the stress levels of staff are dramatically increased. If ignored such a situation can lead to the complete collapse of an organisation.

With the provision of ART in the organisation, only four workers were lost in the subsequent five years. Attrition related costs fell from 1% of annual labour costs to 0.11% of annual labour costs, a reduction of 90%. Not only did the provision of ART enable staff to continue working, it reduced the costs bourn by the organisation."

The provision and accessibility of ART has a positive impact on the workplace. Two agencies in Ghana saw staff responsiveness to ART increase with the improved availability of ARV drugs. As the case study above shows, facilitating staff to access ART enables organisations to continue functioning normally in the face of HIV and reduces costs.

The provision of ART at government and private facilities cannot be taken for granted though. Two respondents in Uganda were quick to point out that the availability of ART can also be donor dependent:

> "There is a looming possibility of donor support for HIV not being increased this year. As a result these government health centres and some of the private ones that are donor dependent have decided not to take on any new patients on ART. They need to ensure that they have enough for those who are already receiving it."

Additionally, the roll out of free ART has not been the quick and easy solution to HIV that many people expected. Reliance on government ART centres in all the study countries is complicated by the inconsistent supply of drugs. Centres frequently run out of stock or receive drugs that are out of date. Social and cultural norms can also dictate access to ART. To avoid recognition and subsequent stigma and discrimination many people chose not to access ART, or they travel to ART centres far away from their local clinic. In India prevailing social norms also prevent some people, particularly women who require an escort, from accessing free ART at government centres. Poverty also plays a significant role. The cost of losing a day's wages and the costs of transportation to the ART centre can also deter people from accessing treatment.

One Ugandan respondent also observed that free ART has reduced the sense of urgency for HIV workplace policy implementation. When they started their workplace response there was a lot of interest and concern about HIV. At that point ART was not free or widely accessible. Employers were anxious about the losses they were incurring due to staff members

becoming sick and unable to work. Colleagues were noticeably ill and there were frequent funerals to attend. HIV was clearly visible. With the onset of free ART, employees who may otherwise be unwell and absent from work are able to continue working. Whilst obviously strongly in favour of free ART, it must be recognised that to maintain ART's effectiveness, HIV needs to be continually addressed. The benefits of free ART will only reach those who know and accept their status and those who are willing and able to access treatment, care and support. An HIV workplace response can create and maintain the conditions that encourage and support HIV-positive employees to access ART.

2.5 Impact of the workplace policy response

> "We have not really thought about monitoring, and I don't know whether we will use formal monitoring methods. We may seek feedback informally. I think what we would be concerned about is whether an enabling environment has been actually created in which it would be practical for a positive staff member to seek support."
> Respondent in India

Monitoring and evaluation (M&E) of HIV workplace policies and responses was generally weak. Only 18 of the 50 agencies conducted any sort of monitoring activities. Most organisations reported that they did not know the impact of their policy responses due to lack of formal monitoring systems or lack of documentation. While donor agencies and INGOs emphasise the critical importance of M&E to partners, they do not follow their own guidelines internally.

M&E activities

The existing M&E systems appear limited. Some agencies collect quantitative data on indicators such as: the numbers of meetings/training sessions held; number of peer educators trained; and, the number of times peer educators are approached for information. Other agencies collect data on expenditure on HIV and other chronic illnesses covered under the health insurance policy. But overall, much of this M&E is related to inputs and outputs, rather than impact and outcomes

Two agencies are moving towards monitoring impact through conducting KAP surveys and periodic assessments and evaluations. One of these agencies, however, said they had not conducted any kind of impact assessment. The other agency conducts an impact assessment every two years, with interim evaluations in between.

Despite the limitations in M&E, most organisations believed their workplace programmes were having a positive impact. Much of the evidence for this was gained through *ad hoc* qualitative M&E such as: the evaluation of training sessions and meetings; review meetings to discuss the workplace interventions; observation in the workplace (e.g. attendance of events, responses of staff during training and meetings, behaviour in the workplace).

Perceived impact

> "We know of some staff who would have left or even died if it were not for services offered."
>
> "[Our staff] turnover related to HIV related illness is lower than it would have been, staff have tended to stay and work".
> Respondents in Uganda

Although the majority of the organisations interviewed did not have documented evidence of impact, they perceived a positive impact on a number of key issues:

- an increase in positive health seeking behaviour
- behaviour change – "knowing one's HIV status serves as a 'wakeup call'"
- a more open workplace – staff are able to talk more openly about sex and HIV and AIDS
- reduced staff turnover – staff serve for longer in the organisation and are living healthier lives
- minimal absenteeism
- reduced stigma (although disclosure still remained an issue with a number of interviewees reporting that staff were still reluctant to talk about their HIV status)
- improved productivity
- changes language in the workplace – one respondent noted that there were "reduced sexual overtones" in the way that staff related to each other
- increased staff morale that came with job assurance and basic care of staff and their families

Workplace policies and responses in the vast majority of the 50 donors and INGOs appear to have helped in creating positive working environments. Not only are health benefits and HIV and AIDS services provided, but organisations develop the skills and tools to cope with HIV in the workplace. Both staff and managers are able to see and implement actions that enable HIV-positive staff to continue working and contributing to the organisation's mission. HIV-positive staff in turn have "confidence in management that they care" (respondent in Kenya). They feel valued as a person and an employee and better able to continue working. This has the subsequent effect of raising morale across the whole organisation as all employees are able to see that they (and their families) will be looked after if they become infected and/or affected by HIV and AIDS.

The positive impact at the organisational level was also replicated amongst individual employees. Across the six countries, in all the organisations interviewed, there was a generally positive response from staff to the workplace policy. Staff uptake of the services offered such as awareness sessions, requests for information and free condoms, was generally good. A number of respondents also reported that employees involved family members and dependents in awareness sessions.

Although most of those interviewed felt that uptake of VCT and ART had increased, they were unable to say for certain. These services are confidential by nature. Most of the agencies interviewed use medical insurance schemes and/or private health facilities to administer VCT and ART. Since insurance claims and medical bills are generally not disaggregated by illness or service it is impossible to know if employees were accessing treatment as provided under the workplace response.

One agency in Uganda arranged an onsite testing day and noted that around 80% of staff and their dependents were tested for HIV. Representatives from the management were the first to take the test and this inspired other employees to follow. This sentiment was echoed by organisations in Burundi and Kenya. In both cases, the commitment of management directly contributed to successful policy implementation and positive staff response.

3. Findings – Support for partner organisations

Over 2,100 organisations are in partnership with the donors and INGOs in the six countries included in this study. In general the partner organisations were a cross section of local NGOs, government ministries and private sector, with the majority being local NGOs.

Over 790 partners were cited as having workplace policies in place. However, most of the respondents were unable to say whether or not their partner organisations had workplace

policies. It is difficult therefore to give an accurate picture of how many partners are being supported to develop and implement workplace policies.

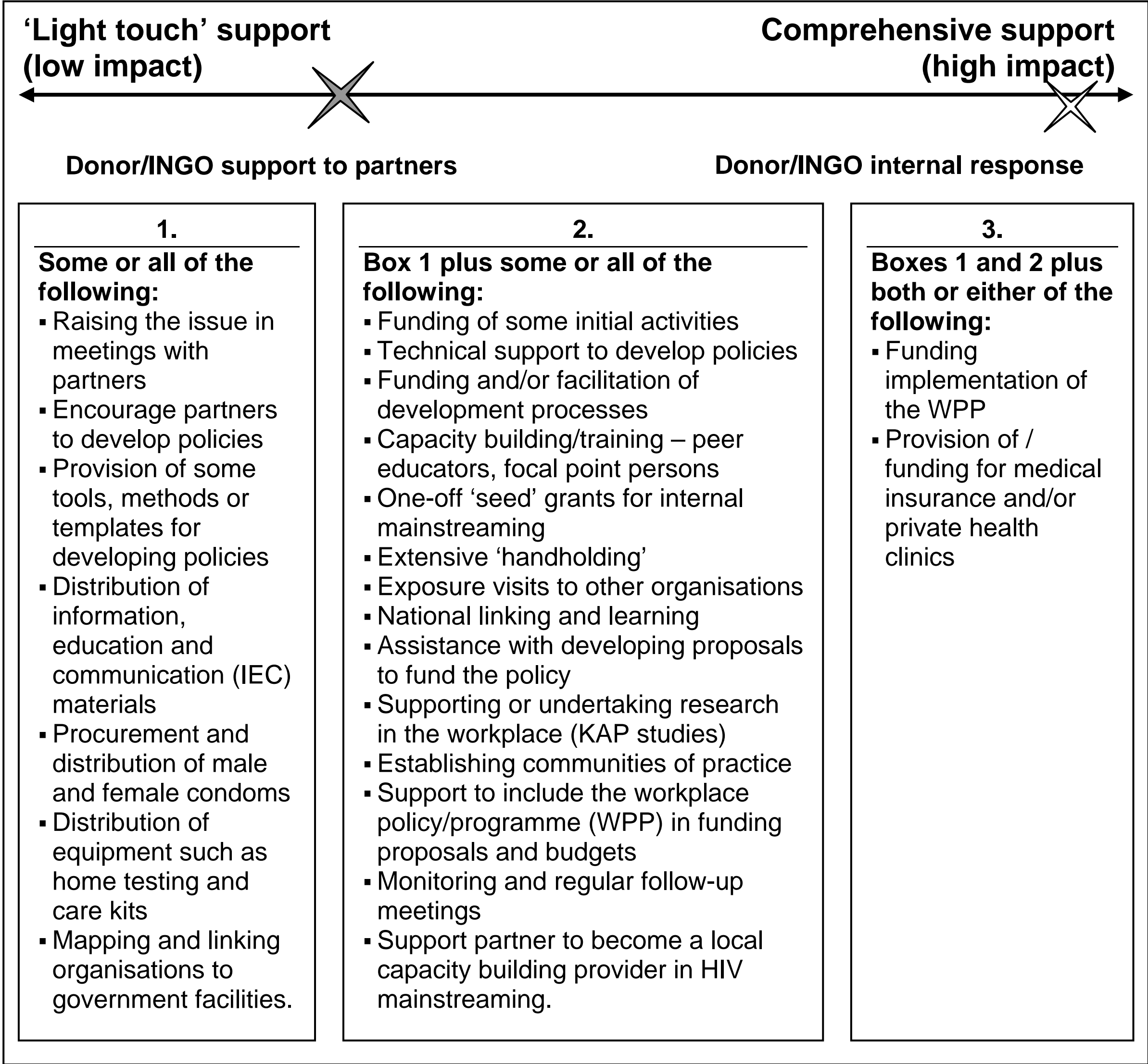
3.1 Types and level of support given to partners

> "International non-governmental organisations are doing more for their own staff and taking very little care of their local partners".
> Jonathan Mbuna and Leonard Satali (Malawi researchers)

Most of the donors and INGOs interviewed support their partners to develop workplace policies, but stop short of funding their implementation or financing the benefits included in the policies. The majority of donors and INGOs acknowledged that what they do for their partner organisations in this regard is significantly less than what they do for staff within their own organisations.

The range of support offered to partner organisations varies from 'light touch' encouragement to comprehensive policy support which includes both technical and financial assistance. Light touch responses tend to be lower impact. To move from discussions or encouragement, organisations often require technical support and financial input. Comprehensive support can have a higher impact since it enables a range of activities to be undertaken and gives staff in partner organisations access to similar benefits that donor or INGO agency staff receive.

Most of the agencies included in this study provided support towards the light touch end of the scale as illustrated below.



Most donors and INGOs provide technical support to their partner organisations. This ranges from providing tools and guidelines for policy formulation to a greater level of involvement through capacity building, training and/or facilitating policy development processes.

There were a few isolated examples in Uganda where the donor agency provided medical insurance for their partner organisation. These agencies assumed it would cover HIV-related issues. However the provision of this support was dependent on the specific contractual arrangements with the partner. In another Ugandan example a donor was funding the implementation of two “large scale HIV workplace programmes”. This support did not however, include medical insurance or access to private health facilities.

One INGO in Ghana provides funding for the implementation of partner organisations’ workplace policies. This does not however, include medical insurance or private health care. Most policies supported by this INGO started out solely as HIV workplace programmes but have since evolved to include other preventable diseases. The same INGO also currently funds a wellness programme in one partner organisation. The programme includes health, social protection and financial wellness.

Overall however, the vast majority of agencies provided technical support coupled with signposting their partner organisations to government health service providers. As described in section 2.4, many government health centres struggle to provide a consistent supply of ARV drugs and VCT testing agents. Where the level of access to adequate government services is low, donors and INGOs should be proactive in assisting their partner organisations to bridge this gap.

3.2 Failure to fund partners’ responses

> “Partners are there to implement programmes and there is little on top of that.”
> Respondent in Malawi

The majority of donor agencies and INGOs reported that it would be impossible to fund partner organisations’ HIV policies and programmes, particularly HIV-related benefits such as health insurance or medical expenses. The costs are perceived to be too high. Additionally, most were unable to provide details of how much their support to partner organisations currently costs.

There were some exceptional examples in Ghana and Uganda where full funding, including implementation, was offered to partners. One donor in Ghana encourages local partners to integrate HIV programmes in their overall plans. The implementation of these plans is then supported. Additionally, one agency in India offered capacity building support as well as financial support. Partners were given a one-off grant if they expressed an interest in developing and implementing workplace programmes. These examples were isolated and not representative of the majority of agencies.

A few agencies indicated that if a partner organisation approached them for support they would “in principle” support the development of a policy, but only in certain circumstances. It would depend on the individual contractual arrangement and they would typically only offer support to those partners they were already in partnership with. As one respondent in India said, “right now, we’re not pushing them to develop a workplace policy, and it is not a mandatory requirement for partnership contracts”.

Regardless of the contractual arrangements, funding for implementation would not be guaranteed and in most cases it was unlikely. As a respondent in Ghana reported, “if it is within the contract, it will be financed, if contrary then it will be considered as a proposal to be assessed.” This was echoed by another donor in India:

> "if a partner asked [us] to fund the development and implementation of an HIV workplace policy in their organisation in isolation, there was little chance that they would be supported… requests for support that were framed appropriately within the larger context of a relevant project… could be considered."

A number of agencies assisted their partner organisations to find funding. They link their partners to other potential donors or lobby on their behalf. Some help their partner organisations to develop proposals. This however, is likely to have a very limited impact. As this research shows, the vast majority of donors and INGOs are not willing to finance the development or implementation of existing partners' HIV workplace policies. It is unlikely therefore that organisations approaching donors with no existing partnership will find funding.

Onus on partner to request support

Most donors are not proactive in supporting partners to implement workplace programmes. According to Doreen Kwarimpa-Atim (Uganda researcher):

> "…[donors] seem to think it is obvious that a partner should have a workplace policy or prefer that a partner first makes the request for support. However, considering that they [the donors] know the value of an organisation responding to HIV, one would expect them to be more active in providing adequate support".

In several of the other country studies, it was also apparent that the onus is on the partner organisation to make the initial request to the donor or INGO for support. This was particularly pronounced in India where donors and INGOs made statements such as:

- "partners who sought support" (India)
- "the [donor] would wait for a demand from the organisations and not take the initiative to ask" (India)
- "should a local partner approach the organisation seeking support" (India)
- "if a partner made a request" (Malawi)

These statements raise important issues. They assume that partner organisations will be aware and accepting of the need to develop a workplace response in order to make the initial request. Whilst HIV workplace policies have been around for some time and they are gaining ground in many countries, not all organisations will be fully aware of why they should develop their own organisational policy response. Many organisations continue to deny that HIV presents a risk to their organisations.[9] As Alice Wainaina (Kenya researcher) explains, "In a faith based organization where the moral code was strict, the respondent observed that people may have a mental block thinking themselves not at risk." Many organisations only face up to HIV in the workplace after crisis has hit them.[10]

Placing the responsibility on the partner organisation to request support also assumes that partners know the support is there if they ask for it. However, this is not usually made clear at any point in the funding and/or contracting process. It also then places partner organisations in the awkward position of going back to their donor to ask for more money (on the basis of being vulnerable to HIV and AIDS). This is often not a viable option given the imbalance in power in the donor–recipient relationship.

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[9] Project Empower (2008), 'Denial, Fear and Fatigue: The emotional blocks to addressing HIV/AIDS in the workplace' (Praxis Note 38)

[10] Betsy Mboizi and Rick James (2005), 'Robbed of Dorothy! The Painful Realities of HIV/AIDS in an Organisation' (Praxis Note 12), Rachel Smith and Project Empower (2010), 'The means is the end: Reflections on the process of developing HIV workplace policies', (Praxis Note 50).

3.3 Challenges in supporting partners

Perceived high costs and limited funding

Limited funding and the cost of supporting partner organisations were the major concerns for the majority of donors and INGOs across the six countries.

Despite the comprehensive nature of their own internal responses most agencies felt that providing an equally comprehensive response in their partner organisation was not financially viable. In some cases they argued that full funding was not desirable. Partner organisations were to be encouraged to finance their response themselves.

Where funding was seen as desirable, it was not always available. One INGO in India noted that almost all the budget of the organisation was derived from project funds, most of which was earmarked for community based interventions not for organisational development. In Malawi some respondents viewed HIV in the workplace as an add-on to organisational costs and that “it is more of a cost than an investment”.

Some felt that the available funds did not meet the perceived or real needs of the partner organisation. This led to misunderstandings and could slow the process of developing and implementing a workplace response.

Most donors and INGOs were unable to fund insurance schemes or access to private clinics meaning that access to VCT and ART may not meet the organisation’s ongoing needs. One respondent in Ugandan said that he receives calls from frustrated partner staff and programme managers complaining about stock running out or expired drugs. They blame him for encouraging them to “start on something that is not sustainable”.

Time constraints

> “It requires a lot of time and meetings which you do not always have.”
> Respondent in Uganda

The availability of partner staff to attend meetings and training can be limited. As one respondent reports, “Availability of time as a resource by peer educators, advocates and also for staff [is limited]… Management has to create structures to secure staff attendance”. High staff turnover exacerbates this situation as it creates a need for continuous training of new staff. This lack of time in the partner organisation was also mirrored by the lack of staff in the donor organisation to follow up on progress.

The limited time spent on developing and implementing the response can also lead to it taking a low priority both within the donor agency or INGO and the partner organisation.

Low priority

As Alice Wainaina (Kenya researcher) writes “workplace programmes draw strength from support by management otherwise they do not take off or tend to be very weak.” Getting this buy-in from managers in partner organisations was reported by a number of donors and INGOs to be very challenging.

HIV workplace policies and responses can be a low priority in an organisation. Often there is only one HIV focal person within an organisation who leads on the HIV workplace response. This role is generally not a part of their formal job description and is viewed as an added work pressure. This creates a situation where development and implementation of the policy is left to one person for whom it may not be a priority. In some partner organisations it is seen to be the donor’s responsibility to take the idea forward. Some donor agencies in

Uganda reported difficulties in encouraging partner organisations to take ownership and responsibility for the workplace policy, particularly if the impetus and support for the policy was from the donor. It gets a low priority within the partner organisation and progress can therefore be very slow.

The low prioritisation can also come from the donor side. HIV workplace policies do not directly contribute to the MDG-related visible results for beneficiaries that donors insist upon. They are therefore not prioritised and activities in favour of MDGs become the priority focus. This reinforces the perception that partner employees are somehow distinct and separate from the beneficiary communities they work with. This is evident not just in the case of HIV workplace policies. We frequently see reluctance by donors to fund necessary overheads such as salaries, staff medical insurance and staff development.

In reality, a partner's employees are part of their communities. They experience the same problems that they are working to address. In high HIV-prevalence countries, partner employees are likely to be supporting members of their extended family. They may be caring for sick relatives and orphaned children. An HIV workplace policy which benefits partner employees (and thus the wider family and social network of the employee) can and should be counted towards a donor's results.

Limited internal capacity

A number of respondents noted that there were challenges in assisting partners to develop HIV policies and programmes due to limited internal capacity in the partner organisation. Meera Pillai (India researcher) noted that "the [human resource] practices in some of the NGO partners may generally be rather weak, and hence such organisations may not be open to extensive consultations on staff vulnerabilities." In Ghana, Burundi and Kenya, several respondents noted that, even where funding is available, technical capacity within the partner organisation to implement a workplace programme is weak.

INGOs or donor agency may also have limited capacity to mainstream HIV. Programme officers do not always know how to assist partners to mainstream HIV into their programmes and the projects. Despite HIV being given priority as a cross-cutting issue by the funding agency, in practice it is still often seen as a 'health programme'. According to Meera Pillai, in India, partners find it difficult to get funding from their donor to bring HIV into non-health projects such as legal support or natural resource management. A strong internal workplace response within the INGO or donor agency will help programme officers understand HIV mainstreaming. They can then enable them to effectively support partners to mainstream HIV in their organisations and work.

Stigma and discrimination

According to a number of interviewees, issues of stigma and discrimination can affect the development and implementation of a workplace policy. Denial of HIV and AIDS and the perception of low risk lead organisations to see HIV and AIDS in the workplace as a low priority. Where there is a policy or response, there can be poor identification of beneficiaries for care and support. This is largely because of late HIV-positive disclosure due to the fear of stigma and discrimination.

In Ghana, three respondents noted that stigma and discrimination is worse for sexual minorities making it more challenging to develop a workplace policy that effectively addresses a range of HIV issues.

4. Implications of the research

This research shows that donors and INGOs across the six countries in this study recognise HIV and AIDS as serious threats to their workplaces, as well as to those of their local partner organisations.

Most donors and INGOs are responding positively to this threat in their own organisations. The vast majority are implementing workplace policies that include medical insurance or private health care; HIV counselling, testing, treatment and care; awareness and prevention activities; and support for HIV-positive staff. Some organisations extended this support to families and dependents and even to domestic staff. It is encouraging to see that so much is being done for the staff of the donor agencies and INGOs.

This research however, has identified a distinct misalignment between the internal responses of donors and INGOs and the level of support they give to partner organisations. This inconsistency raises questions about donor obligations, responsibilities and even values. Moreover, it may undermine the long-term effectiveness and sustainability of the development work they support.

The effectiveness argument

Implementing comprehensive HIV workplace programmes makes good business sense. As this study has shown, the donors and INGOs interviewed were able to point to tangible benefits for their workplaces. In hard economic terms, the benefits of workplace HIV programmes far outweigh the costs. The Ugandan example from this research (page 9) showed a reduction in annual labour costs of 90% following the introduction of ART. This is further supported by a number of other studies. An analysis of seven companies in Zambia found an average net benefit of the HIV workplace programme of US$47 per employee per year. The cost of treating an undiagnosed HIV-positive employee was seven times more than the cost of treating an employee who had been diagnosed.[11] Another Zambian study of public sector employees found that if ART cost US$500 per year, the savings associated with each death averted would pay for six to eight year's worth of ART for an employee.[12]

This effectiveness argument raises issues about the long-term impact of development aid. If it is cost-effective to address HIV in donor agencies, surely it is also cost-effective to address it in partners. If partners' performance and sustainability will be undermined by HIV, this will ultimately affect the impact of donor development aid. Donors and INGOs will ultimately get a better return on their investment in partner organisations if those partners are able to effectively respond to HIV.

A question of values?

The research also raised difficult dilemmas about the extent of donor and INGO obligations or responsibilities towards their partner organisations. Not one of the fifty donor agencies and INGOs in this study supported their partner organisations to implement HIV workplace policies to the same extent as they did within their own organisation. Medical insurance and access to private health services (benefits taken for granted in donor agencies and INGOs) were not an option that donors would support in their partner organisations. They were simply unable or not prepared to cover the costs of such a response.

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[11] CHAMP (2007), 'Cost Benefit Analysis of HIV Workplace Programmes in Zambia' http://pdf.usaid.gov/pdf_docs/PNADK430.pdf

[12] Feeley et al. (2004), 'Cost of AIDS among public healthcare professionals', http://pdf.usaid.gov/pdf_docs/PNADC438.pdf

Support to partner organisations focussed almost entirely on technical support, training and awareness raising activities. Few donors or INGOs assisted with anything more than supporting the process of developing workplace policies. Whilst this assistance is valuable, without the means to fully implement a policy there is a danger that it will become nothing more than a document on a shelf.

Partner organisations are often funded to implement programmes on behalf of INGOs and donors. They must stick to agreed timeframes and implement activities efficiently and effectively with clear M&E and reporting systems. Donors and INGOs understand the impact of HIV and AIDS on their own organisations and proactively address this for their own organisations and their own staff. Yet, as this research has highlighted, they do not afford partner employees the same benefits that they take for granted. This leaves difficult questions about underlying values that will not go away as long as the relationship between donors and recipients exists:

- What does it mean to truly work in partnership with local organisations?
- Is it realistic and reasonable for donors to extend the same level of support to their partner employees that they have internally for their own staff?
- When money is limited, what is the best use; supporting a partner's HIV workplace programme or starting a new project for a community in need?
- Are local partner employees valued the same as international agency staff?

5. Recommendations

The focus of this study is donor and INGO support for HIV in the workplace responses both within their own organisations and in their partners. The recommendations are therefore aimed at donors.

The recommendations arising from this six-country study are that donors:

1. **Know and understand that it makes good business sense to support partners** to implement HIV workplace programmes. HIV causes costs to rise and efficiency to fall. Donors and INGOs should understand that the funding they 'invest' in partner organisations' programmes will be more effectively utilised and be more sustainable when the organisation is functioning at its optimum. This means proactively addressing HIV.

2. **Develop proactive strategies to support partners** in responding to HIV in the workplace. They should take the initiative to discuss with partners how they can develop locally owned and appropriate responses.

3. **Invest in partners' implementation** of their workplace response. This investment should go beyond technical assistance and be consistent with the support they offer to their own staff.

4. **Advocate to and collaborate more with other donors** in implementing workplace programmes. This will help share costs. They can also jointly advocate with national governments for appropriate legislation to encourage HIV resilience.

5. **Adapt their global policies** on health and HIV. Global policies should be tailored to the prevalence, culture and needs in the national context. Donors and INGOs should also put effort into understanding the local context in which their partner organisations are working.

6. **Support HIV focal point people and/or HIV workplace committees** with the time to develop internal and external support for HIV workplace responses.

7. **Continue to address issues of prevention and stigma**. Staff knowledge about HIV is still far from perfect and some attitudes are still discriminatory.

8. **Develop their own monitoring and evaluation systems** so that they know more about whether their workplace programmes are making a difference. This could also include a study to determine the actual costs and associated benefits of implementing workplace interventions in organisations and partners of different sizes.

9. **Investigate and replicate good practice** and set up fora to share learning with other donors.

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