



**the dpsa**

Department:  
Public Service and Administration  
**REPUBLIC OF SOUTH AFRICA**

# DPSA Technical Assistant Report

## *HIV and Aids Workplace Program*





#### Acknowledgement and Disclaimer

This activity was made possible by USAID | Health Policy Initiative, Task Order 1. Under the supervision and technical support of the Senior Technical Specialist; Caroline Mbi-njifo with the following consultants: Enoch Peprah, Easter Kunene, Tracy Konstant, Ndivhuwo Chauke and Pooven Modley. This publication was produced for review by the U.S. Agency for International Development. It was prepared by Caroline Mbi-njifo of the USAID | Health Policy Initiative, Task Order 1.

The USAID | Health Policy Initiative, Task Order 4, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order 1 is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and World Conference of Religions for Peace (WCRP).

#### **Health Policy Initiative, Task Order 4, South Africa Constella Futures**

Postnet Suite A115, Private Bag X18, Lynwood Ridge 0040  
Boardwalk Office Park, MSH House-Block 6, 107 Haymeadow Road, Faerie Glen, Pretoria 0040  
Tel: +27(0)12 991 4370 Fax: +27(0)12 991 5196 Email: [cmbinjifo@constellagroup.com](mailto:cmbinjifo@constellagroup.com)  
<http://www.healthpolicyinitiative.com>

# TABLE OF CONTENTS

1. EXECUTIVE SUMMARY	1
2. BACKGROUND TO THE PROGRAMME	3
3. THE PROJECT PARTNERS	4
3.1 Coordination and facilitation	4
3.2 Selection of participating departments	8
4. PROCESS: FOUR PHASES OF THE TA INTERVENTION	6
PHASE 1. Inception workshop: Turning theory into practice (March 2007)	6
PHASE 2. Pre-onsite visits (May-June 2007)	7
PHASE 3. Three-day onsite technical assistance (July-August 2007)	7
PHASE 4. Follow-up visits (September 2007)	8
5. THEMES ARISING THROUGH INPUT FROM PARTICIPANTS, AND RECOMMENDATIONS	10
5.1 The situation	10
5.2 Human resources	10
5.3 Leadership	10
5.4 Institutional arrangements	11
5.5 The elements of a response	11
6. EVALUATION OF THE TECHNICAL ASSISTANCE	13
6.1 Participants' evaluations	13
6.2 Lessons learned for each phase	14
6.3 Success stories	15
7. CONCLUSION	16

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
DoH	Department of Health
DPSA	Department of Public Service and Administration
DPSSL	Department of Public Safety, Security and Liaison
DSAC	Department of Sports, Arts and Culture
DTP	Department of the Premier (NC & FS)
EAP	Employee Assistance Program
EHW	Employee Health and Wellness
EWP	Employee Wellness Programme
FORHOD	Forum for Heads of Departments
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
HR	Human Resources
IDC	Interdepartmental Committee
KAP	Knowledge, Attitudes and Practice
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
OPSC	Office of the Public Service Commission
PEPFAR	President's Emergency Plan for AIDS Relief
PSR	Public Service Regulations
SMS	Senior Management Service
TA	Technical Assistance
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

## I. EXECUTIVE SUMMARY

The Department of Public Service and Administration (DPSA) has led government's response to the potential impact of HIV and AIDS in the public sector, since Minister Fraser-Moleketi launched the Impact and Action Project in 2000. Initiatives have included amending the Public Service Regulations (PSR), making the development of HIV and AIDS programmes mandatory in all departments. The DPSA has supported this by providing encouragement and information to government departments on the development of policies and programs to respond to impacts of the epidemic. Its guideline 'Managing HIV and AIDS in the Workplace' is the approved standard for all departments.

In 2006, the Office of the Public Service Commission (OPSC) and DPSA conducted a series of evaluations of the progress to date in workplace HIV programs. The surveys revealed that implementation of policies and programmes was inadequate, particularly in the three provinces of Mpumalanga, Free State and Northern Cape.

To respond to these concerns, a partnership between DPSA and USAID| Health Policy Initiative (HPI) was established. It offered technical assistance (TA) to provincial departments in three vulnerable provinces around their workplace HIV and AIDS response. In conjunction with the TA, DPSA is finalising an Employee Health and Wellness Strategic Framework, providing the long-term vision for an effective public service response to workplace HIV.

The TA intervention delivered by USAID|HPI comprised four phases

- i) A 3-day inception workshop for the three target provinces. Concepts around policy development were introduced, information was presented, discussion among participants stimulated, and practical exercises on the drafting of policies and programs facilitated. By the end of the inception workshop, a group of departments had been selected in each province for additional intensive, individualised TA.
- ii) Pre-on-site visits were then arranged to selected departments in each province. Participants presented their current situation and specific needs to their colleagues and the facilitation team. The visit served to guide the TA, and to raise awareness in the department of their needs and expectations from the TA.
- iii) Intensive 3-day TA workshops were provided, during which participants were facilitated through the preparation of policies, programs, budgets and monitoring and evaluation plans for their departments.
- iv) Follow-up visits were made to the offices of departments that had largely completed the TA process during the workshops. The time was used to mentor participants towards the first stages of approval and implementation.

### THEMES ARISING

Among the most useful elements of the TA were the opportunities for departments to share their experiences, and to reflect on the challenges that they faced in designing and implementing HIV and AIDS programs. The following key themes emerged from these various conversations.

- Human resources were inadequate to effectively design and deliver an HIV and AIDS workplace program, with many HIV and AIDS coordinators holding other responsibilities in their departments.
- A lack of interest on the part of most of the Senior Management Service, in most departments, was a major obstacle. Policy and program approval, budget support and departmental motivation were all affected by reluctance among managers to offer enthusiasm to HIV and AIDS programs.
- The institutional arrangements between HIV and AIDS programs and the Employee Wellness Program (EWP) was found to be important. Well integrated programs and institutional structures that supported integration of HIV into EWP had been proved effective.
- Departments with HIV and AIDS committees had found these useful in driving their programs. Representation of appropriate stakeholders on these committees was important. The presence of organized labour unions was highlighted as being particularly valuable.

### Key recommendations:

- *Appoint dedicated staff responsible for the HIV and AIDS programmes*
- *Appointed staff should include senior level responsibility for HIV and AIDS programmes.*
- *HIV and AIDS in the workplace needs to be marketed to the Senior Management Service (SMS), including investments in their awareness and knowledge.*
- *HIV and AIDS programmes should be managed from within the EWP function.*
- *Committees should be formed to engage relevant stakeholders.*
- *Provide additional training in costing and budgets, with particular emphasis on the procedures and costing structures of government departments.*
- *Build M&E capacity through further training, encouraging learning through practice, and providing guiding documentation.*

- Despite a substantial legal allocation of 2% of payroll available on request to HIV and AIDS workplace initiatives, few of the units had sufficient financial resources. Training in costing, budget preparation and an understanding of public sector financial processes would aid these units in gaining access to available finance, and in remaining effective and accountable for these resources.
- Monitoring and evaluation remained a challenge to many HIV and AIDS program managers.

## **EVALUATION AND LESSONS LEARNED THROUGH THE TA**

The majority of participants were well satisfied with their TA experience. The process had been especially useful in the building of planning and policy design skills.

The budgeting and M&E elements of the TA were somewhat less successful, with recommendations that the workshop materials and templates for these components be reviewed.

The 3 days allocated to the core TA workshop were felt to be insufficient for the volume of practical work included in the process. At least a full week's course was recommended for the future.

A major obstacle to the pace at which the TA could be accomplished was a lack of basic computing skill among many participants. Training in word-processing and spreadsheet programs emerged as a need among workshop participants.

## **CONCLUSION**

Participants felt that each phase of the TA had raised their knowledge, confidence and skills, while they acknowledging that the process was just one step in achieving effective HIV and AIDS workplace programs

## 2. BACKGROUND TO THE PROGRAMME

The public service has over a million employees working in approximately 140 departments. It has long recognised both its responsibility and the opportunity it has to take the lead in development and implementation of HIV and AIDS workplace policies and programs. In January 2000, the Minister for Public Service and Administration, Minister Fraser-Moleketi, launched the "Impact and Action Project" in recognition of the potential impact of HIV and AIDS on the public service. As part of this programme, the Public Service Regulations (PSR) 2001 were amended to include the "Minimum Standards for Managing HIV and AIDS in the Public Service Workplace". The amended PSR require all Heads of Departments to ensure that their departments develop and implement HIV and AIDS programmes.

The DPSA supported compliance with the PSR by drafting a guideline of minimum standards entitled "Managing HIV and AIDS in the Public Service: A guide for Government Departments". The manual provides step by step guidance to departments in the development and implementation of relevant programmes.

In 2006, the Office of the Public Service Commission (OPSC) conducted a study aimed at evaluating progress in the public service HIV and AIDS workplace response. The OPSC report highlighted concerns that the public service HIV and AIDS workplace response was insufficient. A further survey by DPSA, followed by a set of focus group discussions, yielded similar findings. Concerns were raised for the three provinces of Mpumalanga, Free State and Northern Cape, in particular:

The following specific capacity constraints were highlighted through these evaluations:

- The Departments of the Premier (DTP) were designated as coordinators of HIV and AIDS workplace policy development and implementation in the provinces. Their capacity to fulfil this function needed to be developed.
- Inadequate skills and support from the Senior Management Service (SMS) for HIV and AIDS workplace programmes was a serious constraint.
- There was insufficient communication and poor political support for strategic alignment of HIV policy.
- Linkages between DPSA and partners needed to be strengthened.
- Budgets for policy implementation were inadequate.
- There was a lack of integration and coordination between the interventions of the Interdepartmental Committee (IDC) on HIV and AIDS and related occupational health committees, such as EHW or Disability Management.
- HIV programmes were not sufficiently integrated with other Employee Health and Welfare (EHW) interventions.
- There was a lack of continuity in policy implementation.
- Monitoring and evaluation (M&E) of policy development and implementation were virtually non-existent.

The DPSA needs analysis was the catalyst for a pilot project to increase capacity in the three target provinces.

The capacity building intervention was delivered through a partnership between DPSA and USAID| Health Policy Initiative (HPI) to provide technical assistance (TA). HPI is a USAID PEPFAR program and successor to The Policy Project. A Memorandum of Understanding was drafted between USAID|HPI and DPSA for Technical Assistance (TA) to five departments in each of the three most vulnerable provinces highlighted in the DPSA research. The TA was delivered between March and September 2007 in two of the three provinces, through a four-phased intervention.

In addition to the TA, DPSA has continued to finalise an Employee Health and Wellness (EHW) Strategic Framework, which will incorporate the outcomes of the TA during its roll-out.

### **The objectives of the OPSC evaluation of the public sector workplace HIV response:**

- i) *To investigate the current levels of implementation of HIV and AIDS policies and programmes, in the Public Service departments*
- ii) *To determine the impact of the Employee Assistance Programmes (EAP) on the ability of the program managers to manage the impact of HIV and AIDS, and*
- iii) *To identify lessons that can be learned from best practice case studies.*

## 3. THE PROJECT PARTNERS

### 3.1 COORDINATION AND FACILITATION

The Provincial Departments of the Premier (DTP) took responsibility for convening and coordinating the technical assistance in their respective provinces. They invited departments, liaised with participants and provided venues.

The DPSA contributed to training sessions and workshops, lending valuable support to the capacity building programme.

A USAID|HPI facilitation team provided a structured series of workshops and mentorship interventions. They guided participants through a practical learning experience on workplace HIV and AIDS policy and programme development.

### 3.2 SELECTION OF PARTICIPATING DEPARTMENTS

The inception workshop was offered to all interested departments in the three provinces.

Five departments in each province were then selected to embark on a further three phases of an intensive TA process. Departments invited to participate were selected in three categories:

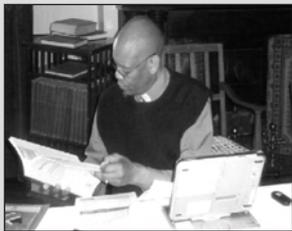
- Those departments which had a documented HIV and AIDS workplace policy and programs (2 per province).
- Those which had a policy, but without a program for implementation (1 department per province).
- Those with neither policy nor program (2 departments per province)

The following further criteria were agreed to underpin the final selection of departments within these categories:

- In support of its role as coordinator of HIV and AIDS workplace interventions, DTP participated in all TA interventions.
- Larger departments, where the need was greatest, would be prioritized.
- Departments with at least one dedicated and skilled staff member to manage the program were preferred.

Selected departments ranged in size from a relatively small office of 120 employees, to a Department of Local Government and Housing which had 350 employees, 40 contract workers and 300 community development workers.

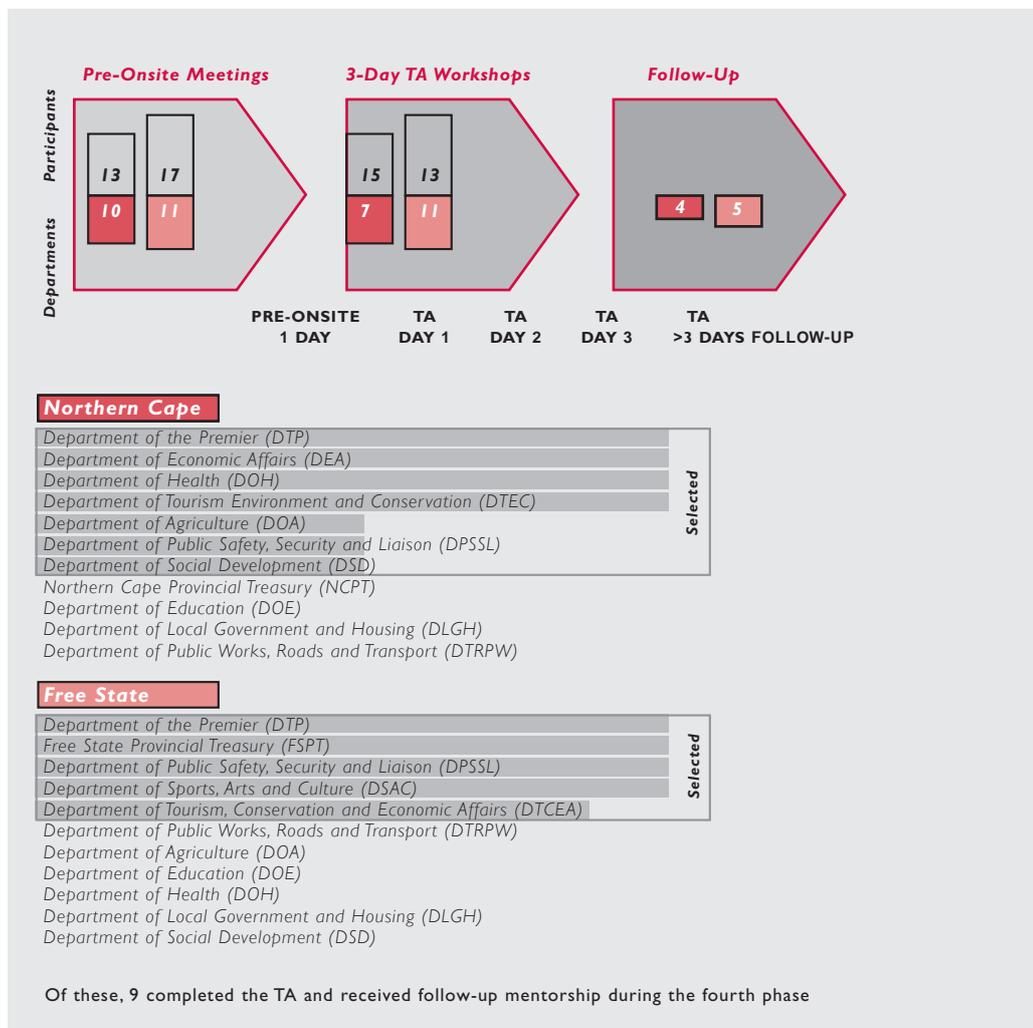
Despite several months of encouragement and negotiation, the Mpumalanga DTP could not be engaged with the TA process. TA in Mpumalanga might need to find a different entry point or another approach for locating interested and committed departments in the province. It would also be useful to ascertain the underlying concerns or needs of the DTP in Mpumalanga.



*Norman Lethebele, Deputy Director  
Employee Health and Wellness DPSA*

Ultimately, a total of 11 Northern Cape departments and 11 Free State departments participated to some extent in the TA (Figure 1). Of these, 9 completed the TA and received follow-up mentorship during the fourth phase.

**Figure 1. The department involved in Phases 2 to 4 of the TA process and the duration of their participation.**



## 4. PROCESS: FOUR PHASES OF THE TA INTERVENTION

### The objectives of the four-phased TA intervention:

- i) develop skills;
- ii) facilitate the formulation of workplace HIV and AIDS policies for participating departments; and
- iii) consider a strategy towards creating an enabling environment for their implementation.

### The objectives of the 3-day inception workshop were:

- i) To understand the workplace HIV and AIDS policy development process, recognizing the influence of different actors.
- ii) To learn how to translate policy into a viable and sustainable HIV and AIDS workplace program.
- iii) To understand how to cost such programs.
- iv) To understand how to implement, monitor and evaluate the program.

### Group exercises:

#### 1) Developing a workplace HIV and AIDS program

Groups drafted an implementation plan for one element of and HIV and AIDS programme, to include the results to be achieved, action steps and resources. Constraints and challenges associated with the program were to be clearly identified.

#### 2) Costing the workplace HIV and AIDS program

The second practical exercise was to cost the group workplace program.

#### 3) Incorporating the M&E plan

The groups fine-tuned their initial workplace programs to incorporate the complete costing of the program, an implementation plan and a monitoring and evaluation strategy.

A four phased technical intervention was planned. Each participating department would be guided through a process of documenting policy alignment, preparing strategic and operational plans, budgeting for resources, and integrating a monitoring and evaluation plan into programmes and policies.

### PHASE I. INCEPTION WORKSHOP: TURNING THEORY INTO PRACTICE (MARCH 2007)

The TA was launched with an inter-provincial 3-day workshop on HIV and AIDS in the workplace. Participants from Northern Cape, Free State and Mpumalanga gathered in Bloemfontein for an introduction to policy development and programme planning. The workshop was aimed at senior government officials as the policy-makers and champions within the public sector.

Participants explored planning and delivery of workplace programmes for HIV and AIDS. They shared ideas, explored potential solutions and developed strategies for the construction of appropriate and sustainable workplace policies and programs, that were relevant to their context.

The facilitation team comprised leaders in the field of HIV and AIDS policy development and workplace program planning, implementation and evaluation. The process combined formal presentations with group discussion. The facilitators' presentations were designed to impart information and to stimulate debate. Group discussions drew on the work experience of participants, grounding the conversation in the reality of workplace situations.

#### KEY SESSIONS:

##### **Global and national perspectives on the impact of HIV and AIDS**

A statistical update on the extent and impact of the HIV and AIDS epidemic, worldwide and in South Africa, was provided. The measures being taken to address the epidemic were explored, particularly those relevant to workplace settings. Participants shared insights on their workplace concerns and the successes and challenges they faced in their response.

##### **Policy development in response to HIV and AIDS in the workplace**

This discussion reviewed the policy design and approval process. The session considered the politics of the response to HIV and AIDS, the stakeholders involved in policy development and their priorities. The need for goal congruence and aligned objectives among the interested parties was discussed.

##### **Costing a feasible HIV and AIDS program**

The group recognized that many programs were poorly implemented and unsustainable because of inadequate costing and insufficient funds. Realistic, thorough costing of HIV and AIDS workplace programs was seen to be critical. The session explored the process of costing and budgeting.

##### **Monitoring and Evaluation**

Few departments had a clear monitoring and evaluation (M&E) plan for their HIV and AIDS workplace programs. This was identified as a key area for improvement.

M&E is the process by which programme effectiveness is gauged, and learning and response through experience become possible. Without M&E there is also no means of demonstrating the value and productivity of the program to stakeholders or of holding it accountable. The session reviewed the principles and design of M&E systems.

##### **Putting policy formulation, costing and M&E theory into practice**

This session gave an overview of the workshop, describing the steps needed to initiate, develop, cost and monitor HIV and AIDS programmes in government departments.

## PHASE 2. PRE-ONSITE VISITS (MAY-JUNE 2007)

The pre-onsite visits were introductory, preparatory meetings between the DPSA / USAID|HPI team and participating departments.

Departments were requested in advance to prepare presentations on their HIV workplace policies and programs, the challenges they faced and their capacity needs. Their presentations and the discussions that followed shed valuable light on the progress, issues and concerns around HIV and AIDS workplace programmes in each of the provinces.

The pre-onsite visits guided the facilitation team and the participating departments towards clarifying and prioritising their needs for support through the core 3-day TA workshop that followed.

## PHASE 3. THREE-DAY ONSITE TECHNICAL ASSISTANCE (JULY-AUGUST 2007)

A practical TA process followed, guiding participants through preparing policies, strategic plans, programs, activities, budgets and M&E plans. Tasks were facilitated incrementally over a period of three days.

Attendees were asked to bring any existing draft concepts and policies into this hands-on policy and program preparation session. Training focused on practical application using these documents situating the learning firmly in participants' contexts, situations and priorities. Participants presented their outputs during daily closing sessions.

Each participating department had been asked to nominate two or three key individuals in its HIV and AIDS workplace response as workshop participants. The intention was to invite groups of 2-3 departments, providing a total of up to 8 participants per workshop. In reality, numbers varied from a single participant and department on some days, to 13 participants from 11 departments in one session.

### KEY SESSIONS:

#### **Revision on HIV and AIDS workplace policies and programmes**

The session opened with a revision of the concepts behind policy design and implementation, ensuring that participants began the TA from a similar departure point.

#### **Policy**

Those with draft policies and plans, identified gaps and finalized these documents as far as possible. The opportunity to ensure that goals were realistic permitted one department, for example, to adjust a goal of "eradicating HIV and AIDS" to "containing the spread of new HIV infection in the department". Participants also rationalised their objectives around support to the immediate families of those infected, in the light of cost implications.

Key actors in policies and responses were identified, and roles in the implementation, communication, marketing and M&E were considered.

#### **Programs**

Based on coherent policy, participants formulated their HIV and AIDS workplace plans. They set clear goals and objectives for programs and activities, and identified the action steps associated with each activity. Well-rationalised program proposals were drafted, ready to present in their respective departments for approval.

#### **Costing**

Insufficient finance was raised as a concern throughout the TA engagement. Comprehensive costing, logically aligned with results, plans and policies, would better enable HIV and AIDS units to motivate for funding. Transparent and informed financial planning would also allow them to remain productive and accountable, protecting their claims to long-term financial support.

### **The pre-onsite visits were intended to:**

- i) Identify the needs of the selected departments in preparing and implementing HIV and AIDS workplace plans and programs.
- ii) Design a TA process around these needs.
- iii) Agree on suitable dates for the TA.

### **Objective of the 3-day TA workshops:**

*The intended output was a document that included policy, programs and plans, with a costed schedule of activities and a monitoring and evaluation (M&E) system.*



*Kopa Nthabiseng, Deputy Director, Labour Relations (FS DTP) and Anne Hilder, Deputy Director, Human Resources (FS DPSSL).*

### Objective of the follow-up:

*Mentorship and review of continuity achieved in finalising, approving and implementing the achievements of the TA.*



*Mr. Bonnie Thekisho,  
Director (EHW NCDTP)*

### Monitoring and Evaluation (M&E)

The final session assisted participants in the design of M&E systems that would track progress against the activities and the outputs of their programs. Most participants found policy M&E fairly straight forward, but many had difficulty designing M&E systems for program and activities.

Confusion arose around distinguishing between output and outcome indicators, for example. Substantial discussion was held on the importance of monitoring both outputs (e.g. the number of peer educators trained) and outcomes (e.g. the interventions that peer educators organized independently after training).

M&E plans included the importance of capturing baseline data through KAP surveys or similar research processes. Tools for baseline surveys were introduced and provided to participants.

### PHASE 4. FOLLOW-UP VISITS (SEPTEMBER 2007)

Finally, follow-up visits were arranged to the offices of departments that had successfully completed the 3-day TA. These visits were used to mentor HIV and AIDS coordinators towards implementation of the policies and programmes developed during the TA support.

Challenges and obstacles were identified and discussed, and departments received targeted and relevant input to help them to take the next steps in their planning, approval and implementation processes.

### KEY THEMES:

The team asked a series of guiding questions in nine thematic areas (Table 1).

**Table 1. Mentorship areas and guiding questions for the follow-up.**

AREA OF PROGRESS	
<b>Management support and buy-in</b>	<p><i>Have you given feedback regarding the TA process and outcomes? Please describe. If not, when do you plan to provide feedback?</i></p> <p><i>Has management involvement been requested? In which areas and in what ways? In what ways has your manager or supervisor been involved in continuation of your policy development and planning? Is implementation being supported?</i></p>
<b>Policy development and approval</b>	<p><i>What consultative steps have been taken to finalize and win buy-in? Which teams or stakeholders have been consulted? Has a draft policy been finalized? If so, when? If not, when do you anticipate finalization and sign off?</i></p>
<b>Programme strategic plan</b>	<p><i>Has the draft program strategic plan been finalized? Has an activity plan with clear action items been developed? If not, when do you anticipate finalizing the strategic and operational plans?</i></p>
<b>Budgeting</b>	<p><i>Has the program budget been finalized? Has financial support been requested? Has it been approved? What steps have been taken to ensure approval? What steps have been taken to ensure a budget increase, if applicable? If not yet begun, when do you anticipate financial application beginning?</i></p>
<b>Monitoring and evaluation</b>	<p><i>Has a draft monitoring and evaluation plan been finalized? If not, what steps have been taken to finalize the plan? Have M&amp;E tools or instruments been developed? If not, when do you anticipate developing the tools? Has application of the tools begun? If not, when do you plan to start using the tools?</i></p>

### **Consultation**

All participants had provided feedback to managers and supervisors immediately after the TA process. A few had supplemented verbal feedback with written reports or PowerPoint presentations. Several participants had also requested input from Senior Management Services (SMS) members and the rest of the staff.

In one department, a committee had been established to share ideas, facilitate consultation and encourage approval.

A lack of support from senior management was a challenge to many participants, with HIV and AIDS units feeling that their role was not well understood in their departments. Participants had all asked their managers to attend meetings, but had generally not succeeded in persuading them to become actively engaged. Senior managers invariably found that they could not prioritize HIV and AIDS into their busy schedules as this was not their core function, and they felt that they could not justify the investment of their time for input. Participants' experiences varied according to their own level of seniority. Where an HIV and AIDS Coordinator was a member of the SMS, access to both staff and other managers was far easier, although even senior staff had difficulty eliciting enthusiasm from colleagues. Junior participants had particularly protracted procedural requirements to follow. One of the greatest challenges was negotiating through the bureaucratic protocol of hierarchical approvals for each step in budgeting, program marketing, communication and implementation. Each process was dependent on review and signature of an SMS member who was often difficult to motivate and not always present.

Highly motivated, knowledgeable and competent teams, which lacked senior authority, found that they had insufficient credibility to engage effectively in consultation.

### **Policy Development and approval**

Several departments had continued to work on their draft policies following the TA and many had finalized a draft. None of the departments had reached the point of having a policy signed off as approved. Time was required to conclude this consultative process. The constraints of inadequate human resources became clear during the follow-up phase. Under-resourced departments had difficulty in allocating sufficient time to completion of policies or for consultative approval processes. Where HIV and AIDS responsibilities were in competition with a heavy, diverse workload, staff found it particularly challenging to concentrate time and effort on HIV policy work.

### **Implementation of activities**

None of the departments had completed their action plans, pending confirmation of their annual budget allocations.

With few exceptions, departments were not yet implementing a coherent, planned HIV and AIDS program. There were, however, ad hoc activities in process, such as condom provision, and distribution of pamphlets, posters or other form of information.

Although progress was uneven, the participants felt confident in their understanding of the activities required and in their capabilities to implement them.

### **Financial Resources**

All departments had submitted a budget request, some using the template provided in the TA, but others not itemizing or costing their submissions at all. Some departments had appended a motivation in support of their budget application.

Budget requests were aligned with the 2% of payroll target, as recommended in national policy as the maximum that can be allocated to HIV and AIDS workplace initiatives. Budget approval was expected once public sector allocations were finalized.

### **Monitoring and evaluation**

None of the departments had worked on the draft M&E plans developed during TA, and no new M&E tools had been developed.

Departments were positive in their intentions to develop this element, and to design a basic set of monitoring processes. Notwithstanding their optimism, understanding of M&E was limited, and participants had difficulty in conceptualizing and formulating M&E systems. Most felt that they needed more M&E training.



*From the left: Lucy Seribe and Khanyesile Wotshela (NC DTEC) and Ontlametse Makutu (NC DPSA).*

## 5. THEMES ARISING THROUGH INPUT FROM PARTICIPANTS AND RECOMMENDATIONS

### 5.1 THE SITUATION

Participants recognized the immediate and potential impact of HIV and AIDS among public service employees and the community at large. There was a great willingness to create a well-planned, well-implemented, consistently monitored HIV and AIDS workplace policies and programs.

Stigma continues to be challenging in our society, and employees associated with an HIV program in any way may fear discrimination. In addition to HIV programme clients, wellness program service providers, peer educators, HIV program directors, and even SMS members, may be reluctant to publicly associate themselves with the program.

For various reasons, the uptake of Voluntary Counselling and Testing (VCT) is low both inside departments and in society in general. Reluctance to test and to discuss HIV openly are critical gate-keepers to access to information, counselling and support.

In any context, HIV and AIDS is fraught with issues arising in organisational culture and in the wider social reaction. In this challenging and sensitive context, government departments are faced with the responsibility for finding an effective, equitable, compassionate and yet pragmatic approach to HIV and AIDS among employees and their families.

### 5.2 HUMAN RESOURCES

Most participants reported insufficient human resources for HIV and AIDS programme implementation

Few departments had allocated responsibility for the HIV workplace program to a dedicated person. Responsibility was usually one task among various other departmental roles. Where a designated post for the HIV workplace programme did exist, the job description was often vague and incomplete. The post was also usually relatively junior, carrying little leverage or authority.

### 5.3 LEADERSHIP

#### **Support of the Senior Management Service**

The need to win senior management's support to middle managers and staff working with HIV and AIDS was seen to be a top priority. Better engagement of senior management would permit the long-term sustainability of institutionalised HIV and AIDS workplace responses in departments.

In those departments with senior, authoritative support, workplace HIV programs were implemented far more easily.

Some examples of desirable levels of support experienced by TA participants included:

- Appointment of responsible staff by a Chief Director;
- Appointment of a dedicated member of the Senior Management Service (SMS) responsible for oversight of EAP and HIV;
- Allocation of a senior HR Director to HIV and AIDS functions, with authority over funds and decisions.

The follow-up phase confirmed that, with the exception of the DoH, most HIV and AIDS workplace program implementers experienced ignorance and disengagement from issues around HIV among senior management. Many considered HIV irrelevant and not related to their core professional function.

#### **Leadership's Capacity**

Many participants were unconvinced by the knowledge and skills of management to engage with and effectively oversee HIV workplace policy and program. Some managers, for example, had not accepted the ethical principles around confidentiality.

This lack of capacity and awareness among management presented a critical obstacle.

---

#### **Recommendation:**

*Appoint dedicated staff responsible for the HIV and AIDS program of at least of Assistant Director level. Depending on the size of the department, at least 50 percent of his/her time should be allocated to HIV workplace objectives.*

---



---

#### **Recommendations:**

*DPSA should lead communication on HIV and AIDS in the workplace, soliciting commitment to programmes at FORHOD meetings (Forum for Heads of Departments).*

*Raise awareness on workplace HIV and AIDS, marketing programmes and actively lobby for an HIV response in all departments.*

---



---

#### **Recommendation:**

*Key decision-makers need to participate in training on policy design and implementation, as well as on basic HIV education.*

---

### **Institutional leadership**

The capacity of the DTP to coordinate the HIV and AIDS response across departments was identified as a priority. The DTP had not yet established its own EAP functions and would need substantial capacity development to fulfil a role in departmental coordination. In the interim, a vacuum in the coordinating role across departments is being experienced. Some individual departments did offer centres of excellence, and participants expressed an interest in continuing to network among departments and share experiences.

## **5.4 INSTITUTIONAL ARRANGEMENTS**

### **Employee Wellness Programmes (EWP)**

Many departments were implementing Employee Assistance Programmes (EAP) and Employee Wellness Programs (EWP), but these were often limited in their integration of HIV and AIDS concerns.

Departments that had located their HIV programmes within their EAP or EWP function found better integration of HIV into wider employee wellness. They reported that this structure reduced stigma and discrimination, and provided a strong platform from which to launch HIV workplace initiatives. An integrated structure also supported strategic alignment, complementarities and the efficient use of resources.

In other cases, HIV workplace programs fell under a separate organisational structure in the HR department or under 'Special Programs'. These structures were generally weaker than those more holistically integrated with employee wellness.

### **Committees**

Several departments had committees that developed policies, planned programs, and guided implementation, although these were dormant in some cases. Committees included Employee Health and Wellness Committees (EHW), Employee Assistance Program Committees (EAP), Provincial AIDS Councils or Working Groups. The Interdepartmental Committees (IDC) also had potential to play a constructive role in an HIV and AIDS response.

### **Outsourcing**

One department had outsourced EAP and workplace HIV to an external wellness service provider. This had proven to be an effective strategy, although development of capacity to manage partnerships and subcontracts was needed to optimize the arrangement.

## **5.5 THE ELEMENTS OF A RESPONSE**

### **Policy**

One of the departments that entered the TA with a finalised and approved HIV policy in place had also innovatively asked all employees who dealt with HIV to sign a pledged code of conduct. In most cases, however, the few departments that had policies, were still in the process of negotiating approval.

Many participants had been unable to find documentation of HIV and AIDS workplace policies in their departments, and most began policy development from the beginning during the TA.

The plans and policies that were available, generally offered clear purpose, mission, goals and objectives. Operational planning, however, was often weaker, with few departments presenting specific, practical action areas, aligned with policies and consistent with desired results.

A further concern was that the policies that were received generally included HIV and AIDS as a minor component of a wider policy without being thoroughly addressed. One of the challenges seemed to lie in the dispersed and reactionary development of HIV and AIDS policy statements in departments. Fragments of possibly contradictory policy had been developed in various contexts, and were embedded in a variety of documents. HIV and AIDS issues were delegated among various units such as human resources, employee wellness and special programs. It was difficult to ascertain the whole response.

### **Recommendation:**

*It would be valuable to conduct a more detailed analysis of the capacity issues facing the DTP.*

### **Recommendations:**

*Emerging HIV and AIDS programs should integrate into existing departmental HIV and AIDS initiatives, as well as Employee Wellness Programs.*

*The ideal structure was seen to be an EHW Unit as an umbrella that included EAP, and HIV and AIDS*

### **Recommendations:**

*Committees should be formed or rejuvenated.*

*Union representatives should be invited to participate in committees.*

*Clear Terms of Reference should be developed for committees, and members should be trained on their responsibilities.*

*The various Inter-Departmental Committees (IDC) could play more active roles in HIV and AIDS programs.*

### **Recommendations:**

*Audits of HIV workplace policy decisions would be useful in some departments, and the integration of these disparate ideas into a coherent strategic response would greatly support effective implementation.*

*The design of HIV and AIDS policies and programs should be consultative and participatory. Essential role players such as HIV and AIDS Units, District and Sub-district Health Coordinators, and Health Promotion Units should be engaged in consultation.*

**Recommendations:**

*Budgeting skill remained a challenge for most participants after the TA. Ongoing training and mentorship assistance in this area are recommended.*

*HIV coordinators should follow up submissions for budgets or increases with senior managers through personal contact.*

*HIV Coordinators should request copies of relevant financial statements and reconciliations, in order to track their own spending and their pace of implementation.*

*Create opportunities to conduct cost free HIV and AIDS activities, such as information distribution and awareness campaigns*

**Recommendations:**

*Provide capacity-building on M&E.*

*In addition to further training, program implementers were encouraged to trust a process of learning by doing in order to develop M&E capacity.*

*Implementers were asked to begin with the step of quantitatively tracking their activities.*

*A coordinating department should distribute material resources to departments, and communicate on the processes for obtaining this support.*

**Recommendations:**

*All departments were strongly encouraged to use the DPSA guide on "Managing HIV and AIDS in the Workplace"*

*Departments from different provinces that are performing well, should be asked to showcase best practice to other departments.*

**Programmes and implementation**

Some departments had begun implementing HIV and AIDS workplace activities, such as:

- Health promotion, such as VCT awareness-raising.
- Behaviour Change Communication (BCC) as part of a comprehensive program including stigma and discrimination, prevention, care and support, and treatment.
- Capacity building workshops and employee training on elements of HIV and AIDS such as prevention, care and support, stigma and discrimination, disclosure and rights.
- Identification and training of peer educators.
- Condom distribution.
- Health campaigns aligned with national and other campaigns, such as 16 Days Against Gender Violence and World AIDS Day.

**Financial resources**

Most participants felt constrained by a lack of financial support for their HIV workplace programs, despite a legal allocation of 2% of payroll which may be claimed on approval of a costed programme plan. Departments receiving this 2% of payroll allocation for HIV and AIDS in the workplace, found that their programs were sufficiently well supported.

These were in the minority, however, and most departments did not have earmarked budgetary support for HIV and AIDS workplace programmes. At best, HIV budgets were shared with the wider EAP program. In many cases financial resources had to be negotiated on an ad hoc basis from other programs, and participants reported that requests for expenditure were regularly rejected. Roughly calculated, most departments spent under R100 per employee per year on HIV in the workplace. Most departments felt that a reasonable budget, earmarked for the HIV and AIDS workplace program, would facilitate their success.

Few participants were skilled in costing and budgeting, even after the TA on this theme. In the absence of clearly defined, justified and rationalized budgets, sufficient funding for programs was unlikely to be approved.

A common challenge for less senior HIV and AIDS program Coordinators was that they were not always aware of the budget allocated to their role, and had limited contact with financial management. A good understanding of their financial resources would help them to be more effective as implementers of a workplace program. Implementers were encouraged to plan and conduct programs which used their time and knowledge as key resources, without the necessity for financial input. In addition to achieving their strategic aims, this would serve to market their units, raise their profile and increase credibility and awareness of their function. "Free" activities might include information sessions, awareness programs, research and surveys.

**Monitoring and Evaluation (M&E)**

Unconvincing M&E processes were identified as a specific weakness, being virtually non-existent for most HIV and AIDS workplace initiatives. Even by the end of the TA, there had been not significant progress in M&E design or implementation.

Monitoring was limited to the routine use of superficial monitoring tools in all departments, such as attendance registers for committee meetings. Departments that distributed condoms did not have a system for recording their stock or uptake from dispensing points. Baseline data were not available. Ongoing collection of monitoring data was not taking place. None of the departments collected HIV prevalence data. Only one department had conducted a Knowledge, Attitude and Practice survey (KAP).

**Information and resources**

Supplies were not necessarily obtained with ease by any department except for the DoH. Sources of condoms, posters and pamphlets were difficult to ascertain.

HIV and AIDS workplace coordinators felt uncertain in their task as innovators and ground breakers. The programs were being developed without the context, framework or precedence of broader provincial HIV and AIDS guidance.

## 6. EVALUATION OF THE TECHNICAL ASSISTANCE

### 6.1 PARTICIPANTS' EVALUATIONS

Most participants were satisfied with their TA experience. Group work and practical exercises were found to be particularly valuable. By the end of the 3-day TA workshop, significant progress had been achieved towards a practical HIV and AIDS action plan. The TA team found that participants generally emerged skilled and confident enough to take planning and implementation forward, and encouraged them to complete the strategy, program and activity elements of their plan.

The TA on budgeting would have been more useful and motivating if it had been more directly relevant to government's budgeting procedures, technical level, actual responsibilities and tasks of the participants. Participants suggested simplify the training on M&E and budgeting, and requested further input on these themes.

#### Participants evaluation of the 3-day TA workshops

Workshop evaluation from the 3-day TA have been analyzed, and the results are presented in Figure 2, Figure 3 and Figure 4



Figure 2. Levels of participant satisfaction and the meeting of expectations (percentages of responses)

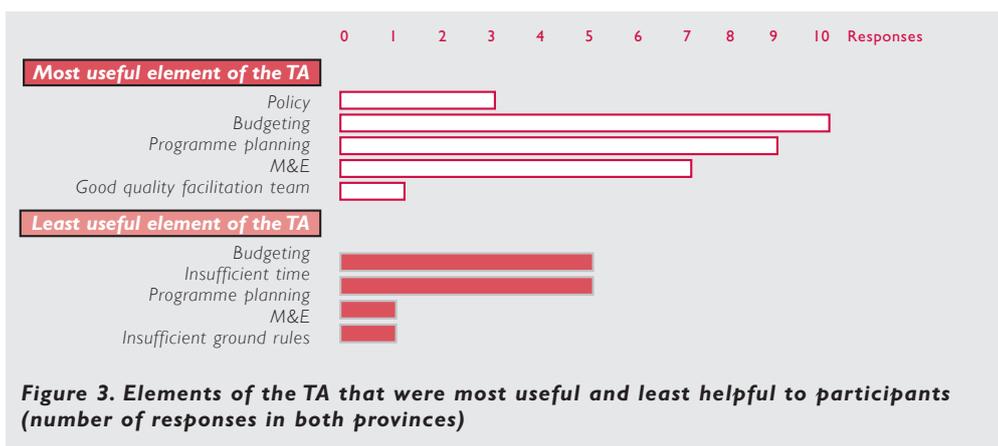


Figure 3. Elements of the TA that were most useful and least helpful to participants (number of responses in both provinces)

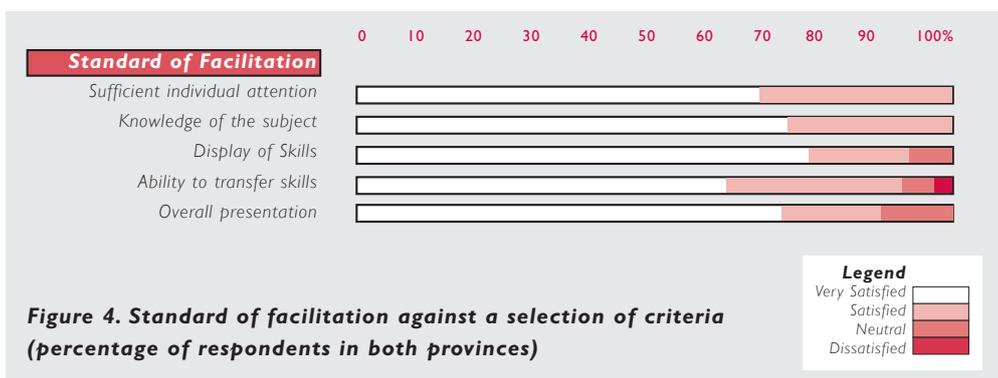


Figure 4. Standard of facilitation against a selection of criteria (percentage of respondents in both provinces)

#### Comments from participants' evaluation form:

##### BUDGETING

"Budget was too detailed and not tailor made to fit the government departments."

"Budget not clear."

"Introduce the public service management finance act."

##### M&E

"I still do not have the confidence to do it on my own or guide someone else."

**Recommendations:**

*A group size of 3 department and 8 individuals is optimal*

---

*Future workshops of this scope should consider a 5 or 6 day duration.*

---

*It might be preferable to hold future such workshops in venues that provide an equipped IT facility.*

---

*Future TA should continue to encourage small groups of departments in shared sessions.*

---

*Review the costing and budgeting element of the TA, and ensure that it is relevant to the financial systems, responsibilities and the level of most participants.*

**6.2 LESSONS LEARNED FOR EACH PHASE****Group size**

Groups ranged from 1 participant from 1 department, to 12 participants from 10 departments. The ideal group size was found to be 3 or 4 departments and not more than 8 participants for this practice-based style of training. A small group enabled the focus and intensity necessary for the “live” development of new policies and programs.

**Optimal workshop duration**

Even where this optimal group size was achieved, however, completion of the exercises in the allotted time was difficult for the 3-day TA process. Notwithstanding poor punctuality it was clear that the anticipated work pace had been over-estimated during planning. The time allocated was insufficient to complete all the tasks fully and satisfactorily. The costing and M&E exercises towards the end of the process were rushed, despite having been highlighted as crucial components for capacity building.

The most successful TA experience emerged where the 3-day TA workshop was extended over 6 days. This period allowed adequate time to thoroughly cover the theoretical and the practical work, and produced higher quality outputs.

**Punctuality**

Poor punctuality was a prevailing challenge, with a starting time of 10h30 instead of 08h30 being common. This caused the effective loss of up to 6 hours in every 3 days.

**Computers**

Many of the 3-day TA workshops faced the challenge of providing enough laptops to meet the needs of the group.

**Computing skills**

One of the major obstacles to the speed of progress was a lack of computing skill among participants. Participants grasped far more than they were able to effectively capture into their documents and better basic knowledge of word processing and spreadsheet software would have enabled substantially greater progress.

Participants did, nevertheless, learn as they worked, and a by-product of the TA was an increase in basic computing confidence.

**Lessons sharing**

There were clear leaders in each 3-day TA group. Less confident departments were able to see the progress and decisions that the stronger teams made through the daily concluding presentations, and had the opportunity to draw from these ideas. Lesson sharing was a constructive and valuable element of the TA process.

**Participation by senior management**

Key decision-makers and senior management had been encouraged to attend the 3-day TA workshops. This was achieved to some extent, although structural arrangement in some departments meant that the most relevant and knowledgeable person for the TA was not often a senior staff member.

One of the 28 participants in the 3-day TA workshops was a Director and 2 were Deputy Directors. Most of the other participants were EAP Coordinators or Managers, responsible for implementation of HIV and AIDS programs.

**Costing and budgeting**

The budgeting element of the TA should be reviewed and adjusted for future workshops, to ensure that it is more directly relevant to public financial management procedures, technical level, and actual responsibilities of participants.

## 6.3 SUCCESS STORIES

### NORTHERN CAPE DEPARTMENT OF HEALTH

The Northern Cape DoH performed exceptionally well. The 3 participants arrived with a strong draft policy that was almost complete. They worked with great enthusiasm and focus and were able to take their work forward substantially.

By the end of their TA engagement they had expanded the scope of their policy from a draft that had been limited to medical interventions such as ART. The final document described a comprehensive workplace policy and program incorporating prevention strategies, communication and training.

Their original budget had concentrated on medical budget items. Having gone through a budgeting exercise in detail, the department's comprehensive program was fully costed by the end of the TA workshop. They began implementation from within their mandate, and were among the few to actively monitor their activities.

Despite their competency and enthusiasm, the team, faced challenges back at the office. Their lack of seniority made it very difficult for them to have policies approved, or even broadly communicated and discussed. Negotiating the attention of senior management in order to have the level of impact they hope to was their greatest obstacle.

### FREE STATE DEPARTMENT OF SPORTS, ARTS AND CULTURE

The DSAC in the Free State made excellent progress. The HIV and AIDS unit in this department was new, and the coordinator had only recently been recruited. They had no policy, no systems and no precedent. The HIV and AIDS Coordinator came to the TA alone, and had a fresh start to make.

The TA enabled her to lay down a strong foundation as a valuable launching process for her role and for the new HIV and AIDS unit. A draft policy was completed and was ready for input and approval from the relevant committees. The programs were developed in a coherent manner, responding clearly to the strategic priorities identified in the policy. The costing was guided by an agreed budget within which the coordinator had authority and responsibility. An M&E component, with clearly defined indicators was designed and documented.

The department was greatly assisted by having a clear, simple structure for its HIV and AIDS response. Enthusiasm and motivation were again valuable in driving a successful TA experience forward.

The follow-up TA supported the coordinator towards approaching management for approval and supporting the momentum achieved during the intervention.

---

*The main factor for their performance seemed to be their team cohesiveness, motivation and focus on the task.*

---



---

*The story demonstrates the value of appointing a delegated person with an established role and the wherewithal to fulfil that role*

---

## 7. CONCLUSION

The technical assistance experience revealed a cadre of enthusiastic and motivated HIV and AIDS programme coordinators, faced with innumerable challenges. Despite encouragement and guidance from DPSA and the commitment of substantial financial support from Treasury, the provinces that participated in this capacity building process had found it difficult to establish an effective response to HIV in the workplace.

The most intractable obstacle seemed to be reluctance among senior managers to engage with an HIV response. As a consequence, approval processes were protracted, budget applications obstructed and implementation curtailed, undermining the credibility of HIV and AIDS programmes in these departments. Another challenge was a lack of certain key skills among HIV and AIDS workplace coordinators, with costing and M&E capacity being particularly concerning.

The TA effectively guided participants through the processes of policy design and programme planning, providing new skills and information in these themes. It only partially addressed participants capacity needs in costing and M&E. Perhaps most productively of all, however, the TA provided participants with an opportunity to share experiences and insights on themes such as relationships with senior management, institutional structures, committees and typical programme activities.

Being faced with one of the most sensitive and yet most urgent issues in today's world, HIV and AIDS workplace response coordinators are placed to make a profound difference in the lives of employees, and in the growth of a strong and mature public service. Their enthusiasm, commitment and perseverance in raising the standard of the public service HIV response is encouraging.

# APPENDICES

## I.1. OVERVIEW AND EVALUATION OF CURRENT POLICIES

### DISCUSSION:

*What does your department already have in place around HIV and AIDS management in the workplace?*

*Do you have?*

---

- **An HIV and AIDS workplace policy?**
- 

- **What are the main elements of the policy in terms of:**

- the results to be achieved;
  - actions to be taken;
  - resources required;
  - the cost?
- 

- **In reviewing the Qualities of Good Policies and Checklist of Minimum Standards above, which of these standards are met by the current policy?**
- 

- **In what ways has the policy been implemented?**
- 

- **How is the policy monitored and evaluated?**

- In what respects has it been effective?
  - In what respects has it not had the desired effects?
- 

- **Which elements of the policy development process have contributed to its effectiveness, and which might have weakened its impact? In what ways has the process influenced the outcome? e.g.**

- When was the policy developed? What implications does this have?
  - Who were involved in its development? What implications does this have?
  - What process was adopted in its development? What implications does this have?
  - How was it communicated to employees? What implications does this have?
- 

- **Are you aware of any other workplace policies that apply directly to your department that have or may have HIV and AIDS implications? If yes, what are those policies and what are the implications?**

## 1.2. NEEDS ANALYSIS

**Return to each of the following pieces of work completed so far:**

1. The impacts of HIV and AIDS in the workplace
2. The purpose of your policy
3. The elements that you see as needed in the policy
4. The main elements of existing policies that address the needs you have identified and the purpose of the policy

**What is missing?**

In which areas of policy do you need to take decisions forward? (Note: if you are satisfied with the policy, but have found implementation lacking, make a brief note since this will be dealt with in the next stage).

### DISCUSSION:

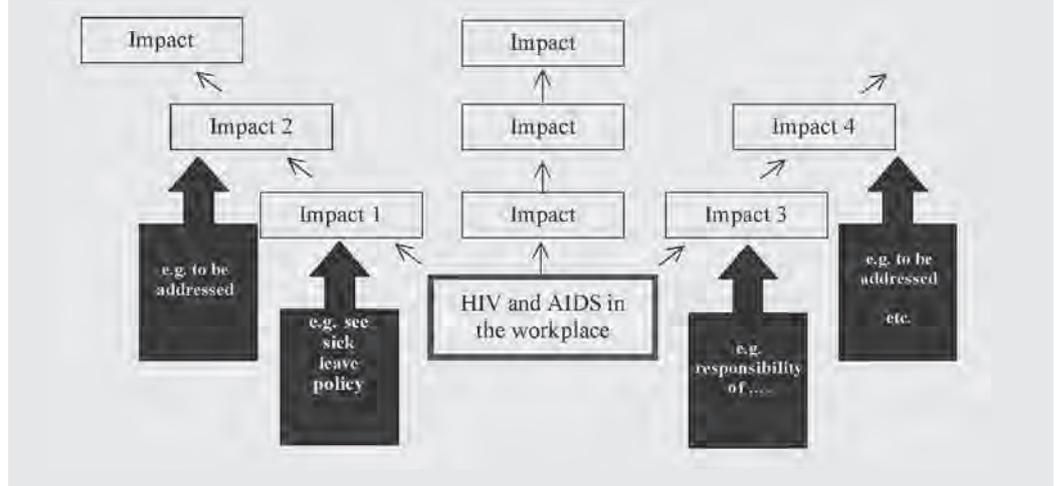
Refer to each of the impacts outlined in the situation analysis, and consider the questions:

***Is the issue already addressed by policy?***

***Is it within your role, capacity and responsibility to address it through policy?***

***Which elements you need policy decision on?***

Discuss and agree those policy decisions.



**Some possible elements to be covered in the policy are:**

- Prevention – e.g. advocacy and communication on prevention, condom distribution.
- Stigma and discrimination – e.g. recourse to resolution;
- Prohibition of employer recommended testing – e.g. recourse to resolution;
- Job security – recourse to objective grievance procedures;
- VCT – e.g. on-site provision, encouragement, advocacy;
- Confidentiality – e.g. recourse in breach of confidentiality, code of conduct;
- Treatment – e.g. support systems, medication time provisions;
- Gender equity – e.g. inclusive consultation;
- Safety in the workplace – e.g. provision of gloves;
- Provision of post-exposure prophylaxis – e.g. policy and procedure for accidental exposure;
- Ethical considerations;
- Communication, education and awareness – e.g. strategies for information dissemination;
- Program integration – e.g. alignment with related policies;
- Incapacity management – e.g. definitions of incapacity; sick leave provision;
- Capacity building – e.g. recruitment and training policies; HIV management capacity
- Service access – e.g. access to health care services with minimal work life disruption

### **I.3. MANAGEMENT RESPONSIBILITIES**

**Development of a workplace policy is just one responsibility of management in managing the epidemic in its workforce. It also needs to:**

- design structures and partnerships to take responsibility for implementing the policy;
- show leadership and commitment;
- conduct risk assessment and related research;
- integrate planning for HIV/AIDS into departmental strategies;
- review HR policies in the light of HIV and conduct HR planning linked to maintaining productivity and managing employee benefits;
- budget for the costs of HIV/AIDS programs and oversee the implementation and monitoring of these programs.

*Each of these themes is addressed thoroughly in 'Managing HIV/AIDS in the Workplace' Pg 37 and Chapters 6-9*

## 2. PROGRAMS

### Reviewing your structures

**Table 1. Guide on HIV/AIDS policy development and supporting structures**

MINIMUM STANDARD	Y/N	IF Y - COMMENTS IF N - ACTION NEEDED	SOURCES OF SUPPORTING INFORMATION IN 'MANAGING HIV/AIDS IN THE WORKPLACE'
Has an HIV/AIDS Coordinator been identified?			Guiding questions on where the Coordinator might be located and his/her core competencies on Page 39-41
Does he/she have sufficient skills, seniority and support to implement the workplace HIV/AIDS response?			
Has an HIV/AIDS Committee been formed?			Guiding questions on composition and location of the Committee on Page 39-41
Does it have adequate human and financial resources Committee?			
Are all stakeholders represented on the Committee?			
Have the Coordinator and the Committee formed partnerships with other departments, organizations and individuals who can assist in implementation of your policy?			Guidelines and examples on partnership on Page 42-43

### Checklist from 'Managing HIV/AIDS in the Workplace' Page 43

#### **Leadership and commitment**

Designating a Coordinator and Committee to manage the HIV/AIDS program does not absolve all other managers from responsibility. One of the key requirements for a successful program is that those responsible for implementation have support, and the most substantial source of support is the leadership, commitment, example and encouragement of all managers.

#### **Managers need to address challenges such as:**

- Following commitment with meaningful action;
- Complacency among some managers and enthusiasm in others;
- Lower support in middle-level management;
- Events as programs where managers might attend an event but not support less visible ongoing interventions;
- Low prioritization of HIV;
- A lack of skills and time to focus on HIV; and
- Inadequate understanding of what being an appropriate HIV ambassador or example means.

For guidelines and good practice on leadership see Pages 44-48 of 'Managing HIV and AIDS in the Workplace'.

The managers who: actively encourage partnerships and integration of HIV into their projects; ensure that HIV/AIDS programs receive resources; wear red ribbons to public events and use the platform to reiterate their support; facilitate support to those affected in their workforce; express their principles on gender equality and human rights; and monitor HIV/AIDS workplace program implementation ensuring that it is effective, are the managers who will help to turn the tide of the epidemic.

**PERSONAL EXERCISE:**

How would you rate yourself as a leader and manager on the lists of challenges and qualities for an HIV champion?

**Table 1.** Template for designing activities into program elements, allocating a responsible person and a planned timeframe for the activity:

**1) PROGRAMS THAT AIM TO PREVENT AND REDUCE NEW HIV INFECTIONS.**

PROGRAMS AND ELEMENTS	PERSON RESPONSIBLE	MONTH OR WEEK (DEPENDING ON YOUR PROJECT DURATION)											
		1	2	3	4	5	6	7	8	9	10	11	12
<p><b>1. Provide ongoing Behaviour Change Communication (BCC)</b>  <b>Provide correct information on HIV/AIDS</b></p> <p>1.1. Distribute pamphlets or other up-to-date written materials to all employees.</p> <p>1.2. Provide information specifically on acceptable sexual behaviour.</p> <p>1.3. Provide information specifically on risks related to drugs.</p> <p>1.4. Put up posters.</p> <p>1.5. Arrange lunch hour theatre.</p> <p>1.6. Organize presentations on policies and programs.</p> <p>1.7. Provide information about, and encourage the use of, community HIV and AIDS services.</p> <p>1.8.</p> <p>1.9.</p> <p>1.10.</p> <p>1.11.</p>													
<p><b>HIV mindfulness</b></p> <p>1.1. Distribute AIDS ribbons.</p> <p>1.2. Hold a World AIDS Day event.</p> <p>1.3. Disseminate in lifts, payslips, email.</p> <p>1.4.</p> <p>1.5.</p> <p>1.6.</p>													
<p><b>2. Education and Training</b></p> <p>2.1. Commission a KAP study <sup>1</sup></p> <p>2.2. Engage and train peer educators.</p> <p>2.3. Engage and train safety representatives.</p> <p>2.4. Engage and train managers.</p> <p>2.5. Engage and train HIV and AIDS focal persons.</p> <p>2.6. Organize formal training sessions.</p> <p>2.7.</p> <p>2.8.</p>													
<p><b>3. Non-discriminatory environment <sup>2</sup></b></p> <p>3.1. Provide support for confidentiality and non-discrimination.</p> <p>3.2. Provide support and guidance on non-stigmatization attitudes and behaviour towards PLHIV.</p> <p>3.3. Disciplinary / grievance procedures for stigma or discrimination.</p> <p>3.4. Publicize legal rights.</p> <p>3.5. Publicize and advocate correct attitudes and behaviour.</p> <p>3.6.</p> <p>3.7.</p>													

<sup>1</sup> KAP stands for Knowledge, Attitude and Practices. The survey employs a questionnaire on basic facts, testing and treatment, myths and misconception, attitudes to PLWHA and sexual behaviour. In the process of gathering information, it also gives information and raises awareness. HSRC and MRC have resources around KAP studies.

<sup>2</sup> The underlying causes of stigma are discussed on Page 81 of 'Managing HIV/AIDS in the Workplace'. Fear of stigma and discrimination are key disincentives for people to learning their status, changing their behaviour or engaging with HIV/AIDS issues as relevant in their lives.

PROGRAMS AND ELEMENTS	PERSON RESPONSIBLE	MONTH OR WEEK (DEPENDING ON YOUR PROJECT DURATION)											
		1	2	3	4	5	6	7	8	9	10	11	12
<p><b>4. STI, TB and other infections prevented and treated</b></p> <p>4.1. Information on STI prevention.</p> <p>4.2. Information on TB and other infections.</p> <p>4.3. Information on various sources of support for management of STIs.</p> <p>4.4. Encourage use of Primary Health Care clinic for STIs.</p> <p>4.5. Provide resourced on-site clinic facilities and train clinic staff.</p> <p>4.6. Discuss STI issues in confidential counselling sessions.</p> <p>4.7. Form partnerships with user-friendly STI service providers.</p> <p>4.8. Promote condom use.</p> <p>4.9.</p> <p>4.10.</p>													
<p><b>5. Infection control (occupational exposure)</b></p> <p>5.1. Promote universal precautions to prevent occupational exposure and infection.</p> <p>5.2. Assume contact with HIV and always take precautions.</p> <p>5.3. Ensure that protective equipment is available (e.g. gloves).</p> <p>5.4. Standard first aid procedures for exposure trained and known.</p> <p>5.5. Regulations for safe disposal agreed, publicized and training provided.</p> <p>5.6. Design and institutionalize systems for recording and reporting incidents.</p> <p>5.7. Provide information, advice and access for post-exposure prophylaxis (PEP).</p> <p>5.8.</p> <p>5.9.</p>													
<p><b>6. VCT <sup>3</sup></b></p> <p>6.1. Create a referral mechanism with VCT providers.</p> <p>6.2. Recruit and train peer counsellors and ensure confidentiality.</p> <p>6.3. Train VCT staff on pre- and post-test counselling.</p> <p>6.4. Promote uptake of VCT.</p> <p>6.5. Provide on-site VCT, supported by consistent supplies of testing materials and information on test protocols.</p> <p>6.6. Provide space for workplace counselling and testing, and ensure that counselling is always provided.</p> <p>6.7. Assure privacy and confidentiality.</p> <p>6.8. Department encourages support for people living with or affected by HIV and AIDS. (continues overleaf)</p>													

<sup>3</sup> VCT has been found to support HIV prevention because: individuals take responsibility for their own sexual health; knowledge of HIV+ status enables people to change their life-style to manage the condition; counselling raises HIV awareness for positive and negative tests; disclosure is encouraged; stigma and discrimination are reduced.

PROGRAMS AND ELEMENTS	PERSON RESPONSIBLE	MONTH OR WEEK (DEPENDING ON YOUR PROJECT DURATION)											
		1	2	3	4	5	6	7	8	9	10	11	12
<p>6.9. <i>Make information available to all staff on home-based care providers.</i></p> <p>6.10.</p> <p>6.11.</p> <p>6.10.</p> <p>6.11.</p>													
<p><b>7. Condom promotion/distribution <sub>2</sub></b></p> <p>7.1. <i>Ensure that employees have ready access to a regular supply of male condoms.</i></p> <p>7.2. <i>Ensure that employees have ready access to a regular supply of female condoms</i></p> <p>7.3. <i>Provide known, diverse distribution points.</i></p> <p>7.4. <i>Offer education on condom use and shared sexual decision-making.</i></p> <p>7.5. <i>Promote male and female condoms.</i></p> <p>7.6. <i>Monitor condom uptake.</i></p> <p>7.7.</p> <p>7.8.</p>	<p><i>e.g. Provincial HIV and AIDS Coordinator</i></p> <p><i>Plus all District Coordinators</i></p>												

Refer to Pages 87-94 of 'Managing HIV/AIDS in the Workplace' for useful examples and details of treatment, care and support programs

**Table 2. Template for designing activities into program elements:**

**2) PROGRAMS THAT PROVIDE TREATMENT, CARE AND SUPPORT TO EMPLOYEES AND THEIR FAMILIES WHO ARE INFECTED OR AFFECTED BY HIV**

PROGRAMS AND ELEMENTS	PERSON RESPONSIBLE	MONTH OR WEEK (DEPENDING ON YOUR PROJECT DURATION)											
		1	2	3	4	5	6	7	8	9	10	11	12
<p><b>1. Wellness programs (treatment and care)<sup>4</sup></b></p> <p>1.1. Medical management for infected employees on-site or referred</p> <p>1.2. Department provides employees with ART</p> <p>1.3. Department provides employees with access to treatment for opportunistic infections including TB.</p> <p>1.4. Access to ongoing counselling on-site or through referrals</p> <p>1.5. Support to develop positive living skills</p> <p>1.6. Health promotion and education, e.g. healthy eating habits</p> <p>1.7. Establishment of continuum of care, e.g. integration / coordination between providers of related services</p> <p>1.8. Family assistance programs</p> <p>1.9.</p> <p>1.10.</p>													
<p><b>2. Social and psychological support</b></p> <p>2.1. Provision of psychosocial support to employees infected/ affected by HIV and AIDS</p> <p>2.2. The department has a comprehensive EAP/EWP</p> <p>2.3. Support groups for infected employees</p> <p>2.4. Provision of, or access to, various forms of counselling<sup>5</sup></p> <p>2.5. Provision of, continued treatment and compliance support</p> <p>2.6. Family support programs</p> <p>2.7. Information on and partnerships with community-based support and other outside sources of support</p> <p>2.8. Education and awareness on the value of accessing support</p> <p>2.9. Supervisors trained to handle on-the-job situations of HIV infected employees</p> <p>2.10.</p> <p>2.11.</p>													
<p><b>3. Family support, including assistance in planning for the future<sup>6</sup></b></p> <p>3.1. Access to legal, financial, psychological support in planning for possible illness, disability or death.</p> <p>3.2.</p> <p>3.3.</p>													
<p><b>4. Home-based care STI prevention and treatment</b></p> <p>4.1. Formation of partnerships, and referral and follow-up systems with professional and trusted home-based care providers</p> <p>4.2.</p> <p>4.3.</p>													

<sup>4</sup> A comprehensive wellness program should include: VCT; psychosocial support; palliative care; clinical management of common opportunistic infections; TB treatment and prevention; nutritional care; STI screening treatment and education; family planning; ART; PMTCT. (From SANAC draft guidelines 2001, outlined in greater detail on Page 89 of 'Managing HIV/AIDS in the Workplace').

<sup>5</sup> Reasons for needing counselling include: receiving a positive test result; involuntary disclosure of a positive result; break-up of relationship; death of a spouse or child; financial difficulties; loss of employment; isolation and fear of stigma; belief and fear of imminent death. (Quoted: Page 90 of 'Managing HIV/AIDS in the Workplace').

<sup>6</sup> 'Managing HIV/AIDS in the Workplace' contains useful resources on this theme. Refer to Page 92 and Appendix One.

Includes input from Workplace HIV/AIDS Programs: An Action Guide for Managers (Rau, 2002)



Designing your monitoring processes

**Table 4.** Template for designing activities into program elements:

PROGRAMS THAT AIM TO PREVENT AND REDUCE NEW HIV INFECTIONS				
PROGRAMS AND ELEMENTS	INDICATOR	TARGET	DATA SOURCE	RISKS/ ASSUMPTIONS
<p><b>1. Provide ongoing Behaviour Change Communication (BCC)</b>  <b>Provide correct information on HIV/AIDS</b></p> <p>1.1. Distribute pamphlets or other up-to-date written materials to all employees.</p> <p>1.2. Provide information specifically on acceptable sexual behaviour.</p> <p>1.3. Provide information specifically on risks related to drugs.</p> <p>1.4. Put up posters.</p> <p>1.5. Arrange lunch hour theatre.</p> <p>1.6. Organize presentations on policies and programs.</p> <p>1.7. Provide information about, and encourage the use of, community HIV and AIDS services.</p> <p>1.8.</p> <p>1.9.</p> <p>1.10.</p>				
<p><b>HIV mindfulness</b></p> <p>1.1. Distribute AIDS ribbons.</p> <p>1.2. Hold a World AIDS Day event.</p> <p>1.3. Disseminate in lifts, payslips, email.</p> <p>1.4.</p> <p>1.5.</p> <p>1.6.</p>				
<p><b>2. Education and Training</b></p> <p>2.1. Commission a KAP study <sup>7</sup></p> <p>2.2. Engage and train peer educators.</p> <p>2.3. Engage and train safety representatives.</p> <p>2.4. Engage and train managers.</p> <p>2.5. Engage and train HIV and AIDS focal persons.</p> <p>2.6. Organize formal training sessions.</p> <p>2.7.</p> <p>2.8.</p>				
<p><b>3. Non-discriminatory environment <sup>8</sup></b></p> <p>3.1. Provide support for confidentiality and non-discrimination.</p> <p>3.2. Provide support and guidance on non-stigmatization attitudes and behaviour towards PLHIV.</p> <p>3.3. Disciplinary / grievance procedures for stigma or discrimination.</p> <p>3.4. Publicize legal rights.</p> <p>3.5. Publicize and advocate correct attitudes and behaviour.</p> <p>3.6.</p> <p>3.7.</p>				

<sup>7</sup> KAP stands for Knowledge, Attitude and Practices. The survey employs a questionnaire on basic facts, testing and treatment, myths and misconception, attitudes to PLWHA and sexual behaviour. In the process of gathering information, it also gives information and raises awareness. HSRC and MRC have resources around KAP studies.

<sup>8</sup> The underlying causes of stigma are discussed on Page 81 of 'Managing HIV/AIDS in the Workplace'. Fear of stigma and discrimination are key disincentives for people to learning their status, changing their behaviour or engaging with HIV/AIDS issues as relevant in their lives.

PROGRAMS AND ELEMENTS	INDICATOR	TARGET	DATA SOURCE	RISKS/ ASSUMPTIONS
<p><b>4. STI, TB and other infections prevented and treated</b></p> <p>4.1. Information on STI prevention.</p> <p>4.2. Information on TB and other infections.</p> <p>4.3. Information on various sources of support for management of STIs.</p> <p>4.4. Encourage use of Primary Health Care clinic for STIs.</p> <p>4.5. Provide resourced on-site clinic facilities and train clinic staff.</p> <p>4.6. Discuss STI issues in confidential counselling sessions.</p> <p>4.7. Form partnerships with user-friendly STI service providers.</p> <p>4.8. Promote condom use.</p> <p>4.9.</p> <p>4.10.</p>				
<p><b>5. Infection control (occupational exposure)</b></p> <p>5.1. Promote universal precautions to prevent occupational exposure and infection.</p> <p>5.2. Assume contact with HIV and always take precautions.</p> <p>5.3. Ensure that protective equipment is available (e.g. gloves).</p> <p>5.4. Standard first aid procedures for exposure trained and known.</p> <p>5.5. Regulations for safe disposal agreed, publicized and training provided.</p> <p>5.6. Design and institutionalize systems for recording and reporting incidents.</p> <p>5.7. Provide information, advice and access for post-exposure prophylaxis (PEP).</p> <p>5.8.</p> <p>5.9.</p>				
<p><b>6. VCT <sup>9</sup></b></p> <p>6.1. Create a referral mechanism with VCT providers.</p> <p>6.2. Recruit and train peer counsellors and ensure confidentiality.</p> <p>6.3. Train VCT staff on pre- and post-test counselling.</p> <p>6.4. Promote uptake of VCT.</p> <p>6.5. Provide on-site VCT, supported by consistent supplies of testing materials and information on test protocols.</p> <p>6.6. Provide space for workplace counselling and testing, and ensure that counselling is always provided.</p> <p>6.7. Assure privacy and confidentiality.</p> <p>6.8. Department encourages support for people living with or affected by HIV and AIDS.</p> <p>6.9. Make information available to all staff on home-based care providers.</p> <p>6.10.</p> <p>6.11.</p>				

<sup>9</sup> VCT has been found to support HIV prevention because: individuals take responsibility for their own sexual health; knowledge of HIV+ status enables people to change their life-style to manage the condition; counselling raises HIV awareness for positive and negative tests; disclosure is encouraged; stigma and discrimination are reduced.

PROGRAMS AND ELEMENTS	INDICATOR	TARGET	DATA SOURCE	RISKS/ ASSUMPTIONS
<p><b>7. Condom promotion/distribution</b></p> <p>7.1. <i>Ensure that employees have ready access to a regular supply of male condoms.</i></p> <p>7.2. <i>Ensure that employees have ready access to a regular supply of female condoms</i></p> <p>7.3. <i>Provide known, diverse distribution points.</i></p> <p>7.4. <i>Offer education on condom use and shared sexual decision-making.</i></p> <p>7.5. <i>Promote male and female condoms.</i></p> <p>7.6. <i>Monitor condom uptake.</i></p> <p>7.7.</p> <p>7.8.</p>				

Refer to Pages 87-94 of 'Managing HIV/AIDS in the Workplace' for useful examples and details of treatment, care and support programs

**Table 5. Template for designing activities into program elements:**

**2) PROGRAMS THAT PROVIDE TREATMENT, CARE AND SUPPORT TO EMPLOYEES AND THEIR FAMILIES WHO ARE INFECTED OR AFFECTED BY HIV**

PROGRAMS AND ELEMENTS	INDICATOR	TARGET	DATA SOURCE	RISKS/ ASSUMPTIONS
<p><b>1. Wellness programs (treatment and care) <sup>10</sup></b></p> <p>1.1. Medical management for infected employees on-site or referred</p> <p>1.2. Department provides employees with ART</p> <p>1.3. Department provides employees with access to treatment for opportunistic infections including TB.</p> <p>1.4. Access to ongoing counselling on-site or through referrals</p> <p>1.5. Support to develop positive living skills</p> <p>1.6. Health promotion and education, e.g. healthy eating habits</p> <p>1.7. Establishment of continuum of care, e.g. integration / coordination between providers of related services</p> <p>1.8. Family assistance programs</p> <p>1.9.</p> <p>1.10.</p>				
<p><b>2. Social and psychological support</b></p> <p>2.1. Provision of psychosocial support to employees infected/ affected by HIV and AIDS <sup>11</sup></p> <p>2.2. The department has a comprehensive EAP/EWP</p> <p>2.3. Support groups for infected employees</p> <p>2.4. Provision of, or access to, various forms of counselling</p> <p>2.5. Provision of, continued treatment and compliance support</p> <p>2.6. Family support programs</p> <p>2.7. Information on and partnerships with community-based support and other outside sources of support</p> <p>2.8. Education and awareness on the value of accessing support</p> <p>2.9. Supervisors trained to handle on-the-job situations of HIV infected employees</p> <p>2.10.</p> <p>2.11.</p>				
<p><b>3. Family support, including assistance in planning for the future<sup>12</sup></b></p> <p>3.1. Access to legal, financial, psychological support in planning for possible illness, disability or death.</p> <p>3.2.</p> <p>3.3.</p> <p>3.7.</p>				
<p><b>4. Home-based care STI prevention and treatment</b></p> <p>4.1. Formation of partnerships, and referral and follow-up systems with professional and trusted home-based care providers</p> <p>4.2.</p> <p>4.3.</p>				

Includes input from Workplace HIV/AIDS Programs: An Action Guide for Managers (Rau, 2002)

<sup>10</sup> A comprehensive wellness program should include: VCT; psychosocial support; palliative care; clinical management of common opportunistic infections; TB treatment and prevention; nutritional care; STI screening treatment and education; family planning; ART; PMTCT. (From SANAC draft guidelines 2001, outlined in greater detail on Page 89 of 'Managing HIV/AIDS in the Workplace').

<sup>11</sup> Reasons for needing counselling include: receiving a positive test result; involuntary disclosure of a positive result; break-up of relationship; death of a spouse or child; financial difficulties; loss of employment; isolation and fear of stigma; belief and fear of imminent death. (Quoted: Page 90 of 'Managing HIV/AIDS in the Workplace').

<sup>12</sup> 'Managing HIV/AIDS in the Workplace' contains useful resources on this theme. Refer to Page 92 and Appendix One.

**Table 6. Template for designing program elements:**

3) CAPACITY BUILDING AND 4) COMMUNICATION				
PROGRAMS AND ELEMENTS	INDICATOR	TARGET	DATA SOURCE	RISKS/ ASSUMPTIONS
<p><b>1. Capacity Building Program</b></p> <p>1.1. Peer educators trained on HIV/AIDS</p> <p>1.2. HIV/AIDS Counsellors trained</p> <p>1.3. SMS capacitated around managing the impact of HIV/AIDS and integration of HIV/AIDS into departmental planning</p> <p>1.4. EAP personnel trained on HIV/AIDS on treatment, care and support.</p> <p>1.5. HR personnel trained on HIV/AIDS policies and procedures</p> <p>1.6. Union officials trained on legal and human rights aspects of HIV/AIDS</p> <p>1.7. SMS trained on monitoring and evaluation of HIV/AIDS workplace policies and programs</p> <p>1.8.</p> <p>1.9.</p>				
<p><b>2. Communication strategy</b></p> <p>2.1. Know your audience: literacy levels, languages, preferred media</p> <p>2.2. Use several media, e.g. pamphlets, posters, memoranda, paylips</p> <p>2.3. Broadcast messages must apply to both men and women</p> <p>2.4. Strategy designed: what information; how; consultation processes</p> <p>2.5.</p> <p>2.6.</p>				

Refer to Pages 87-94 of 'Managing HIV/AIDS in the Workplace' for useful examples and details of treatment, care and support programs

**Table 7. Template for designing the additional program element of policy design and development**

PROGRAMS ELEMENT AND CRITERIA FOR CONSULTATIVE POLICY DEVELOPMENT	INDICATOR	TARGET	DATA SOURCE	RISKS/ ASSUMPTIONS
<p><b>1. Draft Policy and Policy Document</b></p> <p><i>1.1. Draft policy developed by a committee</i></p> <p><i>1.2. All sections and functions represented in the consultation</i></p> <p><i>1.3. Appropriate unions involved in the development of the policy. How many?</i></p> <p><i>1.4. Participants from the departments.</i></p> <p><i>1.5. Participants from other partners and unions</i></p> <p><i>1.6. Senior managers involved in development of the policy</i></p> <p><i>1.7. Recognized methods used in development of the policy</i></p> <p><i>1.8.</i></p> <p><i>1.9.</i></p>				

**Table 8. Indicators and targets: Examples**

<b>3) PROGRAMS, ELEMENTS AND ACTIVITIES SOME EXAMPLES TO ILLUSTRATE THE USE OF THE M&amp;E TEMPLATE LEFT)</b>				
<b>WELLNESS PROGRAMS (TREATMENT AND CARE)</b>	<b>INDICATOR</b>	<b>ANNUAL TARGET</b>	<b>DATA SOURCE</b>	<b>RISKS/ ASSUMPTIONS</b>
<b>Wellness programs (treatment and care)</b>				
Medical management for infected employees on-site or referred	Number of infected employees supported	20	EAP monitoring records (monthly)	Assuming infected employees prefer on-site medical management
Access to ongoing counselling on-site or through referrals	Number of counselling sessions	100	Counsellors logged visit records (monthly)	Risk: That adherence to counselling is low
Support to develop positive living skills	Number of support interventions organized	3	Intervention reports (annually)	Risk: That high risk life-style people will not attend interventions
Health promotion and education, e.g. healthy eating habits	Number of pamphlets distributed	5 designs of 1 000 printed each	Printers invoices and distribution monitoring records (quarterly)	Assuming pamphlets are read
Establishment of continuum of care, e.g. integration / coordination between providers of related services	Number of referrals that are effectively followed	40	Referral tracking forms as agreed with partners (quarterly)	Risk: Partners do not have capacity to manage tracking
Family assistance programs	Number of families supported	5	Counsellors reports (monthly)	Assuming families reside locally
<b>Policy development / Review</b>	Draft policy Policy		Attendance register of participants (as scheduled)	
<b>Condom distribution</b>		500,000 male condoms & 150,000 female condoms	Clinics, hospitals and office condom distribution register (monthly)	
<b>Capacity Building for employees</b>	Number of training sessions Number of TA Assistance activities Number of employees reached		Attendance register of participants (bimonthly)	
<b>Compulsory Counselling and voluntary Testing [CCVT]</b>	350 employees received counselling Number of employees tested			

**Other possible data items include:**

- **Data collection methods**
- **Next steps**

**Indicators for both outputs and outcome**

**Health Policy Initiative, Task Order 4, South Africa**

**Constella Futures**

<http://www.healthpolicyinitiative.com>