



USAID | HEALTH POLICY
FROM THE AMERICAN PEOPLE INITIATIVE



MENTORSHIP WORKSHOP – POLICY CHAMPIONS PROGRAMME

TECHNICAL ASSISTANCE GUIDE ON HIV AND AIDS

PROGRAMME IMPLEMENTATION





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FROM THE AMERICAN PEOPLE | INITIATIVE



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ACRONYMS

AIDS	Anti-Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
DPSA	Department of Public Service and Administration
EAP	Employee Assistance Programme
EHW	Employee Health and Wellness
EWP	Employee Wellness Programme
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
HR	Human Resources
HSRC	Human Sciences Research Council
IDC	Interdepartmental Committee on HIV/AIDS
KAP	Knowledge, Attitudes and Practice
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
MRC	Medical Research Council
MTEF	Medium-Term Expenditure Framework
NGO	Nongovernment Organization
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PILIR	Policy on Incapacity Leave and Ill-Health Retirement
PLWHA / PWHIV	People Living With HIV or AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SANAC	South African National AIDS Council
SMS	Senior Management Service
STI	Sexually Transmitted Infection
TA	Technical Assistance
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing

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INTRODUCTION

1.1. THE HIV AND AIDS SITUATION

“The impact of HIV/AIDS is being felt in the country as a whole, and the workplace is no exception. With infection rates still on the increase, departments must be prepared to deal effectively with HIV/AIDS so as to maintain high productivity and service delivery levels whilst avoiding discrimination of those infected or affected.”

Minister G J Fraser-Moleketi, DPSA

Introduction to “Managing HIV/AIDS in the Workplace: A Guide for Government Departments,” 2002.’

The HIV epidemic has infiltrated and impacted on every sector of society. Policies to address the needs of the employed and their families in the face of the epidemic are needed by every employer, with the public sector as no exception. Minister Fraser-Moleketi goes on to point out that government is the country’s single largest employer, with 1.1 million public servants at national and provincial levels. In addition to supporting members of its workforce and those who depend on them, the public sector also has a role in leading through example and offering a model to private, educational and nonprofit institutions for best practice in HIV workplace policy and programme implementation.

DISCUSSION:

Consider the statistics on the following page. What do you see as the implications of these statistics for the HIV and AIDS programmes?

Also refer to
Page 13 of
“Managing
HIV/AIDS in the
Workplace.”

TABLE I. HIV and AIDS Indicator in South Africa at mid-2006

NATIONAL INDICATOR	STATISTIC
Total HIV infected	5,372,000 (11.2%)
Adults infected (20–4)	4,880,000 (19.2%)
Adult men (20–64)	2,179,000 (17.8%)
Adult women (20–64)	2,702,000 (20.4%)
Youth (15–24)	1,012,000 (10.4%)
Children (0–14)	294,000 (1.9%)
New infections in the year (average of 1,443 per day)	527,000
Total number of AIDS sick at mid-2006	599,000
No. adults and youth receiving antiretroviral treatment	200,000
Total AIDS deaths during 2005	346,000
Total death from all causes during 2005	737,000
Accumulated AIDS deaths mid-year 2006	1,814,000
Percentage of deaths of adults 15–49 due to HIV/AIDS	71%
Life expectancy	50.8 years
Total orphans	1,542,000
Total AIDS orphans	1,019,000
New orphans in 2005	296,000

PROVINCIAL DISTRIBUTION	PREVALENCE (% OF HIV+ IN POPULATION)
Eastern Cape	10.0%
Free State	13.9%
Gauteng	14.5%
Kwazulu Natal	15.7%
Limpopo	6.9%
Mpumalanga	13.4%
Northern Cape	6.9%
North West	12.7%
Western Cape	5.4%

Source: Adapted from Dorrington et al., 2007.

1.2. HIV AND AIDS WORKPLACE POLICY DEVELOPMENT IN THE PUBLIC SERVICE

1.2.1. MANAGING HIV/AIDS IN THE WORKPLACE: A GUIDE FOR GOVERNMENT DEPARTMENTS

The public sector recognizes the urgency and importance of developing and implementing effective policy to address HIV and AIDS in its workplace. The Department of Public Service and Administration (DPSA), in collaboration with the Canadian International Development Agency (CIDA) and the USAID POLICY Project, initiated the Impact and Action Project on HIV/AIDS. A key output of that project was the guideline **“Managing HIV/AIDS in the Workplace: A Guide for Government Departments,”** published in 2002. The guideline was distributed and was used to support design and implementation of HIV/AIDS policy in all provinces.

This toolkit is intended to support the guide and elaborate on some of its advice.

1.2.2. THE DPSA/POLICY PROJECT – PROBLEM ANALYSIS EVALUATION AND REPORT

In September 2006, progress in designing and implementing HIV policy was evaluated, and found to be weakest in the provinces of Northern Cape, Free State, and Mpumalanga (DPSA, 2007). A problem analysis was commissioned through a consortium of partners to define the obstacles to applying “*Managing HIV/AIDS in the Workplace*” in these provinces, and a report was distributed in early 2007. The conclusions and associated recommendations of this report were as follows:

- The capacity of the Premiers Office to coordinate HIV policy development and implementation process has been weak. The report attributed this to poor skills, poor Senior Management Service (SMS) support, and excessive workloads.
- Where the DPSA has initiated Employee Health and Wellness (EHW) processes, these often have been diluted by implementation of separate activities engaging the same stakeholders, without coordination between the activities.
- Attempts at implementation of policies are sometimes disrupted and lack continuity. Skills to implement policies also often are lacking.
- The documentation of monitoring and evaluation (M&E) for policy implementation has not been effective, so there is no record of implementation or its successes and failures. M&E has been a particularly noticeable weakness.
- Budgets for implementation have not been adequate.
- Communication of the policy and programmes has been weak, with no communication strategy and poor political support or strategic alignment.
- The partnerships between DPSA and the Health Policy Initiative (HPI) primarily have been responsible for driving policy design and implementation within South Africa, creating an enabling environment for the implementation of HIV and AIDS programmes.
- Integration or coordination between the Interdepartmental Committee on HIV/AIDS (IDC) interventions and related occupational health committees, such as Employee Health and Wellness (EHW), Policy on Incapacity Leave and Ill-Health Retirement (PILIR), and Disability Management, is not effective.

1.3. OVERVIEW OF THE GUIDE

1.3.1. OBJECTIVES

This guide or toolkit provides the Technical Assistance (TA) process, along with some key resources and facilitation tools for enabling provincial policy development teams to design relevant and effective policies for their provinces during the three days of facilitated TA. The toolkit closely follows and supports “*Managing HIV/AIDS in the Workplace: A Guide for Government Departments*,” since the key objective of the intervention is to build capacity to implement these official guidelines independently, beyond the TA intervention.

The objective of the TA is to provide the employees from each department with the following skills:

- To prepare and implement HIV/AIDS workplace policies and programmes;
- To cost such programmes; and
- To support the design of M&E for the programmes to ensure accountability.

1.3.2. STRUCTURE OF THE TOOLKIT

Section 1: This introduction (a) provides relevant background information on HIV and AIDS; (b) contextualizes the TA in longer capacity building and situation analysis processes; and (c) outlines the objectives of the TA process.

Section 2: Workplace policies for HIV and AIDS (a) outlines the impacts of HIV and AIDS often seen in the workplace; (b) presents guidance on the purpose of policy and how it usually is drafted and agreed upon; (c) presents

some elements of a minimum standard for HIV and AIDS policies; and (d) outlines a facilitated process by which each province can develop its own HIV and AIDS policy.

Section 3: The Programmes – HIV and AIDS policy implementation (a) outlines some minimum standards for HIV and AIDS programmes in the workplace; (b) presents a guideline on programme design; and (c) outlines a facilitated process by which each province can develop its own HIV and AIDS programme, including beginning to take decisions on timeframes and costing.

Section 4: Monitoring and Evaluation (a) outlines the minimum standards expected for an HIV and AIDS M&E process; (b) offers a guideline for the process of deciding and developing a locally relevant M&E system; and (c) outlines a facilitated process by which each province can develop its own HIV and AIDS planned and costed programme.

The Appendices provide supporting information and stand-alone tools or guidelines which may be applied in the facilitated TA process, or which managers may find useful as they continue this process independently.

The manual follows the programme schedule for the TA intervention closely (Table 2), and also is clearly structured to align with the DPSA guide **“Managing HIV/AIDS in the Workplace”**.

TABLE 2. Lesson Plan (Schedule) for a three-day onsite technical assistance intervention

TIME	ACTIVITY	FACILITATOR
	DAY 1	
08:30 - 08:45	<ul style="list-style-type: none"> • Introduction and opening remarks. • Overview of onsite programme. • Agreement and clarification on the authority of the group to take binding decisions, and the process by which these decisions will be taken and documented in this meeting. 	
08:45 - 09:45	<ul style="list-style-type: none"> • Presentation on TA toolkit intervention plan. • Discussion on relevance and need for HIV/AIDS workplace policy. 	
09:45 - 10:45	<ul style="list-style-type: none"> • Presentation and discussion on minimum standards. • Presentation and discussion on developing or revising policies. 	
10:45 - 11:00	TEA BREAK	
11:00 - 12:00	<ul style="list-style-type: none"> • Review of current departments’ workplace policy on HIV/AIDS, highlighting the areas for development in a revised policy. • Possible division into Task Teams for the afternoon session. 	
12:00 - 12:30	<ul style="list-style-type: none"> • Meetings of Task Teams. • Preparation of workplans for the afternoon session. 	
12:30 - 13:30	LUNCH	
13:30 - 15:30	<ul style="list-style-type: none"> • Preparation of revised policy elements by the Task Teams, including areas that require further development beyond the TA process. 	
15:30 - 16:30	<ul style="list-style-type: none"> • Presentations by the Teams of policy elements. • Decisions on adoption of elements by those present • Identification of tasks for finalization of the policies beyond the TA process, and allocation of responsibility, timeframes, and the communication process. 	
	DAY 2	
08:30-08:45	<ul style="list-style-type: none"> • Day one review: Revisiting the presentations. Review of the decisions taken. 	
08:45-09:45	<ul style="list-style-type: none"> • Presentation and discussion on the process for programme development and implementation. • Presentation and discussion on normal practice and minimum standards for HIV and AIDS programmes. 	
09:45-10:45	<ul style="list-style-type: none"> • Review of current programmes, highlighting areas for development in light of the policy decisions taken. • Allocation of programme design areas to Task Teams, if relevant. 	
10:45-11:00	TEA BREAK	

I. KEY PRIORITY AREAS

TIME	ACTIVITY	FACILITATOR
11:00 - 12:30	<ul style="list-style-type: none"> Proposing elements of programmes in terms of policy, vision, strategy, objective, outcomes, activities, and next action steps. 	
12:30 - 13:30	LUNCH	
13:30-14:30	<ul style="list-style-type: none"> Presentations of the programme recommendations. Discussion and decisions on programme elements taken each Team. Agreement on areas which require follow-up beyond the TA and allocation of responsibility, timeframes, and the communication process. 	
14:30-15:30	<ul style="list-style-type: none"> Estimation and preparation of financial plans and budgets to support the programme decisions. 	
15:30 -16:30	<ul style="list-style-type: none"> Presentations by the Teams of programme costing. Decisions of adoption of elements and budget items by those present. Agreement on any additional areas which require follow-up beyond the TA and allocation of responsibility, timeframes, and the communication process. 	
	DAY 3	
08:30-08:45	<ul style="list-style-type: none"> Day one and two review: Revisiting the policy and programme presentations. Review of the decisions taken. 	
08:45-09:45	<ul style="list-style-type: none"> Presentation and discussion on monitoring and evaluation processes, and design of M&E plans. Presentation and discussion on normal practice and minimum standards for HIV and AIDS programme M&E. 	
09:45-10:45	<ul style="list-style-type: none"> Review of current M&E plans, highlighting areas for development in the light of policy and programme decisions taken. Allocation of programme design areas to Task Teams if relevant. 	
10:45-11:00	TEA BREAK	
11:00-12:30	<ul style="list-style-type: none"> Proposing elements of M&E plan programmes in terms of monitoring data or indicators; data collection, collation, analysis, and dissemination; evaluation processes; and programme and policy adjustment processes in response to M&E 	
12:30-13:30	LUNCH	
13:30-14:30	<ul style="list-style-type: none"> Presentations of the M&E plan recommendations. Discussion and decisions on M&E plan elements taken by group. Agreement on areas which require follow-up beyond the TA and allocation of responsibility, timeframes, and the communication process. 	
14:30-16:15	<ul style="list-style-type: none"> Finalizing and consolidation the overall department strategy: policy, programme, budget, and M&E. Clarification of decisions and responsibilities for next steps 	
16:15-16:30	<ul style="list-style-type: none"> Evaluation of the TA process 	

Note on the TA schedule

Please be aware that the above schedule suggests an outline of the themes and a possible structure for the TA intervention, and not a rigid or inflexible programme. Changes may be made at the discretion of the facilitators to achieve the objectives more appropriately.

2

POLICY

A policy reflects a department's position on an issue. Policies usually are developed in response to challenges. They provide the principles and guidelines on which decisions for management should be made, and they need to be documented clearly, comprehensive and complete, agreed upon, and supported.

Policies enable managers and decisionmakers to respond in terms of their leadership, management, and authority, both for the greater effectiveness of their departments and the fair and consistent benefit of employees.

In the broadest definition, policies are nested from the highest level national and international mandates of the Millennium Development Goals or the South African Constitution, down to specific, detailed, locally relevant policies drafted by municipalities or local organizations. Policies on HIV and AIDS in the public service workplace are guided by various international guidelines and national legislation, and call on this national legal authority to support them.

2.1. WHY AN HIV AND AIDS POLICY?

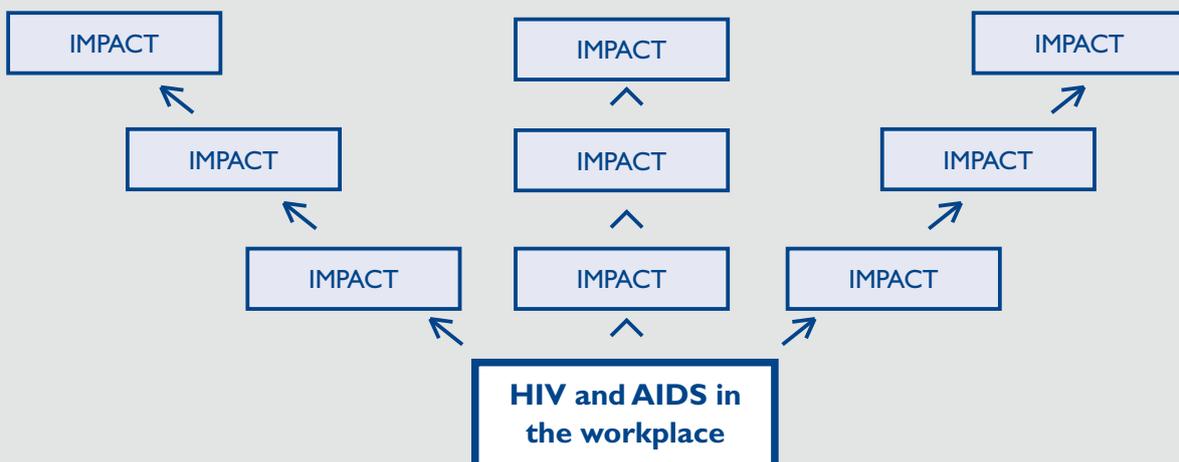
DISCUSSION:

While respecting the confidentiality of your colleagues, can you describe what impacts of HIV and AIDS you have seen in your personal experience at work?

Process note: Impacts should be clearly listed on a flipchart and displayed for future use

EXERCISE – PROBLEM TREE ANALYSIS STEP I:

Having considered your own experiences of the impact of HIV and AIDS, consider its impact in terms of a Problem Tree, and outline the various needs that you know of and expect to emerge as a consequence of the epidemic.



The following questions may guide you:

- How would you describe the impact of HIV and AIDS in your department?
- What are the key challenges posed by this impact on your department?
- Are employees at risk of contracting HIV as a result of the nature of their work?
- What are the different needs that arise because of HIV and AIDS?
- How does HIV and AIDS impact on individuals?
- How do they impact teams?
- How do they impact productivity and performance?
- What are the effects on the psychological well-being of employees?
- What are your main concerns with respect to HIV/AIDS in your workplace?

An excellent outline of impact flows is presented on Page 70 of “Managing HIV/AIDS in the Workplace.”

2.2. RESEARCH RESULTS ON IMPACT OF HIV

The following impacts have been observed in workplace settings as a result of HIV and AIDS.

TABLE 3. Impacts of HIV/AIDS in the workplace

IMPACT	IS THIS AN ISSUE FOR YOU? (Y/N)	YOUR OBSERVATIONS
More sick leave		
More absenteeism as a result of illness		
More absenteeism for medical treatment		
More absenteeism as a result of increased responsibilities for orphans or other dependants		
More absenteeism for funerals		
Mortality		
More applications for early retirement		
Lower staff morale and deteriorating staff relationships because of suspicion, fear, and resentment of workload increases		
Increased health care costs to individuals creating financial stress		
Increased demand for health and welfare services and related benefits		
Lower productivity		
Provision for burial costs		
Increased death benefits costs or increased provident fund claims		
Increased recruitment and training costs and personnel investment		
Other please specify		

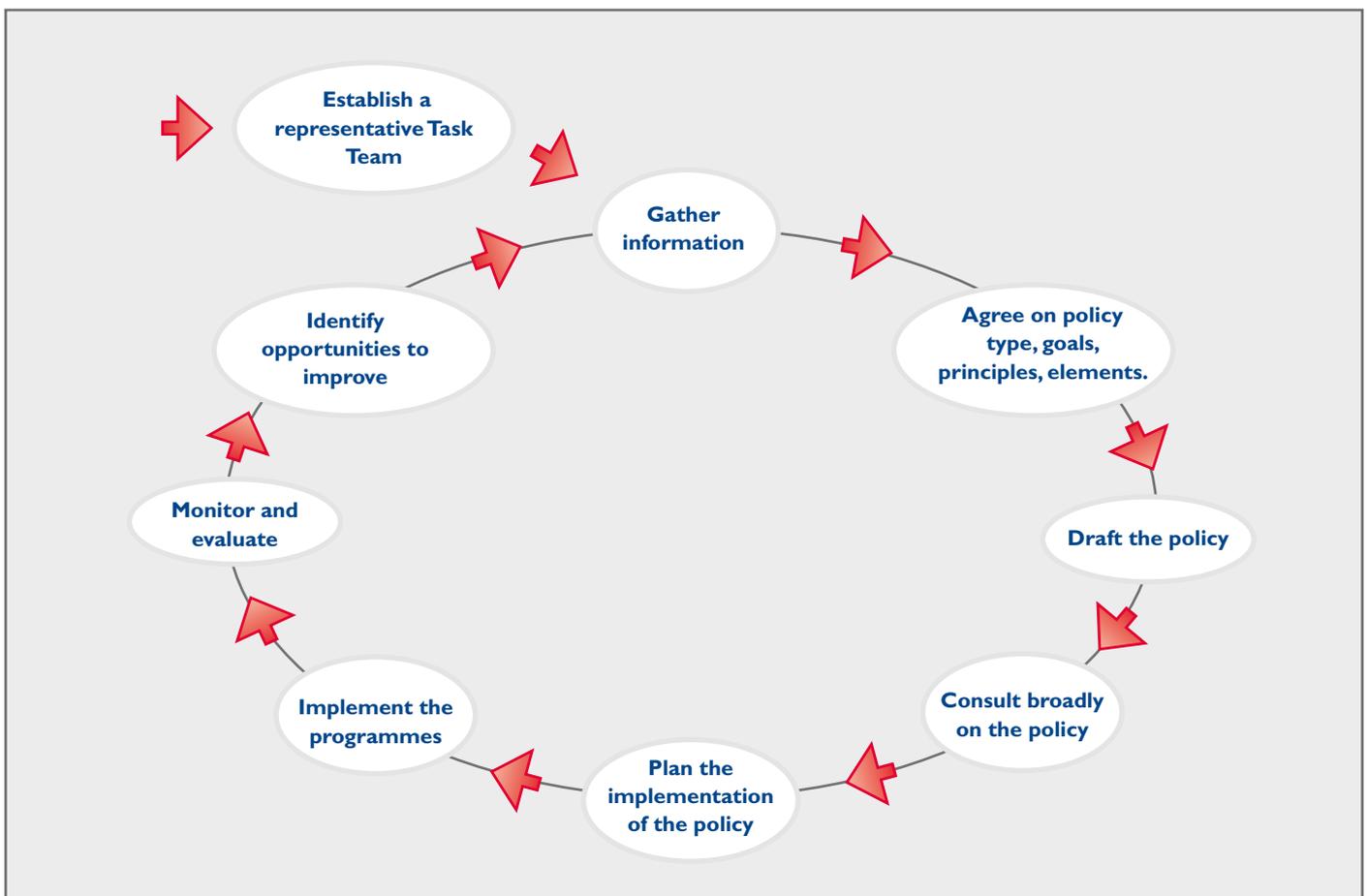
DISCUSSION:

Which of these correspond with your experience, and what are your observations around them?

2.3. DESIGNING YOUR POLICY

2.3.1. STEPS IN DESIGNING A POLICY

Managing HIV/AIDS in the Workplace (Page 51) recommends the following generic process in designing an HIV and AIDS policy:



2.3.2. AGREEING ON THE GOALS AND PRINCIPLES

In considering the elements of a policy to address these concerns and needs, you should be clear on the rationale of the policy in terms of the outcomes and impacts you hope to achieve. As the first step in policy design, we should decide on the changes you would like to see in the situation (or the purpose) and what specific areas of achievement you consider to be most effective in changing that situation (the objectives).

PURPOSE: What is the expected outcome/impact of the policy?

OBJECTIVES: What achievements would be needed to reach those outcomes?

Purpose:**DISCUSSION AND DECISION:**

On the basis of the impacts of HIV and AIDS, what changes would you like to see in the current situation as a result of this policy?

Process note: Purpose should be clearly written up on a flipchart and displayed for future use.

A possible example of a policy purpose in this context might be: 'to address the basic human rights of employees for access to services, information, and support, while optimizing productivity of the department, and the worklife satisfaction of all employees.'

Objectives or Policy Elements:**DISCUSSION AND DECISION:**

Refer to your problem tree and lists of impacts of HIV and AIDS. On which of these issues within the situation do you need to make policy decisions, and what is the concern around each issue that needs to be addressed by the policy decision?

Process note: Purpose should be clearly written up on a flipchart and displayed for future use.

2.4. QUALITIES OF GOOD POLICY**2.4.1. GUIDING PRINCIPLES**

The Department of Labour's Code of Good Practice on Key Aspects of HIV/AIDS and Employment provides five principles which should guide any HIV and AIDS policy:

- The promotion of equality and nondiscrimination between individuals with HIV infection and those without, and between HIV/AIDS and other comparable health/medical conditions is essential.
- Also essential is the creation of a supportive environment so that HIV-infected employees are able to continue working under normal conditions in their current employment for as long as they are medically fit to do so.
- The protection of human rights and dignity of people living with HIV or AIDS is essential to the prevention and control of HIV/AIDS.
- HIV/AIDS impacts women disproportionately and this should be taken into account in the development of workplace policies and programmes.
- Consultation, inclusivity, and encouraging full participation of all stakeholders are key principles which should underpin every HIV/AIDS policy and programme.

Department of Labour, as quoted in "Managing HIV/AIDS in the Workplace," Page 33.

Sources of principles:
Page 32 of "Managing HIV/AIDS in the Workplace."

Refer to the Dakar Declaration on Pages 32–33 for more on the principles that should guide HIV policy and the ILO Code of Good Practice for Managing HIV and AIDS in the Workplace.

2.4.2. MINIMUM STANDARD

A policy which meets the minimum standard should offer an affirmative response to each of the following questions:

- Does the policy prohibit unfair discrimination on the basis of HIV/AIDS and provide for steps to promote nondiscrimination?
- Does the policy prohibit HIV testing without Labour Court authorization?
- Does the policy promote voluntary counselling and testing (VCT)?

Source of minimum standards: Pages 31 and 49 of "Managing HIV/AIDS in the Workplace."

- Does the policy provide for confidentiality of an employee's HIV status?
- Does the policy provide for steps to facilitate access to VCT and post-exposure prophylaxis (PEP) for employees exposed to HIV as a result of an occupational accident?
- Does the policy provide for steps to facilitate access to VCT and post-exposure prophylaxis (PEP) for employees exposed to HIV as a result of an occupational accident?
- Does the policy provide for steps to facilitate compensation for employees infected as a result of an occupational accident?
- Does the policy allocate responsibility for HIV/AIDS?
- Does the policy provide for a communication strategy on aspects of HIV/AIDS?
- Does the policy make provision for monitoring and evaluation (M&E) of its processes and outcomes?
- Does the policy specify appropriate resources for activities and monitoring and evaluation within the policy?
- Does the policy look at the gender implications for all of the above and make provision for gender issues in the working environment?

For minimum standards, also see: Appendix 2, Pages 117–118 of “Managing HIV/AIDS in the Workplace,” which offer a basic minimum policy on workplace environment.

2.5. THE PROCESS

Policy resolves to increasingly fine levels of detail. The overarching purpose and principles may outline a broad value system around which policies are formulated.

The elements of the policy are likely to be more detailed, with mention of sick leave, benefits, confidentiality or discrimination, for example.

Within each element, decisions are required on fine details, such as a definition of psychosocial support under the sick leave benefit, or recourse for breach of confidentiality or suspected discrimination, for example. The piece on determining incapacity in **Managing HIV/AIDS in the Workplace** (Page 55) provides an example of the level of detail that might be required for policy to be implemented effectively.

A policy template can be found on Pages 52–53 of “Managing HIV/AIDS in the Workplace.”

2.5.1. WHO WILL DESIGN THE POLICY?

Policy is generally a strategic response by management on the basis of reliable, trusted information from all levels of the organization. Senior management's commitment to the development of the policy, its funding, implementation, monitoring, evaluation, and accountability are critical for the success of the process. Senior management needs to be certain that strategic decisions are relevant at operational levels, and that those who will implement the policies at those levels also are fully invested and committed to the effective implementation of the policy. Policy development therefore should be consultative.

Consider the likely role of the following in the policy development process:

DISCUSSION AND DECISION:

Who will be involved with policy design, and in what capacity?

STAKEHOLDER GROUP	ROLE
Senior management	
Individual champions	
Unions	
Government agencies with which policy should be aligned and complementary	
Funding agencies	
Research communities	
Partner organizations	
Who else?	

Process note: A stakeholder analysis should be clearly written up on a flipchart and displayed for future use

2.5.2. INFORMATION GATHERING

To ensure that policies are relevant and meet a genuine need, evidence of the issues of concern and their causes will be required. Policies based on rumour, unsubstantiated advice, or fashion are unlikely to fulfill their purpose or effectively improve the situation.

Evidence will continue to be collected through the M&E process, and policy will be adjusted regularly to ensure that it is effective, current, and relevant. Policy development is a living, responsive process based on emerging information.

The legal obligations within the workplace need to be known and integrated into the policy. Reviewing legislation, norms, and standards for workplace policies is also part of the information gathering process, and reference to other examples of other policies is likely to facilitate the process.

2.5.3. CONSULTATION

Dialogue and consultation with stakeholders should be aimed at reaching consensus on the situation and the needs that the policy should address. It is critical to ensure that stakeholders are well represented and that the needs of women are voiced clearly in the consultation process.

2.5.4. NEGOTIATION

Negotiation might be required where elements of the policy involve compromises. Examples of possible compromises might be facilitation of access to health services against maintaining the department's productivity, or provision of health care services through the department against budgetary constraints.

2.5.5. DECISIONS

The following critical decisions need to be taken before the policy can be fleshed out with detail:

- The type of HIV policy (e.g., Should it be integrated into various relevant existing policies or stand-alone?).
- The purpose and objectives of the policy.
- The guiding principles that underpin the policy.
- The key elements of the policy.
- The structures, co-ordination, roles and responsibilities needed for implementation.

Ultimately authority needs to be vested where a final decision can be taken on the policy so that it is binding on the rest of the organization. While the decision can and should be adjusted as evidence comes from M&E, an authoritative decision is needed before the policy can become part of practice. It is usual for a representative committee to be appointed and given this authority.

2.5.6. IMPLEMENTATION

Policies are designed to address challenges. Only in the quality and enthusiasm of their implementation can they achieve this purpose. Implementation can be delegated throughout the department and should include planning processes for activities, responsibilities, timeframes, and budgets. etc.

Relationships with partners are likely to enable policy implementation; also, engagement by partners for policy design and implementation is valuable.

2.6. 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 following:*
 - *the results to be achieved;*
 - *actions to be taken;*
 - *resources required; and*
 - *the cost?*
- *In reviewing the Qualities of Good Policy 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? For example, review the following:*
 - *When was the policy developed? What implications does this have?*
 - *Who were involved in its development? What implications does this have?*
 - *What was the adoption process? 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? For example: are there policies on stigma and discrimination in the workplace or on gender and medical benefits that would apply?*

2.7. 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 these policies

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 addressed in the next stage.)

DISCUSSION:

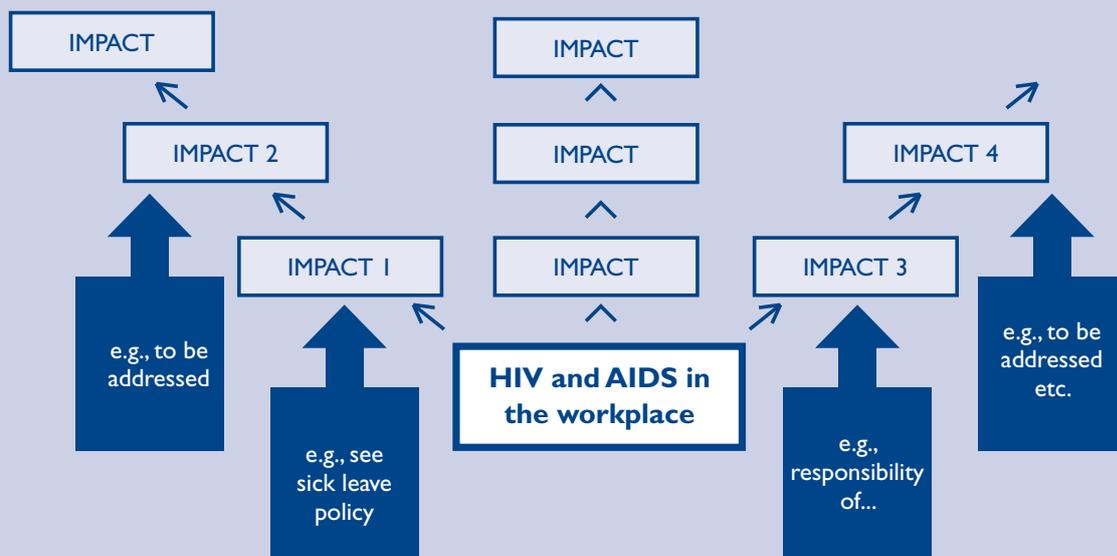
Refer to each of the impacts outlined in the situation analysis, and consider the questions:

Is the issue already addressed by another policy?

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

On which elements do you need to make a decision?

Discuss and agree on those policy decisions.



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

- Prevention – e.g., advocacy of 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., onsite provision, encouragement, advocacy;
- Confidentiality – e.g., recourse following 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;
- Programme integration – e.g., alignment with related policies;
- Incapacity management – e.g., definitions of incapacity, sick leave provision (reasonable accommodation);
- Capacity building – e.g., recruitment and training policies, HIV management capacity; and
- Service access – e.g., access to health care services with minimal worklife disruption.

2.8. MANAGEMENT RESPONSIBILITIES

Development of a workplace policy is just one responsibility in managing the epidemic in the workforce. Management also needs to do the following:

- 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;
- advocate for funding or increasing the funding for programmes, if necessary; and
- budget for the costs of HIV/AIDS programmes and oversee the implementation and monitoring of these programmes.

Each of these themes is addressed thoroughly in “Managing HIV/AIDS in the Workplace,” Page 37 and Chapters 6–9.

3

PROGRAMMES

3.1. STRUCTURES, PARTNERSHIPS, LEADERSHIP AND COMMITMENT

To take policy forward, a team of people needs to be assigned to the task of designing programmes and implementing the policy. According to the minimum standard outlined in **Managing HIV/AIDS in the Workplace** (Page 39), the following structures need to be created and supported:

- A designated member of the Senior Management Service (SMS), with adequate and relevant skills, seniority, and support should be assigned to the implementation of HIV/AIDS workplace programmes.
- An HIV/AIDS Committee with adequate representation of all relevant stakeholders should be instituted.
- HIV/AIDS programmes should be integrated into broader wellness programmes in the Department.
- Partnerships with departments, organizations, and individuals who are able to assist in implementation of the programme should be forged.

3.1.1. REVIEWING YOUR STRUCTURES

TABLE 4. 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 Co-ordinator been identified?			Guiding questions on where the Co-ordinator might be located and his/her core competencies on Pages 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 Pages 39–41
Does it have adequate human and financial resources?			
Are all stakeholders represented on the Committee?			
Have the Co-ordinator and the Committee formed partnerships with other departments, organizations, and individuals who can assist in the implementation of your policy?			Guidelines and examples on partnership on Pages 42–43

Checklist from ‘Managing HIV/AIDS in the Workplace’ Page 43

3.1.2. LEADERSHIP AND COMMITMENT

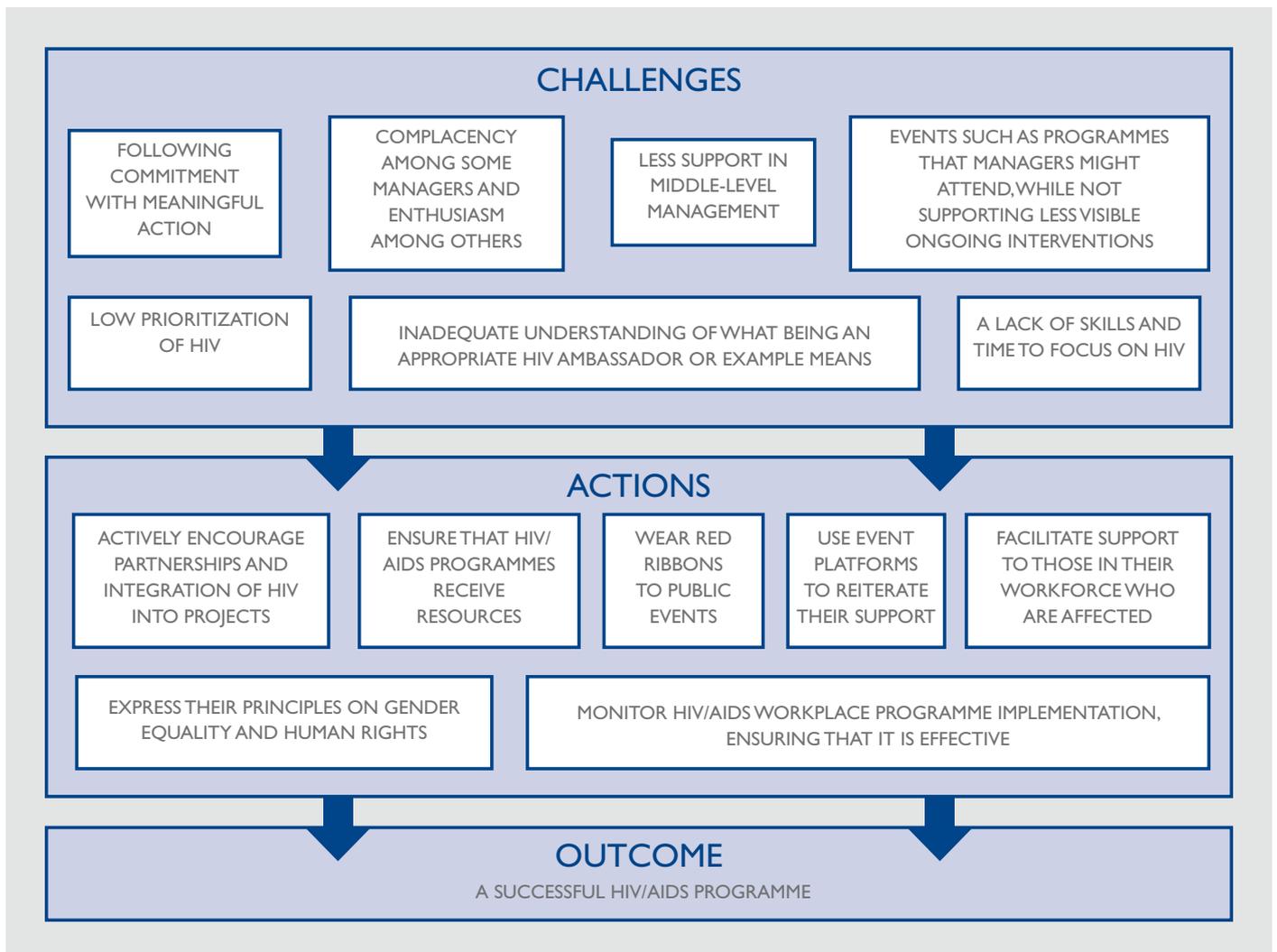
Designating a Co-ordinator and Committee to manage the HIV/AIDS programme does not absolve all other managers from responsibility. One of the key requirements for a successful programme is that those responsible for implementation have support, and the most substantial source of support is the leadership,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

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

Managers need to address challenges such as these:

- Following commitment with meaningful action;
- Complacency among some managers and enthusiasm among others;
- Less support in middle-level management;
- Events such as programmes that managers might attend, while not supporting 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.

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



PERSONAL EXERCISE:

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

3.2. STRATEGIC PLANNING

Unless implementation of your policy is integrated into Medium-Term Expenditure Frameworks (MTEF) and budgets, or strategic plans, building the programmes into short-term operational plans will be impossible.

In regularly reviewing and aligning your policy, you should have clear information on the needs that your HIV strategy should address, as well as its purpose and objectives. You also should be able to demonstrate how your HIV/AIDS policy and strategy align with HIV/AIDS priorities.

An estimate of resources also is critical for the MTEF budget, for submission at the end of June each year.

3.3. OPERATIONAL PLANNING

The operational plan translates the policy and the strategic plan into concrete, practical, and feasible programmes and projects, with clear processes for implementation. You will refer to the operational plan throughout implementation and review.

Even a simple project requires preparation, implementation, and closure. A complex project may require that you think through many details for each of these stages. An operational plan lays out the map of the journey between planning and achievement. It helps you to organise and structure the right activities in the right order. It also provides the basis for your budget and human resource plans.

3.3.1. REVIEW YOUR OBJECTIVES

What are the purpose and objectives of your policy? What changes to the current situation do you hope to achieve as a result of your work? Have your objectives in front of you as you begin to plan your intervention.

A workplace HIV/AIDS programme should have two core branches, as well as two other important supporting areas of focus:

- (1) *Programmes that aim to prevent and reduce new HIV infections.*
- (2) *Programmes that provide treatment, care and support to employees and their families who are infected or affected by HIV.*
- (3) *Capacity building on HIV/AIDS and workplace responses.*
- (4) *Communication strategies for HIV awareness and consultation on workplace responses.*

For details on the MTEF allocation and application process, see Page 63 of “Managing HIV/AIDS in the Workplace.”

For the most recent HIV and AIDS strategic plan look for the National Department of Health (2007) HIV and AIDS and STI Strategic Plan for South Africa 2007–2011 (Draft) March 2007. Available online at: <http://www.doh.gov.za/docs/hivaids-progressrep.html>.

3.3.2. THE PROGRAMME ELEMENTS FOR EACH OBJECTIVE

Managing HIV/AIDS in the Workplace presents, as a starting point, some advice on useful or recognized programme elements for each of these objectives.

1) Programmes that aim to prevent or reduce new HIV infections

What different project elements must be included to reach that objective?

Your aim is to change high-risk behaviour and raise awareness and responsibility, so as to encourage people to prevent new HIV infections.

A typical workplace prevention programme will encompass the following:

- Awareness
- Education and training
- Creating a nondiscriminatory environment
- STI prevention and treatment
- Infection control
- Voluntary counselling and testing
- Condom promotion and distribution

DISCUSSION:

Which of these programme elements are most relevant and effective in your department?

What other programmes might help to prevent new HIV infections?

2) Programmes that provide treatment, care, and support to employees and their families who are infected or affected by HIV.

What different project elements must be included to reach this objective?

Your aims are to reduce HIV mortality and morbidity; improve the quality of life of employees living with HIV/AIDS; and help employees to cope with the additional emotional and financial burden, and plan for their own and their dependents' futures.

A typical workplace treatment, care, and support programme will encompass the following:

- Wellness programmes (treatment and care)
- Social and psychological support
- Family support, including assistance in planning for the future
- Home-based care
- Condom promotion and distribution

DISCUSSION:

Which of these programme elements are most relevant and effective in your department?

What specific needs should they address?

3) Capacity building on HIV/AIDS and workplace responses.

What skills will your department need to implement its HIV/AIDS policy?

Your aims are to ensure that relevant employees and stakeholders have been trained on various aspects of HIV/AIDS; that staff of the Employee Assistance Programme (EAP) have the appropriate attitudes and skills to encourage, accept, and support staff who disclose their status; that the HR staff know and apply relevant HR policies; that relevant staff are trained in post-exposure prophylaxis; that trainers have the right level of knowledge, information, and skills; and that the HIV/AIDS Co-ordinator and Committee have the relevant skills to implement the programme.

DISCUSSION:

Which skills or capacities` do you see as necessary for your department to implement the HIV/AIDS workplace programme?

From "Managing HIV/AIDS in the Workplace," Page 95–99.

4) Communication strategies for HIV awareness and consultation on workplace responses.

How will you ensure that all members of the workforce are aware of the policy and programme focused on HIV/AIDS, and have had opportunities to provide input?

Your aims are to ensure that employees and employers are aware of the HIV/AIDS policy and programme, and understand what it can offer them; that they have had an opportunity to contribute to the development, maintenance, and review of the policy and programmes; and that they have access to media and other forms of communication which disseminate the key messages of the programme.

DISCUSSION:

To what extent does your current communication system meet these needs?

From "Managing HIV/AIDS in the Workplace," Page 101–102.

3.3.3. INFORMATION GATHERING

Information gathered around policy formulation and strategic planning continues to be applied and expanded as you focus on operational planning. It is important to be aware of other initiatives within the department, or in other departments, and to be aware of the successes and failures of these initiatives.

It is particularly important to review opportunities to share resources and provide synergy with other activities. If posters, pamphlets, events, training courses, or condoms are being provided by potential partners, it may be more efficient to work together for mutual benefit than to embark on a similar intervention alone.

3.3.4. CONSULTATION

The target group, those responsible and potential partners who are consulted, will all feel a sense of relevance and ownership, and will be more constructively engaged if they do. With the engagement of committed stakeholders, the objectives are more likely to be achieved than when interventions are not consultative.

3.3.5. USING THE TEMPLATES AND TABLES

A great many examples of possible programme elements are offered in the tables that follow. In considering your own programme, however, it is important to be focused, realistic, and very selective. To meet the specific needs of your department and situation, you might find that you need different policy elements from those given here.

The templates draw on “**Managing HIV/AIDS in the Workplace,**” and also include substantial input from “**Workplace HIV/AIDS Programmes: An Action Guide for Managers**” (Rau, 2002).

TABLE 5. Template for designing activities into possible programme elements:

1) Programmes that aim to prevent or reduce new HIV infections

Refer to Pages 79–86 of “*Managing HIV/AIDS in the Workplace*” for useful examples and details of prevention programmes

Programmes and Elements	Prioritise this element as: 1 - urgent and essential 2 - important 3 - desirable 4 - low priority 5 - not relevant	Progress to date, e.g. None Agreed and approved Written plan Budget approved In implementation Monitoring data available	Immediate next steps required
1. Provide ongoing Behaviour Change Communication (BCC) Provide correct information on HIV/AIDS			
1.1. Distribute pamphlets or other up-to-date written materials to all employees.			
1.2. Provide information specifically on acceptable sexual behaviour.			
1.3. Provide information specifically on risks related to drugs.			
1.4. Put up posters.			
1.5. Arrange lunch hour theatre.			
1.6. Organise presentations on policies and programmes.			
1.7. Provide information about, and encourage the use of, community HIV and AIDS services.			

Programmes and Elements	Prioritise this element as: 1 - urgent and essential 2 - important 3 - desirable 4 - low priority 5 - not relevant	Progress to date, e.g. None Agreed and approved Written plan Budget approved In implementation Monitoring data available	Immediate next steps required
HIV mindfulness			
I.10. Distribute AIDS ribbons.			
I.11. Hold a World AIDS Day event.			
I.12. Disseminate in lifts, payslips, email.			
2. Education and training			
2.1. Commission a KAP study ¹ .			
2.2. Engage and train peer educators.			
2.3. Engage and train safety representatives.			
2.4. Engage and train managers.			
2.5. Engage and train HIV and AIDS focal persons.			
2.6. Organise formal training sessions.			
3. Nondiscriminatory environment ²			
3.1. Provide support for confidentiality and nondiscrimination.			
3.2. Provide support and guidance on nonstigmatisation attitudes and behaviour towards PLHIV.			
3.3. Disciplinary / grievance procedures for stigma or discrimination.			
3.4. Publicise legal rights.			
3.5. Publicise and advocate correct attitudes and behaviour.			
4. STI, TB, and other infections prevented and treated			
4.1. Information on STI prevention.			
4.2. Information on TB and other infections.			
4.3. Information on various sources of support for management of STIs.			
4.4. Encourage use of Primary Health Care clinic for STIs.			
4.5. Provide resourced onsite clinic facilities and train clinic staff.			
4.6. Discuss STI issues in confidential counselling sessions.			
4.7. Form partnerships with user-friendly STI service providers.			
4.8. Promote condom use.			

1. KAP stands for Knowledge, Attitude, and Practices on HIV/AIDS. The survey employs a questionnaire to gather data on basic facts, testing and treatment, myths and misconceptions, attitudes to PLHWA, and sexual behaviour. In the process of gathering information, it also gives information and raises awareness. HSRC and MRC have resources for KAP studies.

2. 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 in learning their status, changing their behaviour, or engaging with HIV/AIDS issues as relevant in their lives.

Programmes and Elements	Prioritise this element as: 1 - urgent and essential 2 - important 3 - desirable 4 - low priority 5 - not relevant	Progress to date, e.g. None Agreed and approved Written plan Budget approved In implementation Monitoring data available	Immediate next steps required
5. Infection control (occupational exposure)			
5.1. Promote universal precautions to prevent occupational exposure and infection.			
5.2. Assume contact with HIV and always take precautions.			
5.3. Ensure that protective equipment is available (e.g. gloves).			
5.4. Standard first aid procedures for exposure trained and known.			
5.5. Regulations for safe disposal agreed upon, publicised, and training provided.			
5.6. Design and institutionalise systems for recording and reporting incidents.			
5.7. Provide information, advice, and access for PEP.			
6. VCT³			
6.1. Create a referral mechanism with VCT providers.			
6.2. Recruit and train peer counsellors and ensure confidentiality			
6.3. Train VCT staff on pre- and post-test counselling.			
6.4. Promote uptake of VCT.			
6.5. Provide onsite VCT, supported by consistent supplies of testing materials and information on test protocols.			
6.6. Provide space for workplace counselling and testing, and ensure that counselling is always provided.			
6.7. Ensure privacy and confidentiality.			
6.8. Encourage support for people living with or affected by HIV/AIDS.			
6.9. Make information on home-based care providers available to all staff.			
7. Condom promotion/distribution			
7.1. Ensure a regular supply of male condoms.			
7.2. Ensure a regular supply of female condoms.			
7.3. Provide known, diverse distribution points.			
7.4. Offer education on condom use and shared sexual decisionmaking.			
7.5. Promote male and female condoms.			
7.6. Monitor condom uptake.			

3. 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 lifestyle to manage the condition, counselling raises HIV awareness of positive and negative tests, disclosure is encouraged, and stigma and discrimination are reduced.

TABLE 6. Template for designing activities into programme elements:

Programmes that provide treatment, care and support to employees and their families who are infected or affected by HIV

Refer to Pages 87– 94 of “Managing HIV/AIDS in the Workplace” for useful examples and details of treatment, care, and support programmes.

Programmes and Elements	Prioritise this element as: 1 - urgent and essential 2 - important 3 - desirable 4 - low priority 5 - not relevant	Progress to date, e.g. None Agreed and approved Written plan Budget approved In implementation Monitoring data available	Immediate next steps required
1. Wellness programmes (treatment and care)⁴			
1.1. Medical management for infected employees onsite or referred			
1.2. Department provides employees with ART			
1.3. Department provides employees with access to treatment for opportunistic infections including TB.			
1.4. Access to ongoing counselling onsite or through referrals			
1.5. Support to develop positive living skills			
1.6. Health promotion and education, e.g. healthy eating habits			
1.7. Establishment of continuum of care, e.g. integration / coordination between providers of related services			
1.8. Family assistance programmes.			
2. Social and psychological support			
2.1. Psychosocial support to employees infected/affected by HIV and AIDS			
2.2. The department has a comprehensive EAP/EWP			
2.3. Support groups for infected employees			
2.4. Provision of, or access to, various forms of counselling ⁵			
2.5. Provision of, continued treatment and compliance support			
2.6. Family support programmes			
2.7. Information on, and partnerships with, community-based support and other outside sources of support			
2.8. Education and awareness on the value of accessing support			
2.9. Supervisors trained in appropriate management for HIV+ employees			
3. Family support, including assistance in planning for the future⁶			
3.1. Access to legal, financial, and psychological support in planning for possible illness, disability, or death.			
4. Home-based care STI prevention and treatment			
4.1. Formation of partnerships and referral and follow-up systems with professional and trusted home-based care providers.			

4. A comprehensive wellness programme 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, and PMTCT. (From SANAC draft guidelines 2001, outlined in greater detail on Page 89 of “Managing HIV/AIDS in the Workplace.”)

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

6. “Managing HIV/AIDS in the Workplace” contains useful resources on this theme. Refer to Page 92 and Appendix One.

TABLE 7. Template for designing programme elements:

3) Capacity Building and 4) Communication

Refer to Pages 95–99 of “Managing HIV/AIDS in the Workplace” for challenges and issues regarding capacity, and to Pages 101–103 for challenges and ideas around communication strategies

Programmes and Elements	Prioritise this element as: 1 - urgent and essential 2 - important 3 - desirable 4 - low priority 5 - not relevant	Progress to date, e.g. None Agreed and approved Written plan Budget approved In implementation Monitoring data available	Immediate next steps required
1. Capacity Building Programme			
I.1. Peer educators trained on HIV/AIDS			
I.2. HIV/AIDS Counsellors trained			
I.3. SMS capacitated around managing the impact of HIV/AIDS and integration of HIV/AIDS into departmental planning			
I.4. EAP personnel trained on HIV/AIDS treatment, care, and support.			
I.5. HR personnel trained on HIV/AIDS policies and procedures			
I.6. Union officials trained on legal and human rights aspects of HIV/AIDS			
I.7. SMS trained on monitoring and evaluation of HIV/AIDS workplace policies and programmes.			
2. Communication strategy			
2.1. Know your audience: literacy levels, languages, preferred media			
2.2. Use several media, e.g. pamphlets, posters, memoranda, payslips			
2.3. Broadcast messages must apply to both men and women			
2.4. Strategy designed: what information; how; consultation processes			

TABLE 8. Template for designing the additional programme elements:

Policy Design and Development			
Programmes and Elements	Prioritise this element as: 1 - urgent and essential 2 - important 3 - desirable 4 - low priority 5 - not relevant	Progress to date, e.g. None Agreed and approved Written plan Budget approved In implementation Monitoring data available	Immediate next steps required
I. Draft Policy and Policy Document			
I.1. Draft policy as developed by a committee.			
I.2. All sections and functions represented in the consultation			
I.3. Appropriate unions involved in the development of the policy. How many?			
I.4. Participants from the departments.			
I.5. Participants from other partners and unions			
I.6. Senior managers involved in development of the policy			
I.7. Recognized methods used in development of the policy			

ACTIVITIES

Now that you have used the objectives of your implementation process project to create clear programme areas and specific programme elements, you are ready to plan your activities in detail.

An activity comprises **Who**, **What**, and **When**:

Who? Which staff, groups, organizations, and individuals will be actively involved, and what are their roles?

What? Who will do what? It is a useful brainstorming exercise to list all the possible activities that might be needed for your project to be implemented. We often neglect the detail. Activities might include agreeing, collecting, confirming, counting, discussing, mailing, meeting, motivating, negotiating, ordering, organising, paying, phoning, photocopying, posting, preparing, printing, purchasing, recording, recruiting, requesting, supervising, training, writing.

When? Once you have a list of activities, grouped according to programme elements, and in approximately the right order within each element, you can prepare the timeframe for your project plan

How long will each of these activities take? Complete a table like Table 8.

In completing the timeframe, think about which activities depend on another activity before they can begin, and ensure that the timeframe flows accordingly. Ask yourself for each activity, "What would need to happen before this would be possible?" The preparation phase often is neglected in project plans, with many planners writing 'distribute condoms' as their first activity. However, before you actually distribute, you may need to procure, negotiate partnerships, consult on vending points, design a recording and stock control system, buy containers, or engage a handyman in order to install a single vending unit up.

Complete your programme plan

Now go to each programme element and write down all of the activities that will need to take place for the output to be achieved. Your attention to detail at this stage is important.

Unless you know exactly what will need to be done, it is difficult to realistically estimate either your timeframes or your costs.

Using the templates

In the templates on the following pages, delete the elements that do not apply to your situation, and include any additional elements that you will need. Just as with any of the other templates, this planning framework should be adapted to include any other information that supports the planning processes used in your department.

TABLE 9. Template for designing activities into programme elements, allocating a responsible person and a planned timeframe for the activity:**1) Programs that aim to prevent and reduce new HIV infections.**

Refer to Pages 95-99 of 'Managing HIV/AIDS in the Workplace' for challenges and issues are capacity
And to Page 101-103 for challenges and ideas around communication strategies

Programmes and Elements	Person responsible	MONTH or WEEK (depending on your project duration)											
		1	2	3	4	5	6	7	8	9	10	11	12
1. Provide ongoing Behaviour Change Communication (BCC)													
Provide correct information on HIV/AIDS													
I.1. Distribute pamphlets or other up-to-date written materials to all employees.													
I.2. Provide information specifically on acceptable sexual behaviour.													
I.3. Provide information specifically on risks related to drugs.													
I.4. Put up posters.													
I.5. Arrange lunch hour theatre.													
I.6. Organise presentations on policies and programmes.													
I.7. Provide information about, and encourage the use of, community HIV and AIDS services.													
HIV mindfulness													
I.12. Distribute AIDS ribbons.													
I.13. Hold a World AIDS Day event.													
I.14. Disseminate in lifts, payslips, and email.													
2. Education and training													
2.1. Commission a KAP study ⁷ .													
2.2. Engage and train peer educators.													
2.3. Engage and train safety representatives.													
2.4. Engage and train managers.													
2.5. Engage and train HIV and AIDS focal persons.													
2.6. Organise formal training sessions.													
3. Nondiscriminatory environment⁸													
3.1. Provide support for confidentiality and nondiscrimination.													
3.2. Provide support and guidance on nonstigmatisation attitudes and behaviour towards PLHIV.													
3.3. Disciplinary / grievance procedures for stigma or discrimination.													
3.4. Publicise legal rights.													
3.5. Publicise and advocate correct attitudes and behaviour.													

7. KAP stands for Knowledge, Attitudes, and Practices on HIV/AIDS. The survey employs a questionnaire to gather data on basic facts, testing and treatment, myths and misconceptions, attitudes to PLHWA, and sexual behaviour. In the process of gathering information, it also gives information and raises awareness. HSRC and MRC have resources for KAP studies.

8. 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 in 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
4. STI, TB, and other infections prevented and treated													
4.1. Information on STI prevention.													
4.2. Information on TB and other infections.													
4.3. Information on various sources of support for management of STIs.													
4.4. Encourage use of Primary Health Care clinic for STIs.													
4.5. Provide resourced onsite clinic facilities and train clinic staff.													
4.6. Discuss STI issues in confidential counselling sessions.													
4.7. Form partnerships with user-friendly STI service providers.													
4.8. Promote condom use.													
5. Infection control (occupational exposure)													
5.1. Promote universal precautions to prevent occupational exposure and infection.													
5.2. Assume contact with HIV and always take precautions.													
5.3. Ensure that protective equipment is available (e.g. gloves).													
5.4. Standard first aid procedures for exposure and training provided.													
5.5. Regulations for safe disposal agreed upon, publicised, and training provided.													
5.6. Design and institutionalise systems for recording and reporting incidents.													
5.7. Provide information, advice and access for PEP.													
6. VCT⁹													
6.1. Create a referral mechanism with VCT providers.													
6.2. Recruit and train peer counsellors and ensure confidentiality.													
6.3. Train VCT staff on pre- and post-test counselling.													
6.4. Promote uptake of VCT.													
6.5. Provide onsite VCT, supported by consistent supplies of testing materials and information on test protocols.													
6.6. Provide space for workplace counselling and testing, and ensure that counselling is always provided.													
6.7. Assure privacy and confidentiality.													
6.8. Department encourages support for people living with or affected by HIV and AIDS.													
6.9. Make information on home-based care providers available to all staff.													

9. 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.

Programmes and Elements	Person responsible	MONTH or WEEK (depending on your project duration)											
		1	2	3	4	5	6	7	8	9	10	11	12
7. Condom promotion/distribution													
7.1. Ensure that employees have ready access to a regular supply of male condoms.	<i>e.g. Provincial HIV and AIDS Coordinator Plus all District Coordinators</i>												
7.2. Ensure that employees have ready access to a regular supply of female condoms													
7.3. Provide known, diverse distribution points.													
7.4. Offer education on condom use and shared sexual decisionmaking.													
7.5. Promote male and female condoms.													
7.6. Monitor condom uptake.													

TABLE 10. Template for designing activities into programme elements: allocating a responsible person and a planned timeframe:

2) Programmes that provide treatment, care and support to employees and their families who are infected or affected by HIV

Refer to Pages 87–94 of “Managing HIV/AIDS in the Workplace” for useful examples and details of treatment, care, and support programmes

Programmes and Elements	Person responsible	MONTH or WEEK (depending on your project duration)											
		1	2	3	4	5	6	7	8	9	10	11	12
1. Wellness programmes (treatment and care)¹⁰													
1.1. Medical management for infected employees onsite or referred.													
1.2. Department provides employees with ART.													
1.3. Department provides employees with access to treatment for opportunistic infections including TB.													
1.4. Access to ongoing counselling onsite or through referrals.													
1.5. Support to develop positive living skills.													
1.6. Health promotion and education, e.g. healthy eating habits.													
1.7. Establishment of continuum of care, e.g., integration / co-ordination between providers of related services.													
1.8. Family assistance programmes.													
2. Social and psychological support													
2.1. Provision of psychosocial support to employees infected/affected by HIV and AIDS.													
2.2. The department has a comprehensive EAP/EWP.													
2.3. Support groups for infected employees.													
2.4. Provision of, or access to, various forms of counselling.													
2.5. Provision of, continued treatment and compliance support.													
2.6. Family support programmes.													
2.7. Information on and partnerships with community-based support and other outside sources of support													
2.8. Education and awareness on the value of accessing support													
2.9. Supervisors trained to handle on-the-job situations of HIV infected employees													
3. Family support, including assistance in planning for the future¹²													
3.1. Access to legal, financial, and psychological support in planning for possible illness, disability, or death.													
4. Home-based care STI prevention and treatment													
4.1. Formation of partnerships and referral and follow-up systems with professional and trusted home-based care providers.													

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

10. A comprehensive wellness programme 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, and PMTCT. (From SANAC draft guidelines 2001, outlined in greater detail on Page 89 of “Managing HIV/AIDS in the Workplace.”)

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

12. “Managing HIV/AIDS in the Workplace” contains useful resources on this theme. Refer to Page 92 and Appendix One.

TABLE 11. Template for designing programme elements, allocating a responsible person and a planned timeframe:

3) Capacity Building and 4) Communication

Refer to Pages 95-99 of 'Managing HIV/AIDS in the Workplace' for challenges and issues are capacity
And to Page 101-103 for challenges and ideas around communication strategies

Programmes and Elements	Person responsible	MONTH or WEEK (depending on your project duration)											
		1	2	3	4	5	6	7	8	9	10	11	12
Capacity Building Programme													
I.1. Peer educators trained on HIV/AIDS													
I.2. HIV/AIDS Counsellors trained.													
I.3. SMS capacitated around managing the impact of HIV/AIDS and integration of HIV/AIDS into departmental planning.													
I.4. EAP personnel trained on HIV/AIDS on treatment, care and support.													
I.5. HR personnel trained on HIV/AIDS policies and procedures.													
I.6. Union officials trained on legal and human rights aspects of HIV/AIDS.													
I.7. HIV and AIDS policies developed and regularly reviewed.													
I.8. SMS trained on monitoring and evaluation of HIV/AIDS workplace policies and programmes.													
Communication strategy													
I.11. Know your audience: literacy levels, languages, preferred media.													
I.12. Use several media, e.g. pamphlets, posters, memoranda, payslips.													
I.13. Broadcast messages must apply to both men and women.													
I.14. Strategy designed: what information; how; consultation processes.													

3.3.6. BUDGETING

A detailed workplan gives you much of the information you need to write the project budget.

The budget is an estimate of project costs falling under certain line items (e.g., communication, travel, consumables, printing, salaries, consultant fees, and training costs).

Budgeting is a useful part of the project planning process in several respects:

- It helps you to manage your finances.
- It also gives you and your stakeholders the best reflection of the scale of the project.
- It takes you to a deeper level of operational detail in your planning, forcing you to think about activities, costs and inputs.

A carefully thought-out budget, together with your workplans and timeframes, are the two components of your operational plan that prepare you for implementation. A poorly thought-out budget, in which costs are forgotten or underestimated, can be the downfall of your project.

Pages 64–69 of
“Managing HIV/AIDS”
in the Workplace offer
information, challenges,
examples, and
guidelines on budgeting.

3.3.7. THE COMPONENTS OF A BUDGET

These annotations explain each of the elements of a budget.

Use the same currency throughout and remember to say what the currency is.

		UNIT	NO. UNITS	UNIT COST (RANDS)	TOTAL
	Salaries and stipends, accommodation, travel, running costs, data processing, office overheads at a %, contingency at a %.	R, km, flights, nights, flat fee, monthly fee.	How many of those units in this budget-monthly fee X how many months	Number of Rands per unit.	Number of Units X Unit cost
LINE ITEM 1					
Description	Explain exactly what each item is and how you have arrived at your estimate.		How many nights, months, or flights? Enter the number only as a numeric.	How much does each night, km, man-day or per diem cost? Enter as a numeric.	
SUBTOTAL 1					
LINE ITEM 2					
Description	You will be entering the number of items into the next column as a number without text. This is where you say what that number is. Is it the number of kilometres, flights, man-days, months, or nights?			Here you multiply the number of units by the unit costs. Always calculate. Never type it in.	
SUBTOTAL 2					
LINE ITEM 3					
Description				Each line item is added up as a subtotal.	
SUBTOTAL 3					
TOTAL					
	Some of your line items, such as contingency or admin fees, may be a percentage of your total costs. Using the first total, calculate the percentage you will apply.				
LINE ITEM 5 (PERCENTAGES OF TOTAL)					
Description					
GRAND TOTAL					

TABLE 12. Sample budget, giving some examples of line items, descriptions, units, unit costs, and calculated totals

Some examples		Unit	No. Units	Annual Unit Cost (SA Rand)	Total
TIME PERIOD: MM/200Y – MM/200Y					
Program:					
Activity:					
LINE ITEM 1	Salaries and fees				
Description	Medical officer: 3 full-time staff at X location, with Y responsibilities, on R250,000/year, including benefits	Full-time staff	3	250,000	750,000
	Pharmacist: 1 full-time, at X location, salary shared with Y department ... etc.	Shared, full-time staff	0.5	200,000	100,000
	Nurses: 4 full-time staff at onsite and clinic VCT sites, responsible for co-ordinating psychosocial support. Salary of R70,000, all-inclusive.	Full-time staff	4	80,000	320,000
SUBTOTAL 1					1,170,000
LINE ITEM 2	Equipment (once-off costs this year)				
Description	Computer: Desktop x specifications...	item	1	10,000	10,000
	Data projector: one for each EAP team	item	2	3,000	6,000
	Flipchart stands: one for each support group venue	item	4	250	1,000
SUBTOTAL 2					17,000
LINE ITEM 3	Rental and infrastructure costs				
Description	20% contribution to counselling centre building	Part cost	0.2	200,000	40,000
	Utilities	Full cost	1	24,000	24,000
SUBTOTAL 3					64,000
TOTAL					1,251,000
LINE ITEM 5 (PERCENTAGES OF TOTAL)					
Description	Contingency of 5%				62,550
GRAND TOTAL					1,313,550

Please note that this is purely a worked example and is not intended to reflect either a real budget or realistic unit cost estimates. All costs should be approximations.

3.3.8. LINE ITEMS

Begin by brainstorming all of the costs you might possibly incur as a result of HIV/AIDS, within the sphere of responsibility of your role. Divide these costs into appropriate major categories to develop a budget framework.

The following should be considered within a department's HIV/AIDS budget, and the appropriate sources of funding, support, resources or partnerships incorporated into the planning cycle:

Coordination costs

- An HIV/AIDS coordinator, possibly in a dedicated position.
- Administrative support to an HIV/AIDS coordinator.
- HIV/AIDS Committee costs such as venues, travel, meeting time.

Policy and programme implementation costs

- HIV/AIDS education and awareness activities.
- Condom procurement and promotion costs.
- Wellness programme personnel and costs.
- Training of peer-educators, counsellors, SMS and HR staff.
- Every element of active prevention, treatment, care, and support programmes will carry specific costs.

Loss of Productivity Costs

- Increased recruitment costs, such as advertising, time for screening, induction and training costs.
- Costs of more employees taking early ill-health retirement.
- Costs of temporary or relief staff when employees are absent.
- Overtime costs when existing staff cover for absent staff.
- Costs of adapting job requirements for disabled staff.

From Pages 67–68 of “Managing HIV/AIDS in the Workplace.”

Commonly used line items:

Salaries or personnel costs: Calculated on the proportion of their time allocated (e.g., administrator 30%) and their support costs (the overhead costs that enable them to do their work). For full-time, long-term staff, remember to include leave and retrenchment allowances, as well as such costs as medical insurance and provident fund, along with taxes and net pay.

Capital once-off or establishment costs or assets: Equipment such as computers, printers, fax machines, vehicles, and medical equipment.

Activities, operational, or project costs: Training, workshops, research, cost assessments, impact assessments, KAP surveys, education, or communication as activities. Research may include the associated costs, such as questionnaire printing, meetings or focus groups, and report production and dissemination. Training may include travel, venue, accommodation, per diem, refreshments, printing of training materials, and facilitators' fees. Communication may include graphic design, printing, and distribution.

Administrative costs or office overheads: Office space, email, computer support, cleaning, electricity, accounting services.

Contingency: If permitted, include a small percentage in the budget to cover unforeseen expenses. (We usually imagine that a project will go far more smoothly than it actually does.)

3.3.9. CALCULATE YOUR REQUIREMENTS

Include as much detail as you can. How many pamphlets? How many days? How many participants? How many ink cartridges? How many venues? Beware of the tendency to underestimate the time your tasks will take.

During the preparation of your budget, you will be thinking about your programme in the greatest detail to date. You might even change the way you conceive the project. Revising the workplan while you are preparing the budget is both likely and acceptable.

Use the workplan as the starting point:

Go through each output and activity and think about:

- i) What will be needed
- ii) How many of them
- iii) Capital equipment – now that you know the number of people to be recruited, what equipment will they need?
- iv) Operating costs – e.g., project co-ordination, will apply to all activities.

3.3.10. RESEARCH, QUOTES, AND COST ESTIMATES

The less guessing you do, the fewer errors there will be in your final estimate. Conduct impact assessments, review available data, ask questions of other departments with equivalent programmes, phone for quotes, and use recent budget reports from similar projects. Discuss fees and salaries with your HR department so as to use the best information possible to calculate your costs.

This is the information that supports your Unit Costs.

3.3.11. BUDGET NARRATIVE

You need to justify your budget. The budget spreadsheet is followed by a budget narrative. Why are the larger items cost-effective? Point out cost-saving strategies you have used. Justify any apparent extravagance. Explain more complex calculations.

Consider cost-effectiveness. Will the final results be worth the expense?

Pre-empt the questions that are likely to come up during the approval process, making sure that the budget is clear and easy to understand. If a strong budget justification has been prepared, it is less likely that essential items will be cut during the proposal review.

3.3.12. TRIMMING THE BUDGET

How can the budget be reduced?

Consider your nonfinancial resources. Everything you have is a resource. Do not waste or undervalue anything. You may have access to volunteers or interns, office space, free advertising, steering committee time, or a discussion forum. It is unlikely that any department will finance an HIV/AIDS programme in its entirety. Partner organizations, such as other departments, NGOs, and funding agencies, often appreciate the opportunity to enter into partnerships with departments.

Value any resources offered as if you were paying for them yourself, include them in your project plan, and use them optimally through your project. This will leverage your application for additional funds through the department's budget, or from other sources.

If consultants are needed at the beginning, they should train local personnel to take over their work as soon as possible.

3.3.13. PRESENTING AND NEGOTIATING THE BUDGET

Before your budget can be considered complete, it must be checked and approved. The following steps normally will be required in preparing a budget.

STEP ONE: Arrange to brief the management team, well in advance of the department's annual planning cycle, on the costs relating to implementing the HIV/AIDS programme.

STEP TWO: Departmental budgeting will require detailed information on direct and indirect costs, as well as the costs of impact on productivity. The HR department, for example, might be asked to analyse sick leave patterns.

STEP THREE: Justify each item in the budget, providing objective information on the risks and benefits of funding or not funding certain activities.

STEP FOUR: Develop proposals on how each type of cost will be met; e.g., shared with other departments, recouped, absorbed, or through fundraising.

STEP FIVE: Review this expenditure against the set indicators in Treasury's guidelines.

Page 67 of "Managing HIV/AIDS in the Workplace" offers strategic ideas on how to optimize financial support for HIV/AIDS

From Pages 66–67 of "Managing HIV/AIDS in the Workplace."

4

MONITORING AND EVALUATING HIV/AIDS POLICY IMPLEMENTATION AND PROGRAMMES

How will you know if you are achieving your objective? How will you demonstrate your effectiveness and learning processes, and be held accountable? A monitoring and evaluation (M&E) plan is absolutely critical.

At project milestones, when you formally evaluate and realign your policy and programmes on the basis of experience, you will review and adapt your workplan to make sure that you are still on the best route possible towards achieving your objective. M&E should not be seen as a separate and inconvenient necessity. It is actually the life force of relevance and planning, building policies and programmes on the basis of experience and reality.

4.1. THE COMPONENTS OF AN M&E PLAN

4.1.1. WHAT IS EVALUATION?

Evaluation is the periodic assessment of the relevance, performance, efficiency, and impact (both rationalized and unexpected) of your objectives. It tells you the extent to which project implementation on the ground has moved towards achieving the goals and objectives of the project. It also identifies and analyses the factors that have contributed to the project's successes and shortcomings, providing feedback for project redesign.

4.1.2. WHAT IS MONITORING?

Monitoring is the continuous collection of activity data, tracking the project's implementation against agreed schedules, targets, and budgets.

4.2. PERFORMANCE CRITERIA

What makes a programme first-rate or poor? What are the criteria of success? In a broad project overview, it is useful to rate it according to its efficiency, effectiveness, relevance, impact, and potential sustainability.

i) Efficiency (Project implementation)

Will the project meet its objectives within the agreed time and cost? If so, why? If not, why not?

ii) Relevance and Quality of Design

The programme and policy were designed to meet a need. Does that need still exist? Is the project still relevant? How could the design be improved?

iii) Effectiveness to date

How likely are you to achieve your objectives and the purpose of your policy? Are the planned beneficiaries really receiving the benefits of the project?

iv) Impact

To assess impact, it is important to have collected a broad range of baseline data at the outset. Baseline data describe the situation before the project so as to assess how the situation has changed with your intervention.

Some changes will be clearly associated with your work, but sometimes it is difficult to attribute credit or blame to a programme as opposed to other coincidental factors. You may ask yourself whether your work has probably contributed to a given outcome, and why you feel justified in having made this contribution.

Although impact on your predefined purpose might take time to demonstrate and may never be demonstrated clearly (e.g., new HIV infections prevented), there are impacts that will emerge from every intervention that should be captured. Families that benefit from future planning, people's lives saved by ARTs, or managers who become HIV champions, all could be impacts of your work. Unless you are communicating, evaluating, and remaining sensitive to how your intervention affects the situation, you might not detect positive or negative impacts, and so be in a position to guide the programme accordingly.

v) Potential Sustainability

How likely is it that the policy will be implemented as part of the normal institutional behaviour of the department, that regular cost research will result in approved budgets for HIV costs and losses, and that HIV/AIDS programmes will become integrated across normal departmental functions?

4.3. INDICATORS

Indicators are used to determine whether predefined targets have been met, and whether the rationale that you used to design the programme is in fact valid; e.g., if you determined that posters would reduce stigma and discrimination, how will you know whether this is in fact the case?

Indicators also are often used to determine the volume of activity justified by a budget. For example, we would expect budget expenditures to result in training a certain number of people, distributing a number of condoms, printing and disseminating a number of pamphlets, and having a number of policies approved. Activity indicators and targets are very important to budget reporting, and must be supported by monitoring data, with the information on volume of work diligently collected.

It is generally more difficult to predict what the outcomes or wider results of this volume of activity will be. As a result, finding reliable and responsive indicators for the knock-on effects of a programme is challenging; e.g., will training change behaviour; will condoms be used; will pamphlets be read; and will policies achieve their purposes? It is therefore important to ensure that M&E is sensitive to changes and information not necessarily captured by predefined indicators, so that the genuine outcomes of programmes are understood.

4.4. TARGETS

Where an indicator is chosen as a measure of project progress, such as the number of activities completed or volumes of consumables used, it should be accompanied by a target if it is to have any meaning in project monitoring. It is absolutely critical that this target is reflected in the budget. There is no point in establishing a target to distribute a million condoms, and only budgeting for 100,000.

A target generally is presented in terms of Quantity, Quality, and Time for each indicator: How much of the activity do you reasonably expect to be necessary and sufficient to meet your objective: necessary meaning "not too much," and sufficient meaning "not too little." The research that underpins your planning will help you in deciding on realistic targets.

4.5. BASELINE

The baseline is the data that we collect before the project starts to describe levels of a problem or characteristic before the project intervention. Without this starting point, changes are difficult to measure. A KAP survey frequently is used in M&E for both baseline and outcome monitoring. We might commission a survey during planning to ascertain areas of Knowledge, Attitudes, and Practices on which our intervention should focus. These data would guide our planning processes. They also would provide the baseline for our intervention.

Sometime later, after the programme has been implemented, another identical KAP survey could be used to measure

whether Knowledge, Attitudes, and Practices have changed. We can then consider the results, support them with a more direct evaluation study, make certain assumptions about external factors, such as national media, local trends, or changing demographics that might have changed the KAP results, and offer a documented outcome of our intervention.

Most important, we can adjust our policy, programme, and activities to reflect the learning achieved through the M&E process.

4.6. CAUTIONARY NOTE ON OBJECTIVITY

Performance management is often biased by a wish to convey our success stories and to be seen as achievers. Ideally, we should be operating in an institutional environment in which there is no such thing as failure, only useful lessons for the future.

Monitoring should embrace learning and should allow you to share frustrations and take risks. Innovation seldom is achieved without a little trial and error. Unless error is viewed positively, innovation is unlikely.

4.7. DESIGNING YOUR MONITORING PROCESSES

TABLE 13. Template for designing activities into programme elements:

1) Programs that aim to prevent and reduce new HIV infections					
Programmes and Elements	Indicator	Target	Data Source	Risks/ Assumptions	Person Responsible
1. Provide ongoing Behaviour Change Communication (BCC) Provide correct information on HIV/AIDS					
1.1. Distribute pamphlets or other up-to-date written materials to all employees.					
1.2. Provide information specifically on acceptable sexual behaviour.					
1.3. Provide information specifically on risks related to drugs.					
1.4. Put up posters.					
1.5. Arrange lunch hour theatre.					
1.6. Organise presentations on policies and programmes.					
1.7. Provide information about, and encourage the use of, community HIV and AIDS services.					
HIV mindfulness					
1.1. Distribute AIDS ribbons.					
1.2. Hold a World AIDS Day event.					
1.3. Disseminate in lifts, payslips, and email.					
2. Education and Training					
2.1. Commission a KAP study ¹³ .					
2.2. Engage and train peer educators.					
2.3. Engage and train safety representatives.					
2.4. Engage and train managers.					
2.5. Engage and train HIV and AIDS focal persons.					
2.6. Organise formal training sessions.					
3. Nondiscriminatory environment¹⁴					
3.1. Provide support for confidentiality and nondiscrimination.					
3.2. Provide support and guidance on nonstigmatisation attitudes and behaviour towards PLHIV.					
3.3. Disciplinary / grievance procedures for stigma or discrimination.					
3.4. Publicise legal rights.					
3.5. Publicise and advocate correct attitudes and behaviour.					
4. STI, TB, and other infections prevented and treated					
4.1. Information on STI prevention.					
4.2. Information on TB and other infections.					
4.3. Information on various sources of support for management of STIs.					
4.4. Encourage use of Primary Health Care clinic for STIs.					
4.5. Provide resourced onsite clinic facilities and train clinic staff.					

13. KAP stands for Knowledge, Attitudes, and Practices on HIV/AIDS. The survey employs a questionnaire to gather data on basic facts, testing, and treatment, myths and misconceptions, attitudes to PLHWA, and sexual behaviour. In the process of gathering information, it also gives information and raises awareness. HSRC and MRC have resources for KAP studies.

14. 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 learn their status, changing their behaviour, or engaging with HIV/AIDS issues as relevant in their lives.

Programmes and Elements	Indicator	Target	Data Source	Risks/ Assumptions	Person Responsible
4.5. Discuss STI issues in confidential counselling sessions.					
4.7. Form partnerships with user-friendly STI service providers.					
4.8. Promote condom use.					
5. Infection control (occupational exposure)					
5.1. Promote universal precautions to prevent occupational exposure and infection.					
5.2. Assume contact with HIV and always take precautions.					
5.3. Ensure that protective equipment is available (e.g. gloves).					
5.4. Standard first aid procedures for exposure and training provided.					
5.5. Regulations for safe disposal agreed upon, publicised, and training provided.					
5.6. Design and institutionalise systems for recording and reporting incidents.					
5.7. Provide information, advice, and access for PEP.					
6. VCT ¹⁵					
6.1. Create a referral mechanism with VCT providers.					
6.2. Recruit and train peer counsellors and ensure confidentiality.					
6.3. Train VCT staff on pre- and post-test counselling.					
6.4. Promote uptake of VCT.					
6.5. Provide onsite VCT, supported by consistent supplies of testing materials and information on test protocols					
6.6. Provide space for workplace counselling and testing, and ensure that counselling is always provided.					
6.7. Ensure privacy and confidentiality.					
6.8. Department encourages support for people living with or affected by HIV and AIDS.					
6.9. Make information on home-based care providers available to all staff.					
7. Condom promotion/distribution					
1.1. Ensure that employees have ready access to a regular supply of male condoms.					
1.2. Ensure that employees have ready access to a regular supply of female condoms					
1.3. Provide known, diverse distribution points.					
1.4. Offer education on condom use and shared sexual decisionmaking.					
1.5. Promote male and female condoms.					
1.6. Monitor condom uptake.					

15. 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 lifestyle to manage the condition, counselling raises HIV awareness for positive and negative tests, disclosure is encouraged, and stigma and discrimination are reduced.

TABLE 14. Template for designing activities into programme elements:

2) Programmes that provide treatment, care and support to employees and their families who are infected or affected by HIV

Refer to Pages 87–94 of “Managing HIV/AIDS in the Workplace” for useful examples and details of treatment, care, and support programmes.

Programmes and Elements	Indicator	Target	Data Source	Risks/ Assumptions
1. Wellness programmes (treatment and care)¹⁶				
1.1. Medical management for infected employees onsite or referred.				
1.2. Department provides employees with ART.				
1.3. Department provides employees with access to treatment for opportunistic infections including TB.				
1.4. Access to ongoing counselling onsite or through referrals.				
1.5. Support to develop positive living skills.				
1.6. Health promotion and education, e.g. healthy eating habits.				
1.7. Establishment of continuum of care, e.g. integration / coordination between providers of related services.				
1.8. Family assistance programmes.				
2. Social and psychological support				
2.1. Provision of psychosocial support to employees infected/affected by HIV and AIDS.				
2.2. The department has a comprehensive EAP/EWP.				
2.3. Support groups for infected employees.				
2.4. Provision of, or access to, various forms of counselling. ¹⁷				
2.5. Provision of, continued treatment and compliance support				
2.6. Family support programmes.				
2.7. Information on and partnerships with community-based support and other outside sources of support.				
2.8. Education and awareness on the value of accessing support.				
2.9. Supervisors trained to handle on-the-job situations of HIV infected employees.				
3. Family support, including assistance in planning for the future¹⁸				
3.1. Access to legal, financial, and psychological support in planning for possible illness, disability or death.				
4. Home-based care STI prevention and treatment				
4.1. Formation of partnerships and referral and follow-up systems with professional and trusted home-based care providers.				

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

16 A comprehensive wellness programme 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, and PMTCT. (From SANAC draft guidelines 2001, outlined in greater detail on Page 89 of “Managing HIV/AIDS in the Workplace.”)

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

18 “Managing HIV/AIDS in the Workplace” contains useful resources on this theme. Refer to Page 92 and Appendix One.

TABLE 15. Template for designing programme elements:**3) Capacity Building and 4) Communication**

Refer to Pages 95–99 of “Managing HIV/AIDS in the Workplace” for challenges and issues regarding capacity, and to Pages 101–103 for challenges and ideas regarding communication strategies.

Programmes and Elements	Indicator	Target	Data Source	Risks/ Assumptions
1. Capacity Building Programme				
I.1. Peer educators trained on HIV/AIDS				
I.2. HIV/AIDS Counsellors trained.				
I.3. SMS capacitated around managing the impact of HIV/AIDS and integration of HIV/AIDS into departmental planning				
I.4. EAP personnel trained on HIV/AIDS treatment, care, and support.				
I.5. HR personnel trained on HIV/AIDS policies and procedures				
I.6. Union officials trained on legal and human rights aspects of HIV/AIDS				
I.7. SMS trained on monitoring and evaluation of HIV/AIDS workplace policies and programmes.				
2. Communication strategy				
2.1. Know your audience: literacy levels, languages, preferred media				
2.2. Use several media, e.g. pamphlets, posters, memoranda, pay slips				
2.3. Broadcast messages must apply to both men and women				
2.4. Strategy designed: what information; how; consultation processes				

TABLE 16. Template for designing the additional programme element of policy design and development

Programmes element and criteria for consultative policy development	Indicator	Annual Target	Data Source	Risks/ Assumptions
1. Draft Policy and Policy Document				
I.1. Draft policy developed by a committee				
I.2. All sections and functions represented in the consultation				
I.3. Appropriate unions involved in the development of the policy. How many?				
I.4. Participants from the departments.				
I.5. Participants from other partner groups and unions.				
I.6. Senior managers involved in development of the policy				
I.7. Recognized methods used in development of the policy				

TABLE 17. Indicators and targets: Examples

Programmes, Elements and activities <i>Some examples to illustrate the use of the M&E template above)</i>				
Wellness programmes (treatment and care)	Indicator	Annual Target (e.g.)	Data Sources (frequency)	Risks/ Assumptions
Medical management for infected employees onsite or referred	Number of infected employees supported	20	EAP monitoring records (monthly)	Assumption that infected employees prefer onsite medical management
Access to ongoing counselling onsite 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 organised	3	Intervention reports (annually)	Risk: That high-risk lifestyle people will not attend interventions
Health promotion and education, e.g. healthy eating habits	Number of pamphlets distributed	5 designs of 1000 printed each	Printers' invoices and distribution monitoring records (quarterly)	Assumption that pamphlets are read
Establishment of continuum of care, e.g. integration / coordination between providers of related services	Number of referrals 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)	Assumption that families reside locally
Policy development / Review	Draft policy Policy		Attendance register of participants (as scheduled)	
Condom distribution		500,000 male condoms and 150,000 female condoms	Clinics, hospitals and office condom distribution register (monthly)	
Capacity building for employees	# Of training sessions # TA Assistance activities # of employees reached		Attendance register of participants (bimonthly)	
Compulsory Counselling and Voluntary Testing (CCVT)	350 employees received counselling # of employees tested			

Other possible data items include the following:

- Data collection methods
- Next steps
- Indicators for both outputs and outcomes

4.8. SUPPORTING AN M&E PLAN AND SYSTEM

As you complete an indicator and target table such as this, it will become clear that you need to design forms, spreadsheets, databases, filing systems, and protocols to collect these monitoring records, log sheets, reports, invoice capture, and tracking forms. A system of simple, convenient data capture and processing for each activity is the essential ingredient of a monitoring system.

The challenge will be how you (a) ensure that the information reaches those responsible for accountability for the project, while (b) being useful to those who are implementing, and (c) without occupying a disproportionate amount of time which could be spent in operating the programme. In designing your M&E plan, try to ensure that it is streamlined into your project activities. Ideally, most of your monitoring information should be generated through normal project processes. M&E should not become a separate burden and a costly line item in terms of either time or effort, although you should be prepared to justify the necessary expense of collating, reporting, and responding through M&E.

4.9. FEEDBACK TO YOUR PROJECT PLAN

No plan is stagnant. A plan is a process that moves closer to its target through review and revision with the benefit of experience. The mechanisms for improving your plan through monitoring need to be built into the plan itself.

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APPENDICES

6.1. APPENDIX I. MINIMUM STANDARDS, GUIDELINES, OR OPTIONS FOR INDICATORS

6.1.1. POLICY DEVELOPMENT

- How many training sessions have been held for policy development and how many employees attended?
- How many networks and committees have been formed?
- How many policy advocacy tools have been developed and disseminated?
- How many advocacy activities have been carried out and how many employees were reached?
- How many unions have been involved in the advocacy efforts?
- How many policy and advocacy strategies and guidelines have been developed?

6.1.2. PROGRAMMES

Condom distribution

- How many female condoms have been distributed?
- How many male condoms have been distributed?

Capacity Building

- How many training sessions were held to build capacity for employees and how many were reached?
- How many organizations/departments have been worked with to strengthen the directorate/function?
- How many proposals have been developed and how many projects have been designed?
- How many technical assistance activities have been received [TYPES] and who has received the TA?

Sexually Transmitted Infections

- How many employees were referred for STI diagnosis and treated?
- How many service providers have been formally engaged in partnerships? List.
- How many employees have been served [by gender]?
- How many clinics and hospitals [government and private owned] that provides the services

Behaviour Change Communication (education and awareness-raising campaigns for prevention)

- How many BCC events for employees were held?
- How many training sessions on the BCC approach were held and how many employees were reached?
- How many peer education training sessions were held and how many peer education groups [by gender] trained?
- How many employees were reached in any way?
- How many studies/assessments were conducted?

VCT

- How many employees have been trained as lay counsellors??
- How many employees [by gender and age] visit the VCT sites?
- How many employees [by gender and age] were tested?
- How many employees [by gender and age] received their test results?
- How many new VCT sites have been established?
- How much does it cost the department to provide VCT for an employee?

Antiretroviral Therapy

- How many clinicians have been trained in ART management?
- How many employees are receiving ART?
- What percentage of the employees receiving ART is adhering to treatment at the 95% level?

6.2. APPENDIX 2. A SELECTION OF M&E SAMPLE FRAMEWORKS

6.2.1. CONDOM DISTRIBUTION [MALE AND FEMALE]

Problem Statement (or situation analysis):								
Goal:								
Objectives:								
Frameworks completed and agreed upon:	Conceptual							
	Results							
	Logical							
Activity/Item	Output Indicator	Outcome Indicator	Timeframe	Responsible Person	Data Sources	Frequency of Data collection	Data Collection Methods	Next Steps

6.2.2. COMPULSORY COUNSELLING AND VOLUNTARY TESTING M&E TOOL

Problem Statement (or situation analysis):								
Goal:								
Objectives:								
Frameworks completed and agreed:	Conceptual							
	Results							
	Logical							
Activity/Item	Output Indicator	Outcome Indicator	Timeframe	Responsible Person	Data Sources	Frequency of Data collection	Data Collection Methods	Next Steps

6.2.3. CAPACITY BUILDING M&E TOOL

Problem Statement (or situation analysis):								
Goal:								
Objectives:								
Frameworks completed and agreed:	Conceptual							
	Results							
	Logical							
Activity/Item	Output Indicator	Outcome Indicator	Timeframe	Responsible Person	Data Sources	Frequency of Data collection	Data Collection Methods	Next Steps

6.2.4. POLICY DEVELOPMENT M&E TOOL

Problem Statement (or situation analysis):								
Goal:								
Objectives:								
Frameworks completed and agreed upon:	Conceptual							
	Results							
	Logical							
	Did a committee develop the policy?	Were all sections/ functions of the department represented?	How many unions were involved in the development of the policy?	# of participants from the department	# of participant from other partners/ unions.	# of Senior Managers involved in the development of the policy.	Method[s] used in the development of the policy.	Next Steps
DRAFT POLICY								
POLICY DOCUMENT								

**Health Policy Initiative, 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
<http://www.healthpolicyinitiative.com>